ACQUISITION OF PHYSICIAN PRACTICES
ISSUE ANALYSIS 95-1

ACQUISITION OF PHYSICIAN PRACTICES

This is the first Issue Analysis of the Healthcare Financial Management Association's Principles and Practices (P&P) Board. An Issue Analysis is written in response to the need for practical information on emerging issues in healthcare financial management. To provide the healthcare industry short-term assistance on emerging issues, the P&P Board will prepare an Issue Analysis. In order to expedite information to the industry, an Issue Analysis is not sent out for public comment. The purpose of Issue Analysis 95-1, Acquisition of Physician Practices, is to provide practical guidance to assist healthcare financial managers who are involved in the acquisition of physician practices and to assist physicians/owners interested in selling their practices. This P&P Board document does not address accounting principles or financial reporting issues related to these acquisitions.

1. BACKGROUND

Most healthcare organizations were initially formed as single operating entities. Many healthcare entities now seek to create integrated healthcare systems such as physician hospital organizations, medical group practices, and fully integrated healthcare systems through the acquisition of physician practices and, possibly, a payer component.

The transition to managed care and capitation, with its related assumption of risk, has changed the nature of many healthcare providers from revenue centers to cost centers. Revenue for an integrated healthcare system is increasingly being generated through the payment of a fixed amount per member per month for each covered life. The focus is now on the provision of preventive healthcare services to ensure the future good health of these covered lives. The provision of inpatient services, professional care,
outpatient services, and long-term care has become a cost to the system. Within a fully integrated healthcare system, a referral by a physician to another provider of care may be detrimental to the financial health of the healthcare system. This concentration on clinical pertinence and appropriateness of care requires significant physician input and support within the integrated delivery system. This change in focus may result in salaried physicians and/or the acquisition of physician practices.

There is a myriad of federal and state laws and regulations which affect the ability of a healthcare entity to acquire physician practices. These include state law prohibitions on the corporate practice of medicine, state medical practices acts, state health planning regulations, state licensing requirements, federal and state fraud and abuse and self-referral laws, and for tax-exempt entities, the prohibitions on inurement and private benefit. These laws have a significant effect on which healthcare entities can purchase physician practices, the assets of those practices that can be purchased, and how those purchases can be structured.

II. PURPOSE

Practical guidance related to the acquisition of physician practices as part of the development of an integrated delivery system is difficult to obtain. The lack of authoritative guidance on integrated delivery systems has caused considerable diversity in practice. The purpose, therefore, of this Principles and Practices (P&P) Board document is to provide practical guidance to assist healthcare financial managers who are involved in the acquisition of physician practices and to assist physicians/owners interested in selling their practices.

The Internal Revenue Service (IRS) and the Department of Health and Human Services’ Office of the Inspector General (OIG) are scrutinizing the formation of these integrated delivery systems with a focus on the acquisition of physician practices. This document should not be construed as legal advice. Legal guidance is well beyond the scope of this document. The use of experienced counsel from the outset of the acquisition of a physician practice will minimize potential risk with fraud and abuse issues. Accounting and financial reporting guidance on these issues is not addressed in this document.

III. DEVELOPMENT OF BOARD STRATEGY

The first step in the formation of an integrated delivery system is the development of an overall strategy. The purchaser’s board of directors must define its goals and should approve an overall plan and policy for physician practice acquisitions directly correlated to the development of its strategy for the formation of an integrated delivery system. It is important that healthcare entities understand the number, distribution, and location of the physicians they need to accomplish their overall objectives. This policy should describe the criteria that the board wishes to follow in the acquisition of medical practices, such as:

1. high quality and appropriateness of care
2. primary care orientation
3. strategic location in medically underserved areas
4. existence of managed care contracts
5. board certification and credentialing
6. community benefit
7. participation in the Medicare and Medicaid programs
8. formal free-care policy
9. open access policy

Utilizing board approved policies will establish a clear intent for any third party reviewing the implementation of the strategy. Each proposed acquisition should then be evaluated in light of these objective standards in a memorandum which indicates how the practice meets the goals of the purchaser’s board. If the purchaser is a not-for-profit healthcare entity, a fundamental standard should be the provision of high quality, cost-effective health care to all citizens of the community.

