The Comprehensive Course on Physician Hiring (Part 2)

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Financial Disclosure

I have the following financial interests or relationships to disclose:

- Shareholder and employee of BSM Consulting.

Session Topics

- Use of Professional Advisers
- The Employment Offer
- Typical Contract Terms
- Co-Ownership

Part 1 of this course discussed feasibility analysis, recruitment, selection and transition processes for a new associate.
Use of Professional Advisers

- Options
  - Attorneys
  - Consultants
  - Accountants
- Managing Costs
- Role in Decision-Making

Always use qualified counsel when entering into any legally binding document.

The Employment Offer

- Verbal Offer
- Letter of Intent/Offer Letter
- Formal Contracts

Typical Contract Terms

Employment Length
- Usually One to Three Years
- Automatic Renewal

Check the handout resource for a summary of typical provisions.
## Typical Contract Terms

### Requirements of Employed Physician

- Usually Exclusive/Full-Time
- Exceptions for Outside Activity
- Board Eligibility/Certification
- Equitability of Duties

### Requirements of Employer

- Staff
- Space
- Supplies
- Equipment

### Base Compensation

**Typical Ranges/Newly Trained Ophthalmologists**

- Comprehensive: $120k to $150k
- Pediatrics: $120k to $160k
- Cornea/Glaucoma/Neuro-Op: $150k to $175k
- Refractive (exclusive focus): $175k to $225k
- Oculoplastics (exclusive focus): $175k to $225k
- Vitreo-Retinal (exclusive focus): $175k to $350k

Terms may vary depending on geographic area and practice circumstances.
Typical Contract Terms

Base Compensation

- Typical Ranges/Experienced Ophthalmologists
  - Comprehensive + $25k to $50k
  - Subspecialties per Negotiation

Terms will reflect levels needed to attract physicians with higher standards of living compared to residents/fellows.

Incentive-Based Compensation

- Typical Structures:
  - Percentage Above Threshold (comprehensive usually at 25-30% > 3x base)
  - Greater of Percentage or Guarantee
  - Performance-Based
  - Discretionary

Avoid overcompensation that reduces/eliminates incentives for co-ownership.

- Access to Source Documents

Avoid overcompensation that reduces/eliminates incentives for co-ownership.
Typical Contract Terms

**Retirement Plan/401(k) Profit Sharing Plan/Section 125 Plan**
- Per Plan Requirements
- Absence of Benefit as Offset to Compensation

Check the handout resource for a summary of typical provisions.

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Typical Contract Terms

**Insurance Benefits**
- Per Plan Requirements
- Absence of Benefit as Offset to Compensation
- Practice-Paid Medical for Physician/Dependent Negotiable
- Group Life/Disability

Check the handout resource for a summary of typical provisions.

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Typical Contract Terms

**Professional Liability Insurance**
- Same Limits/Carrier
- Prior Acts Coverage
- Occurrence vs. Claims-Made
  - “Tail” Premium Costs upon Termination
  - Typical Provisions

Check the handout resource for a summary of typical provisions.
Typical Contract Terms

**Relocation Allowance/Signing Bonus**
- Relocation at $5,000 to $10,000 with receipts
- Repayable upon Year 1 Termination
- Sometimes paid as Bonus in Lieu of Relocation
- Bonuses otherwise unusual in Ophthalmology

Typical Contract Terms

**Professional Expenses**
- Practice Typically Covers:
  - CME at $3,000 per year with receipts
  - State License/DEA Registration
  - Hospital/ASC Dues
  - Society Dues with prior approval
  - Cell Phone
  - Mileage at IRS rates (excluding commuting)

Typical Contract Terms

**Leave Allowances**
- Vacation/Personal at Three Weeks
- CME at One Week
- Sick Leave/Holidays per Policy
- Unpaid Disability at 90 Days

As a general rule, practices should cover those reasonable costs incurred by the associate to provide services under the contract.

State and federal law may impose additional requirements regarding leave.
**Typical Contract Terms**

**Termination**
- Without Cause with 60- to 90-Day Written Notice:
- With-Cause Due to:
  - Death/Disability
  - Loss of Licensure/Privileges/Malpractice Coverage
  - Sanction by Medicare/Other Payers
  - Gross Negligence
  - Felony Arrest

For-cause events should be defined within the formal contract by legal counsel.

Check the handout resource for a summary of typical provisions.