As part of the development of this strategy, it is imperative that the board be aware of the legal constraints involved in the formation of an integrated delivery system. This analysis outlines the current fraud and abuse, “anti-kickback,” and tax issues related to the acquisition of physician practices. However, the reader is advised to reference more recent guidance from the OIG and the IRS. Several states currently do not allow the corporate practice of medicine, and therefore, corporate structure is also a major consideration.
Where state law prohibits the corporate practice of medicine, generally hospitals and business or non-physician corporations (e.g., PHOs1 or MSOs2) cannot acquire all aspects of a physician's practice and employ the physicians. However, such an entity would likely be able to acquire the tangible or hard assets of a physician's practice and certain intangible or soft assets, such as technical know-how, but not necessarily physician practice goodwill or managed care contracts. In lieu of or in addition to corporate practice of medicine prohibitions, a state may have medical practices acts governing which types of entities can practice medicine and requiring that medical corporations consist entirely of physicians, but not excluding hospitals from employing physicians. Other states may merely have professional licensing statutes governing who can actually perform physician services, but not excluding a hospital or business corporation from employing physicians.

The IRS and the OIG have stated that they will carefully scrutinize physician practice acquisitions. The IRS is concerned that a not-for-profit healthcare entity may acquire a physician practice for more than its fair value and then create an inurement or private benefit problem, thus jeopardizing the tax-exempt status of the not-for-profit entity. The IRS also is concerned that the transactions not be in contravention of the Medicare and Medicaid fraud and abuse laws. The OIG is concerned that healthcare entities may acquire a physician practice for more than its fair value and that the additional amount might be seen as payment for the referral of patients.

IV. METHODS OF ACQUISITION

Physician practices can be acquired in a number of ways, including all cash transactions, cash and notes, and stock exchanges. If the entity seeking to purchase the practice can legally acquire the entire practice, all of these methods might be possible. However, the issuance of notes may raise financial relationship issues under federal and state self-referral laws, and the exchange of stock assumes that the entity exchanging the stock can own the physician practice.

1. A physician hospital organization (PHO) is an entity created by a hospital and a physician organization, or physicians and physician groups, to assist in managed care contracting on behalf of the parties.

2. A management service organization (MSO) is an organization which provides services to physicians and physician groups or to a hospital or hospitals. MSOs are sometimes called medical service organizations.

In many states PHOs and MSOs can own only hard assets and certain soft assets of physician practices. The remaining assets, such as physician practice goodwill and managed care contracts, might have to be owned directly by the physician group. Physician practices also might be purchased directly by non-profit foundations or by hospitals.

V. ASSESSMENT OF PHYSICIAN PRACTICES

A memorandum should be prepared for each proposed acquisition with an evaluation assessing how the practice meets the goals as defined in the board's strategy. More specifically, the following steps should be taken for each proposed acquisition. A detailed Medical Practice Acquisition Due Diligence Checklist is included in the Appendix as a reference.

A. Development of a Business Plan

The purchaser should develop a business plan for each practice acquisition. Due diligence on the physician's practice is a critical first step. Due diligence includes site visits and interviews with the physicians/owners to analyze fundamental business areas of the practice such as operations, physical facilities, market analysis, financial position (including assets to be acquired and liabilities assumed), regulatory position, and managed care contracts and limitations.

An appropriate business plan should also include financial projections. A detailed financial analysis should be performed on the practice's historical financial data. Analyses of the practice's profitability, growth, and productivity trends should be analyzed based on practice performance over the past three to five years. Comparisons to other physician practices and to industry averages are critical in order to assess the financial performance of the practice, so that the risks and earnings potential associated with a practice are measured. Financial projections should justify the salaries to be paid. Salaries should be appropriate and provide for an appropriate return on investment to the organization or other benefit to the organization.

B. Valuations

Valuations should support the reasonableness of the price paid for a physician practice and should be performed prior to settling on the pur-
purchase price. The IRS uses fair market value in most cases involving
physician practices. Fair market value is defined by the IRS as the price
at which a willing buyer and a willing seller would agree, neither being
under any compulsion to buy or sell, and both having reasonable knowl-
edge of the relevant facts.3 The IRS states that all assets acquired will be
at or below fair market value and will be the result of independent
appraisals and arm’s-length negotiations.

The IRS also asserts that intangibles are difficult to measure in terms of
real value and often are a likely place to inflate the valuation.4 While an
independent appraisal of to-be-acquired tangible, real, and personal
property must be completed, an independent appraisal of intangible
assets is highly recommended to document the fair market value of those
assets. “Goodwill” refers to the income that will be derived from the
patients who continue to patronize the practice. “Going concern” per-
tains to the ability of the practice to continue treating patients because
the office is physically in place and functional. The time the physician
intends to remain with the practice is a major factor in determining
goodwill. The appraiser should ensure, and specifically state, that the
valuation of intangibles is not based in any way upon the value of future
referrals to the purchasing entity.

A preliminary step in the valuation process involves determining the com-
ponents of assets and liabilities for valuation purposes. Asset components
include:

• Current assets—cash, accounts receivable, marketable securities,
  medical supplies, etc.
• Fixed assets—building, medical equipment, office furniture and
  equipment, etc.
• Intangible assets—goodwill, going concern, capitated contracts, trained
  workforce, medical records, practice parameters, software, favorable
  leases, employment agreements, non-compete agreements, etc.

Any liabilities to be assumed must also be determined. These include:

• Current liabilities and accruals—accounts payable, salaries payable,
  vacation pay, deferred compensation, accruals for pension costs, tax
  obligations, etc.

4. Continuing Professional Education, Exempt Organizations, Technical Instruction
Program for FY 1995, Department of the Treasury, Internal Revenue Service.

• Long term liabilities—notes payable, long-term debt, etc.
• Other liabilities—unfavorable leases, impending lawsuits, etc.

Historical financial performance data including gross and net revenues,
expenses, physician compensation, accounts receivable collection ratios,
accounts receivable days outstanding, employee expense ratio, and over-
head ratio should also be reviewed for valuation purposes.

A critical step in the valuation process is the performance of an inde-
pendent appraisal that details the market value of the assets acquired.
There are three commonly recognized approaches to valuation: the
income approach, the market approach, and the cost approach. The
Appendix includes descriptions of these three valuation methods. At
least two of these valuation calculations should be prepared, compared,
and reconciled as part of the appraisal process for the purchase of a
physician practice.

The purchaser should ensure that the assumptions used for financial
projections in the valuation process (physician salaries, etc.) are consist-
tent with operations after the acquisition of the physician practice.

C. Other Issues

1. Payer Risks
The effect of the acquisition on both the purchaser’s and the seller’s
managed care contracts should be evaluated. This should include
reviewing for exclusivity clauses in any existing contracts. The purchaser
should also determine whether the seller has been rejected previously
by any payers. The attractiveness of the physician practice to payers is a
significant fact in both the purchase, valuation, and achievement of the
overall board strategy.

2. Malpractice Insurance
The purchaser of a physician practice should review the historical mal-
practice coverage of the practice to determine the basis of coverage
(occurrence vs. claims made). This determination will inform the pur-
chasers of the required tail coverage that may need to be acquired. The
purchaser should also review the history of the malpractice claims of the
practice or its malpractice experience. Outstanding malpractice claims
should also be reviewed in detail.
3. Physician Remuneration

In order to continue a favorable relationship with the physician, the purchaser should assess the retirement plan during the planning stage of the acquisition. The retirement plan should be reviewed for adequacy of funding, outstanding accruals, and for reasonableness of continued benefits under this plan. The purchaser should communicate any potential changes in retirement benefits at an early stage in the physician practice acquisition process. Not-for-profit entities will not be able to continue most plans.