**Restrictive Covenants**
- Competition/Solicitation/Interference
- Defined by Area/Time
- Determined by State Law

 Exceptions:
- Liquidated Damages
- Public Policy
- “Red Pencil”

Restrictive covenants require assistance by qualified legal counsel.

Check the handout resource for a summary of typical provisions.

**Co-Ownership**
- Key Issues:
  - Timeframe for Offer
  - Percentage of Ownership
  - Method for Pricing
  - Payment Terms
  - Income Allocation
  - Redemption of Shares

Co-ownership is based on mutual consent and is not binding, therefore buy-in terms are usually summarized in a separate letter/memorandum rather than within the employment agreement.

Check the handout resource for an article describing typical provisions.
Co-Ownership

- Other Entities
  - Optical Dispensary
  - ASC
  - Real Estate

Negotiation

- Maintain Flexibility and Perspective
- Set Limits and Be Firm
- Maximize Leverage through Alternatives/Deadlines
- Control your Advisers
- Keep Sight of the Greater Good

The negotiation process can often provide useful windows into the future working relationship.

Questions?

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Please be sure to complete a course evaluation.
Key Contract Provisions for Full-Time Ophthalmologists in Private Practice Settings

The outline below is designed to describe typical terms found in many contracts but the points should not be viewed as recommendations or as necessarily appropriate for your practice’s specific circumstances.

Contract terms and preparation of a formal employment agreement should always be determined in concert with qualified legal counsel. Do not attempt to construct any binding legal agreement without appropriate professional advice.

Employment Term
- Typically one to three years.
- Renewal opportunity typically based on mutual agreement.

Requirements of Employee
- Usually requires exclusive, full-time employment.
- Exceptions often made if outside activity is not competitive and does not interfere with duties to practice (for example, teaching/lectures, writing, expert-witness testimony, etc.), allowing associate to keep resultant income.
- Usually requires board eligibility/certification.
- Typically includes equitable share of call coverage.
- Work schedules, duties, assigned office locations, patient mix, case mix will normally be similar to those of other physicians unless agreed otherwise.

Requirements of Employer
- Agrees to provide adequate staff, supplies, equipment and space.

Compensation
- Usually comprises combination of guaranteed base salary plus incentive-based compensation.
- Base compensation for subspecialists typically higher than comprehensive specialists but dependent more on nature of services provided than subspecialty held.
- Regional variations arise depending on supply/demand of positions in local market.
- Experienced physicians usually command higher base compensation but incentive-based compensation similar to less-experienced physicians.
- Incentive-based compensation usually computed annually and set at fixed percentage of gross profit (i.e., collections less refunds and costs of goods) exceeding a defined threshold.
- Associate normally will have right to review calculations and source documents used to determine incentive-based compensation.

Compensation structures for potential co-owners should not be so generous as to create a reduction in compensation upon co-ownership, thus removing much of the incentive for the associate to proceed toward co-ownership. In most instances, compensation as a co-owner net of buy-in payments should be proximal to or greater than levels enjoyed as an associate, all other things being equal.
Retirement Plan
- Eligibility per plan requirements, contributions paid by practice per plan requirements.

Insurance Benefits
- Practice-paid medical insurance (and dental, if available).
- Dependent coverage negotiable, sometimes paid by practice.
- Professional liability insurance at same coverage levels and with same carrier used for other practice physicians (tail coverage negotiable but usually paid by employee).
- Group life and disability insurance if provided to other employees.

Relocation Benefit
- Benefit negotiable but usually provided as a maximum allowance subject to lowest of three competitive bids.
- Some contracts may require repayment upon termination during the first year of employment.
- Equivalent amount often paid as signing bonus in lieu of allowance if associate not required to relocate, otherwise signing bonuses in ophthalmology are unusual.

Professional Expenses
- CME at a maximum allowance per year, proximal to costs of one major meeting and mutually approved local meetings.
- Licenses, DEA registration, hospital/ASC dues, IPA fees, society dues, journal subscriptions, cell phone usually paid by practice.
- Mileage reimbursement between facilities per IRS rate (excluding nondeductible segments that include the associate’s home).
- Board exam fees negotiable, sometimes paid by practice.
- Other business expenses, such as travel and entertainment, are sometimes reimbursed by the practice subject to prior approval and appropriate documentation.

Leave
- Vacation at three weeks during first year, sometimes with additional week during second year.
- Education leave at one week per year.
- Sick leave usually subject to practice policy for other employees.
- Holidays per practice policy (associate may need to assume equitable share of call).
- State and federal law may impose additional requirements for family-related leave and state law may require payment for unused vacation upon termination.