It is also imperative for the purchaser to assess the current physician benefits paid for by the practice for reasonableness. The purchaser should communicate any potential changes in benefits at an early stage in the physician practice acquisition process.

The purchaser's business plan for post-acquisition practice should address physician salaries. Corporate policy for salary ranges should be developed by an independent committee of the purchaser's board. Variations will exist from one contract to the next, but constructing some basic parameters that are consistent with corporate policy may avoid misunderstandings in the future. These salary standards should be based on the market in the local or regional area.\(^5\)

Physician compensation should not be tied to any volume of services, unless the services are personally performed by the physician. Any incentive compensation arrangement with a physician that is even partially based upon a percentage of gross or adjusted gross receipts should have a cap. Any bonuses called for in an employment contract should also have a ceiling. Each physician's total compensation package, including guaranteed salaries, incentive compensation, potential bonuses, and benefits, should be evaluated against corporate policy and the market in the local area. The purchaser should take care in establishing incentive compensation that does not motivate physicians to provide excessive services, particularly in a capitated environment. An incentive plan whereby a bonus pool is split among the physicians based on qualitative and quantitative data may create more appropriate physician incentives.

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5. Physician salary survey information and guidelines are available from groups such as the Medical Group Management Association, the American Association of Medical Colleges, and the American Medical Association. However, this data may not be specific to the purchaser's community and it may be two to three years trailing. The purchaser should ensure that salary data is current and specific to the community.

VI. OPERATIONAL ISSUES

A. Physician Practice Management Expertise

The personnel skills necessary for management of physician practices must be developed or obtained. Unique skill sets relative to billing, staffing, marketing, and other aspects of operating a profitable physician practice are necessary. An MSO within the existing corporate structure can be developed to maximize the profitability generated from these physician practices. Furthermore, such a structure can be used to explore opportunities to manage practices for physicians who may not be interested in being acquired but may wish to remove the burden of operating their practice on a day-to-day basis. This service creates substantial linkage with other physicians without the financial burden of acquisition.

B. Financing Methods

The purchase price of the physician's practice should be paid up-front or, if paid over time, should be guaranteed to the physician. Payment of the purchase price over time may raise an issue under Stark II.\(^6\) Stark II has an exception for an isolated financial transaction; however, representatives of the OIG have suggested that the payment of the purchase price over time could make the transaction fall outside of the parameters of this exception.

One means of financing the acquisition of a physician practice is for the seller to finance the purchase by entering into an installment sales transaction where the buyer agrees to pay for the practice over a period of time. To minimize IRS and OIG concerns, a note should be executed between the parties with a reasonable interest rate, properly scrutinized for a period of time not to exceed what a healthcare entity might obtain from a bank for such a loan, such as three to five years, and fully amortized. Healthcare entities need to be concerned that such financing is on a commercially reasonable basis so as not to cause any IRS or OIG con-

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cern. Another means of financing might include obtaining a loan from a
commercial bank or the issuance of bonds.

C. Physician Representation on Board

In January 1993, the IRS favorably determined the status of Friendly
Hills HealthCare Network which established a 20 percent "safe harbor"
for physician representation on the board of an integrated delivery system.
However, this is merely a "safe harbor" and not a specific legal limitation.
The IRS must evaluate operations of an integrated delivery system to see
if the physician presence on the board affects the charitable goals of the
organization. The integrated delivery system should have updated con-

lict-of-interest policies in place and ensure review of physician compensa-
tion packages by an independent committee of the board.

VII. IRS CONSIDERATIONS

The most current guidance available from the IRS is cited below. How-
ever, the IRS periodically releases Continuing Professional Education
manuals, private letter rulings, and general counsel memoranda, and the
reader is advised to reference these documents.

Tax-exempt status can be jeopardized if inurement, private benefit, or anti-
kickback issues are raised in the acquisition of a physician practice. The
purchase of a physician practice by a tax-exempt entity at more than fair
market value, the sale or rental of a practice by a tax-exempt entity at less
than fair market value, or an operating agreement resulting in physicians
receiving more than fair market value for their services can also jeopardize
tax-exempt status. In determining fair market value, the IRS has long rec-
ognized that payments by an exempt organization may include appropriate
amounts for goodwill and other intangibles. It appears to be generally
accepted by the IRS from its tax-exemption determination of not-for-profit
foundations that medical foundations and other tax-exempt entities can
purchase the goodwill associated with physician practices. However, to
obtain tax-exempt status, in addition to a small percentage of physician
insiders (e.g., 20 percent of the board of directors of the foundation), the
foundation generally must conduct some form of medical research and
education, participate in the Medicare and Medicaid programs, and, if the
foundation has a hospital ensure that its medical staff is open.

The IRS' Continuing Professional Education, Exempt Organizations,
Technical Instruction Program for FY 1995 (CPE manual) states that the
discounted cash flow method is the preferred method for calculating fair
market value. It further states that the discounted cash flow should be on
an "after-tax" basis. The CPE manual also recognizes the market
approach. The IRS has reluctantly recognized that if competitive bidding
is higher than the discounted cash flow, then that would establish a higher
"market" value. However, if "market" is elevated due to the value of
future referrals, the anti-kickback statute will still apply. The purchaser
should accumulate data to establish the "market," specifically excluding
the value of future referrals, and retain these contemporaneous records.

The IRS issued a proposed revenue ruling, "Tax Consequences of
Physician Recruitment Incentives Provided by Hospitals Described in
Section 501(c)(3) of the Internal Revenue Code," Announcement 95-25,
on April 3, 1995. This proposed revenue ruling addresses the question of
whether a hospital violates its tax-exemption requirements when it
provides incentives to recruit private practice physicians to join its non-
employee medical staff or to provide services on behalf of the hospital.
The ruling states that in order to meet the requirements of section
501(c)(3), a hospital or other tax-exempt healthcare organization must
provide recruitment incentives in a manner that does not violate the
organizational and operational tests of section 501(c)(3).

To demonstrate favorable recruitment incentive practices, the IRS con-
structed four very specific scenarios which do not jeopardize tax-exempt
status. However, the ruling states that "the addition of any facts or circum-
stances that are not specifically set forth in an example (or the deletion of
any facts or circumstances) may alter the outcome of the transaction
described in the example."

The IRS also sets forth a fifth scenario which violates the Medicare and
Medicaid Anti-kickback statute, thereby placing the entity's tax-exempt
status in jeopardy.

In each of the favorable scenarios, the recruiting hospital provided objec-
tive evidence demonstrating the need for the physician service being
recruited. In all of these scenarios, the hospital also used arm's-length
negotiations, had a written agreement setting forth specific incentives
which were approved by the Board of Directors, and reported any taxable
benefits to the IRS. The IRS also stated that incentives such as the pay-

ment of a bonus, the guarantee of a mortgage, the reimbursement of malpractice insurance, the provision of subsidized office space for a limited time, and reasonable private practice income guarantees are all considered to be incentives reasonably related to recruiting a physician within the context of the scenarios.

Fundamentally, the hospitals in the favorable scenarios did not violate their tax-exemption requirements because the transactions furthered charitable purposes, did not result in increment, did not result in the hospital serving a private rather than public purpose, and were lawful. The IRS is soliciting public comment on the proposed ruling until July 3, 1995.

VIII. OIG CONSIDERATIONS

The most current guidance available from the OIG is cited below. However, the OIG releases ongoing fraud alerts and the reader is advised to reference these documents.