Termination
- For-cause termination without notice per defined definitions (including but not limited to breach, loss of licensure, gross negligence, inability to be insured for malpractice, loss of hospital privileges, sanction by Medicare or other payer, felony arrest, among other conditions).
- Certain for-cause conditions may be accompanied by notice-and-cure provisions allowing party to address the alleged deficiency and forestall termination.
- Without-cause termination subject to 60- to 90-day written notice.
Restrictive Covenant
- Included if enforceable in local jurisdiction, generally includes non-solicitation and non-interference language.
- Restricted area usually described as mileage-based radius encompassing 75 to 80 percent of patient service area, typically enforceable for one to three years.
- Sometimes waived in exchange for liquidated damages (must be compensatory and not punitive), paid by employee at amount usually equal to one-year’s compensation plus benefits.
- Enforceability determined by state law and requires expert guidance by legal counsel.

Future Co-Ownership
- Contract may briefly reference intent of parties toward co-ownership subject to mutual consent.
- Details usually found in separate non-binding memorandum or letter of understanding.
- Practice should be able to address key issues such as timing, percentage of co-ownership, method of determining price, expected payment terms, income allocation formula for co-owners, and method for redemption upon buyout.
- Provisions for co-ownership within affiliated entities such as dispensaries and ASCs should be addressed; co-ownership is usually made available simultaneous to practice offer.
- Co-ownership within real estate partnerships often optional, provided practice executes fair-market-based lease with partnership.
Essential Elements of Co-Ownership in a Private Practice

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In most cases, an associate who joins a private practice will be eligible for co-ownership at some point. The term “co-ownership” means becoming a “partner” if the practice’s legal form is a partnership, becoming a “shareholder” if the practice is a corporation (“PC”), or becoming a “member” if the practice is a limited liability company (“LLC”) or limited liability professional corporation (“LLPC”). This article explains the principal terms involved in most such transactions.

The Timeframe for Eligibility
The majority of physicians hired by a private practice will become co-owners in some manner, although some positions will not entail a co-ownership track at all. In almost all instances involving co-ownership, a new associate will join a practice as an employed physician for a one- to three-year term before becoming eligible for co-ownership.

This employment term is critical for several reasons. It allows the associate to establish a viable practice from a financial standpoint, allowing the purchase of an ownership share to be financially feasible. It also allows both the associate and the practice to assess compatibility in terms of personality, work ethic, practice philosophy, quality of care, and those other intangibles that define the success of a professional relationship. The employment period also recognizes the reality that not all relationships work as well as initially hoped, allowing the parties the relatively easier option of terminating an employment relationship compared to the complexity of severing a co-ownership relationship.

If the co-ownership offer extends beyond three years, various reductions to the buy-in price may be appropriate. Such adjustments may reflect some measure of the foregone income an employed physician commonly forfeits during the extended employment term compared to the higher compensation available to a co-owner. Adjustment also may recognize the personal goodwill established by the employed physician over this extended period, making that individual less reliant on the practice’s goodwill for referrals and patient volume.

The Percentage Share of Ownership
In most cases, a new co-owner will receive a co-ownership share no less than the percentage share held by any other co-owner. For instance, an associate joining a solo practitioner will typically hold an equal 50-percent share of the practice, while an associate joining an extant three-person group will often hold a 25 percent share in concert with the three other co-owners.

The full voting rights attached to the percentage of co-ownership should be available immediately to the new co-owner upon closing and are not withheld subject to the buy-in price being fully paid. Admittedly, this provision can sometimes seem uncomfortable to a solo practitioner adding a second co-owner, given the possibility of impasse and diluted control. Accordingly, equal co-ownership in a two-physician group is often accompanied by certain senior owner rights including a unilateral redemption option (i.e., the senior owner can buy out the new owner at any time) and the senior owner’s rights to sole ownership of the practice name, location, telephone number, website address, etc., upon departure of
the new owner for any reason. Such protections usually expire upon conclusion of the buy-in term and assume the parties have established an effective enough working relationship to render such provisions unnecessary at that point.

In some cases, staged co-ownership options may be offered, allowing the new co-owner to gradually accumulate sufficient shares leading to a full co-ownership position. For example, a prospective fourth co-owner might be provided options to acquire a 5-percent annual share in each year over a five-year term, leading to a full 25-percent co-ownership interest if all options are exercised. This approach can often prove helpful if the new co-owner cannot afford a full buy-in upon initial eligibility for co-ownership, or is unsure whether a full share is desired. Voting rights would be tied to the percentage of shares associated with cumulative options purchased by the new co-owner, i.e., if three 5-percent options have been exercised, the voting rights at that time would be 15 percent.