Depending on the structure of the acquisition of the physician practice, both the seller and the buyer could be subject to significant risks under the Medicare and Medicaid anti-kickback statute. For a transaction to be illegal under the anti-kickback statute, payments must be made with the intent to induce referrals. The “safe harbor” regulations identify certain arrangements which are exempt from civil or criminal prosecution under the statute. The preamble to the safe harbor regulations states that when a hospital purchases a physician’s practice “in order to ensure the hospital of a steady stream of referrals,” it may result in the “very abuses the statute is designed to prevent.”

Stark II includes an exception for isolated financial transactions, such as a one-time sale of property or practice, if the amount of the remuneration is consistent with fair market value and does not take into account directly or indirectly the volume or value of any referrals by the referring physician. The sale of the physician practice must be pursuant to an agreement which would be commercially reasonable even if no referrals were made to the purchaser.

The safe harbor regulations include a limited exception for the purchase of a practice by another practitioner if the sale is completed within one year, and the selling practitioner will not be in a position to make referrals to the purchasing practitioner after one year from the date of the sale. There is also a safe harbor for payments made pursuant to a bona fide employment relationship, if at fair market value and not taking into account the value of any referrals.

D. McCarty Thornton, associate general counsel of the OIG, responded to an informal inquiry from T. J. Sullivan, technical assistant (Health Care Industries) of the IRS, regarding the application of the anti-kickback statute to certain types of situations involving the acquisition of physician practices. In this December 22, 1992, letter, Mr. Thornton stated that the OIG has “significant concerns” about physician practice acquisitions because frequently “hospitals seek to purchase physician practices as a means to retain existing referrals or to attract new referrals of patients to the hospital.” The letter rejected the traditional or common methods of economic valuation and specifically questioned any payment in excess of the fair market value of the hard assets of the physician practice. Mr. Thornton stated that the OIG would question specific items including payment for goodwill, the value of the ongoing business unit, covenants not to compete, exclusive dealing arrangements, patient lists, or patient records. The OIG notes that if the financial welfare of the physicians involved improves significantly after the acquisition, or if referral patterns, after the acquisition, show increasing “loyalty” to the buyer, that it is likely that one purpose of the acquisition was to offer remuneration for future referrals.

In April 1995, a decision by the 9th Circuit Court of Appeals may cause the government to meet a higher burden of proof that providers “knowingly and willfully” violated the Medicare anti-kickback statute. In The Hanlester Network v. Donna E. Shalala, Secretary of the Department of Health and Human Services, the first court challenge to the statute involving physician self-referral joint ventures, the government tried to exclude the network partners from the Medicare program as a result of the actions of the network’s vice president for marketing. The Court ruled that while the vice president had violated the statute, the govern-

8. 42 U.S.C. 1320a-7b
ment did not prove that the individual partners knew of her activities. Therefore, the individual partners should not be held accountable and excluded from the Medicare program. However, using the legal theory of vicarious liability, the Court agreed that the corporation was in violation of the statute.

The facts of Hanlester date back to the late 1980s. At that time, the OIG charged Hanlester and its partners with violating the anti-kickback statute by offering and paying remuneration to physician-investors to induce them to refer lab tests to Hanlester Network Laboratories and by soliciting and receiving payment in return for laboratory tests.

The government did not lose all of its arguments. The Court rejected Hanlester’s argument that the statute was vague and did not give “fair warning.” The government’s contention that the term “remuneration” broadened the reach of the statute and its definition of “to induce,” a key phrase in the statute, were also upheld. Finally, the Court upheld the government’s contention that the referral of program-related business did not have to be clearly articulated in the agreement for the agreement to be in violation of the statute.

IX. SUMMARY

The acquisition of a physician practice can be a vital first step in the creation of an integrated health network to provide efficient, low-cost, high-quality healthcare services to the healthcare provider’s community. It is a complicated initiative which requires a deliberative process comprised of development of a board strategy, assessment of the physician practice, evaluation of post-acquisition operational issues, and a thorough knowledge of legal and regulatory issues.