Minority shares, defined as a percentage of co-ownership less than that held by any other co-owner, are offered in some practices as a means of providing the stability and security of co-ownership while allowing the senior owner(s) to maintain a majority of voting rights. Minority co-ownership may be appropriate where the founder wishes to maintain a controlling interest, or where the new co-owner has minimal or no interest in practice management, or where the associate’s personal productivity level is insufficient to warrant a full share. A minority interest also may be appropriate or for part-time physicians or for non-MDs, subject to state board of medicine restrictions. Pricing of minority shares is usually discounted compared to full shares due to the lesser inherent value of shares having lesser voting authority. Minority co-owners are not necessarily compensated in the same manner as full co-owners and may be exempt from the co-owners’ income distribution formula altogether.

The Buy-In Price

Ideally, the price charged to a new co-owner will be proximal to the value of the share being purchased. Confirming this aspect requires valuation of the practice and allocation of the various aspects of value to the individual who is buying in. That allocation depends on the individual’s co-ownership percentage, the individual’s projected share of the co-owners’ distributable net income, and the manner in which co-owners allocate such net income.

The primary components of value in most practices are:

1. **Adjusted Net Equity**: This is defined as everything the practice owns less what it owes as expressed on the balance sheet. Net equity includes assets such as cash, debts that others owe to the practice, equipment and improvements, along with liabilities including debts owed by the practice to lenders and others. Adjustments are made to exclude receivables and any capitalized intangibles, both of which are computed separately in the valuation analysis. Adjustment is also applied to equipment and improvements, increasing the tax-based value of these assets to fair market value instead.

   Adjusted net equity is often used as the basis for computing stock value in a corporation or for computing the capital share within a partnership or LLC. Equity is allocated to the individual share based on the percentage of ownership being acquired. Thus, a new 25-percent co-owner should expect to pay 25 percent of the practice’s net equity value as part of the buy-in.
2. **Collectable Accounts Receivable:** Receivables represent the value of services provided by the practice for which payment has not yet been received. In the context of a new co-owner, these are the monies that will fund compensation during first few months of co-ownership.\(^1\) Valuation begins with the gross receivables amount reduced by amounts deemed uncollectable due to excess age or other factors, if applicable.\(^2\) That resulting balance is then adjusted to reflect contractual allowances, discounts, and other adjustments. The percentage of historical collections as a percentage of gross charges is usually suitable for this adjustment. For example, if the practice billed $1,000,000 and collected $600,000 in a given period, the collectable receivables (after adjustment for excess aging) would be proximal to 60 percent of the gross receivables balance.

Receivables are usually allocated based on the new co-owner’s projected access to those funds as compensation. Accordingly, if the individual were projected to receive 20 percent of the practice’s distributable net income, that same percentage would typically be applied to the total practice receivables value for determination of buy-in pricing. However, where expense allocations are used to determine physician compensation, the individual co-owner’s adjusted receivables balance may be applied as the buy-in price instead.

3. **Intangible Assets:** Intangibles are described in different ways, whether as “goodwill,” “going concern value,” or “blue sky.” In essence, these terms describe the value of a practice having an established presence in the market encompassing its patient base, referral provider relationships, administrative infrastructure, and other aspects that would typically be difficult or time-consuming to replicate in a *de novo* practice. The value of intangibles can be determined as a percentage of the practice’s historical gross revenue compared to actual sales of other practices, which will vary among specialties. Alternately, intangibles can be measured as a multiple of the practice’s historical annual profitability, focusing on the incremental compensation available to a co-owner compared to the compensation available to a non-owner, all other things being equal. Not all practices have demonstrable goodwill value and not all situations will call for its inclusion as part of a buy-in.

Intangibles are usually allocated in the same manner as receivables, based on the new co-owner’s projected share of practice net income. Again, if the individual were projected to receive a 20 percent share of that net income, the intangibles pricing would usually be proximal to 20 percent of the practice’s total intangibles value.

The vast majority of practice buy-ins will utilize some variation of this valuation method. However, co-ownership of affiliated entities such as surgery centers, imaging centers, retail dispensaries, spas, and other ventures may be valued using different methods. For example, surgery centers often are valued

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\(^1\) Some buy-in plans will exclude receivables, paying those collections to the senior co-owner(s) instead. While this reduces the cost of the buy-in, exclusion can skew results of a productivity-based income distribution system during the new co-owner’s first year and create cash flow challenges for the practice since such funds are not being paid into the practice itself. In most cases, receivables should be included as part of the buy-in.

\(^2\) Uncollectable receivables are usually defined as (a) amounts more than 120 days old exceeding 20 percent of the total receivables balance, or (b) amounts exceeding 60 days’ gross charges, whichever is greater.
based solely on a multiple of “excess earnings,” essentially profits, reflecting the valuation approach common to the publicly traded companies that often purchase such facilities. Start-up ventures lacking historical data may be valued using discounted cash flow analysis, which projects future performance and computes the current value of those subsequent profits. Neither of these approaches is ideal for computing the price of a practice buy-in but can be acceptable in these other contexts.

Terms of Buy-In Payment
Most buy-ins will be financed internally by the practice, usually over a five-year term. Rarely, the new co-owner will be required to obtain outside financing from a lender and pay the entire buy-in amount at closing. Since this route entails higher tax and interest costs for the buyer, the buy-in price is normally discounted in these circumstances to partially or fully offset such costs.

The amount attributable to stock (corporation) or capital (partnership/LLC) must be paid on a post-tax basis in accordance with Internal Revenue Service regulations. The allocation of total price between stock/capital and receivables/intangibles can usually be approached with a degree of flexibility and should be determined in consultation with qualified tax advisors. Typically, the buy-in amount attributable to stock/capital will be paid in equal monthly installments and include interest proximal to the prime rate.

The buy-in attributable to receivables and intangibles is often paid through an internal redistribution of income to the senior co-owner(s). As such, a portion of compensation otherwise payable to the new co-owner under the income distribution formula is shifted to the senior co-owner(s) instead. For the new co-owner, such transfer allows consideration for the buy-in without creating a taxable event. Meanwhile, the senior co-owner(s) is taxed on such amounts at their incremental rate of personal income tax. In most cases, the majority of the total buy-in will be accommodated through a redistribution, which places most of the tax burden on the senior co-owner(s). This follows the concept that a recipient of income is responsible to pay taxes on the amount received, and recognizes that many buy-ins would become unaffordable for a new co-owner if the full tax costs of the transaction were assigned to that new co-owner. This approach creates an equitable allocation of tax costs and benefits, which is a vital component of any buy-in structure.

The receivables/intangibles amount may be fixed or variable. If fixed, a set amount is determined as the buy-in price for those aspects and simply amortized monthly as a redistribution of income over the usual five-year buy-in period. A fixed amount (also known as the “exact method” of buy-in) is sometimes preferable due to the certainty of knowing the absolute amount to be paid. However, if the projections used to establish the buy-in price prove inaccurate, that approach creates a risk of overpayment or underpayment for both parties relative to value. Also note that current tax law tends to discourage use of the “exact” approach in professional corporations. Regardless, many practices use a variable approach that defines the redistribution amount as a percentage of compensation otherwise payable to the new co-owner during the five-year buy-in period. This percentage-based approach (also known as the “inexact method”), effectively mitigates much of the overpayment/underpayment risk for both parties. ³ If the new co-owner’s compensation proves higher than projected, the receivables/intangibles

³ These percentages typically decline over each year. For example, 30 percent of the new co-owner’s otherwise receivable compensation might be redistributed in the first year of buy-in to the senior co-owners, then 25, 20, 15 and 10 percent in each year thereafter, culminating upon conclusion of the fifth year. But if initial years’ cash flow
buy-in increases to reflect that greater value. Contrariwise, if compensation is lower than projected, the receivables/intangibles buy-in decreases accordingly. The net result is fair for both parties and reduces problems associated with inaccurate projections.

The Income Distribution Formula
The basic proposition for a new co-owner is the availability of higher compensation due to co-ownership, even net of buy-in payments, compared to compensation as an employed associate. In effect, investment in the practice “business” should logically produce an immediate and positive return on the co-ownership investment.

Compensation to co-owners is determined by the income distribution formula, defining the way in which distributable net income (or “profit”) is allocated. Formulas in most physician specialties are based primarily on individual productivity, which can prove troublesome for a new co-owner still in the process of establishing a financially viable practice. Some formulas buffer this effect by allocating a portion of distributable net income equally. As a rule, equal allocations of net income tend to favor lower producers compared to a productivity-only formula, often working to the advantage of many younger co-owners. Other formulas are based on cost allocations where each individual assumes responsibility for shares of fixed and variable expenses. These formulas can be daunting for a younger co-owner whose revenue may be insufficient to cover assigned costs. As a rule, equal allocations of expenses work to the disadvantage of a lower producer compared to productivity-based expense allocations.