SELECT BIBLIOGRAPHY


APPENDIX

Medical Practice Acquisition
Due Diligence Checklist

The following is a sample due diligence checklist. These items are not intended to be all-inclusive.

Practice Name: ____________________________________________

Date Due Diligence Started: _________________________________

Date Due Diligence File Delivered to Finance: ___________________

Team Member
Responsible: __________________________Name/Phone #: __________

Coordinator of
Due Diligence File:

A. Financial:

B. Reimbursement/
   Medical Billing Issues:

C. Credentials/Clinical Review/
   Patient Demographics:

D. Personnel:

E. Practice Efficiency/
   Physical Layout:

F. Legal and Regulatory:

A. FINANCIAL

1. Perform analytical review of financial statements over the past three to five years and inquire as to major changes

2. Assess profitability, growth, and productivity trends and compare to other practices and industry averages

3. Test tracing of trial balance detail into financial statements

4. Trace/reconcile financial statements to tax returns

5. Review cash disbursements ledger (A/P postings) for selected periods

6. Review cash receipts journal (A/R postings) and trace to daily deposits

7. For selected sample, test tracing of patient charges from bills to A/R system

8. Review office bad debt/account adjustment policies and history of bad debt write-offs

9. Review payroll tax returns and examine tax payment cancelled checks

10. Review bank reconciliations for selected months

11. Vouch purchase documents for major items on fixed asset listing
Procedure | Assigned To/Due Date:
---|---
12. Inventory physical presence and condition of fixed assets (used as the basis for asset allocation during valuation process) |  
13. Confirm major receivables from Medicare, Medicaid, HMOs, PPOs and other third parties. Review appropriateness based on contract |  
14. Confirm loan balances (in excess of $10,000 each) and terms for debts to be assumed |  
15. Review equipment and real estate leases, obtain market comparable information and assess transferability |  
16. Perform search for unrecorded liabilities |  
17. Review adequacy of financial and patient accounting system and any related computer systems |  
18. Interview Medical Office Manager to assess if computer data is transferable to applicable software |  
19. Other special issues—list |  

B. REIMBURSEMENT/MEDICAL BILLING ISSUES:
Procedure | Assigned To/Due Date:
---|---
1. Review appropriateness of charge master and billing forms (Superbill) |  
2. Pull sample of three month's Explanation of Medical Benefits (EOMBs) from third party payers |  
3. Select appropriate sample of patient encounters from EOMBs and from selfpay patients |  
4. For selected encounters:
   a. Review appropriateness of diagnosis based on medical record |  
   b. Review for proper application of charge schedule |  
   c. Review reasonableness of lab and ancillary orders |  
   d. Review referrals made, appropriateness thereof |  
   e. Review payments received, appropriateness thereof |  
5. Based on sample above, document adequacy of medical records |  
6. Document known and proposed changes in reimbursement which will impact future physician revenues |
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<th>Procedure</th>
<th>Assigned To/Due Date:</th>
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<tr>
<td>7. Calculate accounts receivable collection ratios and days outstanding and compare to other practices and industry averages</td>
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<td>8. Review lab/ancillary facility certifications, as applicable</td>
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<td>9. Prepare file memo on work performed and conclusions drawn therefrom</td>
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**C. PROFESSIONAL CREDENTIALS/CLINICAL REVIEW/PATIENT DEMOGRAPHICS:**

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<tr>
<th>Procedure</th>
<th>Assigned To/Due Date:</th>
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<tbody>
<tr>
<td>1. Review Continuing Medical Education status for physicians</td>
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<td>2. Confirm current specialty board status of physicians</td>
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<td>3. Review physician record with respect to patient complaints to practice or available agencies or societies</td>
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<td>4. Select sample of patient charts and form opinion on overall compliance with medical record standards</td>
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<td>5. Gather patient demographic information including payment source, age, sex, and geographic dispersion</td>
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<td>6. Prepare file memo on work performed and conclusions drawn therefrom</td>
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**D. PERSONNEL:**