Whatever method is used should consider the effects on newer co-owners and ensure buy-ins will be feasible. This issue obviously affects the allocation of receivables/intangibles value and the personal cash flow of the new co-owner. But it also affects future practice recruitment: Prospective associates will likely be repelled by a buy-in obligation that leaves them with limited income for years after becoming a co-owner. And the inability to recruit affects the eventual buyouts of the senior co-owners. All of these factors must be tied together for the income distribution and buy-in structures to work effectively for the practice.

Redemption of Practice Shares
The buyout provisions for practice shares are an integral part of the buy-in transaction. These define how the new co-owner’s share would be redeemed upon termination and also outline the extent of that co-owner’s responsibility for buying out other co-owners.

Buyouts rest on the premise that the departing co-owner is leaving something of value to the remaining co-owner(s). In regard to net equity, that co-owner is selling their ownership share in cash, equipment, and other assets while being relieved of their share of debts and other obligations. That aspect of the buyout should reflect such changes. Buyout of receivables reflects the value of work produced within

for the new co-owner is projected to be insufficient to support this schedule, a flat-line 20 percent per year might be applied instead (20/20/20/20/20). As the rule, the sum of these percentages should not exceed 100 and should be based on comparison of the allocated receivables/intangibles share and the amount projected to be paid by the new co-owner. In many cases, receivables/intangibles value will prove insufficient to support a sum of percentages as high as 100, thus lesser percentages such as 25/15/10/10/10 or some other variation will be applied as appropriate.
the practice for which payment will be received after the co-owner leaves. Rather than providing the surviving co-owner(s) with a windfall, most buyouts will require those survivors to pay the departing co-owner for their share of that asset. Intangible value in a buyout implies that the revenue stream and profits of the departing co-owner will be maintained by the survivors for their benefit as successors to the departing co-owner. If the survivors are unable to do so due to capacity limits or differences in training or expertise, or if departure of the individual is attributable to actions that materially harm the practice (such as termination for cause, termination with inadequate prior notice, termination followed by competitive practice, etc.), a buyout for intangibles may be limited or eliminated.

In most cases, the approach to valuation of buyouts should be similar to that used for buy-ins. This follows the premise that the value of a given percentage co-ownership share will be consistent regardless of whether an individual is entering or leaving co-ownership. Some buyouts are backloaded, meaning that a departing co-owner receives a buyout payment greater than the buy-in price or actual value, perhaps based on a stipulated amount or formula dissociated from value. Such provisions are inherently inequitable and should be avoided.

Under current tax law, the buyout amount must be fixed as a specified amount at the time of departure rather than based on some function of revenue or profits derived by the survivor(s). The net equity share is commonly paid in monthly or annual installments over a five-year term with interest, commonly taxed to the departed co-owner as a capital gain. Consideration for receivables and intangibles is usually categorized as deferred compensation and paid to the departing co-owner in monthly or annual installments over a five-year term without interest, taxed as ordinary income.4

Although buyouts cannot include contingent formulas based on future practice performance, the surviving co-owner(s) can be protected by instituting a maximum cap on buyout payments, often based on such payments constituting no more than 5 percent of the practice’s annual revenue. Any buyout amounts foregone as a result the payment cap would be extended into subsequent years until the buyout obligation is paid by the practice in full. Such provisions do not reduce the buyout obligation but do provide appropriate protection from cash flow problems associated with extensive buyout payments within a given year.

The Process for Developing Buy-In Terms

Assessment of co-ownership terms requires the assistance of qualified financial, tax, and legal advisors. Typically, the practice will develop proposed co-ownership terms to include the aspects cited above. These terms are presented to the prospective co-owner for review and evaluation with his/her advisors. A counterproposal from the prospective co-owner usually follows. Some degree of negotiation and compromise should be anticipated by both sides as a natural part of the process.

Ideally, the parties should seek for a fair and equitable arrangement rather than insisting on their best possible deal. Striving for fairness enhances prospects for a successful long-term relationship, allowing the physicians to proceed as co-owners in a positive manner that serves their personal and professional interests, as well as the best interests of their patients.

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4 Under current tax law, payments for deferred compensation cannot begin until after the departing co-owner’s complete separation from the practice, including any post-buyout employment period.