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<tr>
<th>Procedure</th>
<th>Assigned To/Due Date:</th>
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<tbody>
<tr>
<td>1. Review personnel listing and compare salary scales to other local facilities and buyer's criteria</td>
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<td>2. Gather history of physicians' salaries and compare to local and regional market and specialty standards</td>
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<tr>
<td>3. Interview selected personnel and determine compatibility of functions with buyer's other organizations</td>
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<tr>
<td>4. Review all employment contracts or &quot;special deals&quot;</td>
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<td>5. Review compatibility of employee benefits with other local facilities and buyer's criteria</td>
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<td>6. Review retirement plan for adequacy of funding, outstanding accruals, and for reasonableness of continued benefits under the plan</td>
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<td>7. Review vacation policy and accrued vacation list</td>
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<td>8. Other areas–list</td>
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<td>9. Prepare file memo on work performed and conclusions drawn therefrom</td>
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## E. PRACTICE EFFICIENCY/PHYSICAL LAYOUT

<table>
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<tr>
<th>Procedure</th>
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<tbody>
<tr>
<td>1. Visit practice site and assess overall condition and physical appearance of office and equipment</td>
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<td>2. Review adequacy and timeliness of office filing systems, both financial and patient records</td>
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<td>3. Review/assess office layout efficiency</td>
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<td>4. Assess room for practice expansion modification within current facility</td>
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<td>5. Estimate capital improvements/additions needed for next two years</td>
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<td>6. Prepare file memo on work performed, conclusions drawn, and note statement of how this practice fits into buyer's strategic plan</td>
<td></td>
</tr>
</tbody>
</table>

## F. LEGAL AND REGULATORY

### Procedure

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Assigned To/Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review corporate status</td>
<td></td>
</tr>
<tr>
<td>2. Run UCC search on practice, shareholders, spouses, etc.</td>
<td></td>
</tr>
<tr>
<td>3. Review lease obligations to be assumed</td>
<td></td>
</tr>
<tr>
<td>4. Review all loan documents for liabilities to be assumed</td>
<td></td>
</tr>
<tr>
<td>5. Review all managed care contracts for limitations and exclusivity clauses</td>
<td></td>
</tr>
</tbody>
</table>

### Business Valuation Methods

The following is a summary of the three generally accepted business valuation methods:

#### A. INCOME APPROACH

The income approach is the most commonly used approach for valuing physician practices. It incorporates the specific operating characteristics of the seller's business into cash flow analysis. The most common method of the income approach used for valuing medical practices is the
discounted cash flow method. A projection is made of the future cash flows of the practice, including projections for growth and also including residual values at the end of the projection period, and is adjusted to present value at a rate commensurate with risk.

The income approach recognizes that the value of a physician practice is equal to the present worth of the future benefits of ownership. The income approach quantifies the potential financial benefits of owning the physician's practice and encompasses three major components: estimated future cash flows, the discount rate, and the residual value.

Cash flow statements are developed for a projection period, typically for ten years following. This projection is based on data from prior years (preferably at least five years), then adjusted for any projected variations. Reasonable assumptions regarding revenue increases (separately calculated based on source), patient volume, and expense increases should be based upon current market conditions, expected growth (keeping in mind space allowance and physician staffing), and estimates of inflation rates. It is important to analyze the projections in the context of historical operating performance and management's expectations regarding the future prospects of the practice within relevant economic and industry factors.

After a reasonable level of revenue and expense is calculated, available cash flow for each period is defined as follows. It is generally computed after marginal corporate income taxes.

The formula can be expressed as follows:

\[
\text{Available Cash Flow} = \frac{\text{Operating Income Less Taxes} + \text{Depreciation and Amortization} \pm \text{Changes in Net Working Capital} - \text{Capital Expenditures}}{}
\]

Available cash flow should be multiplied by the discount rate to determine the present value of the physician practice. The discount rate should reflect both market and group risk. The residual value of the practice at the end of the projection period should be discounted to present value and added to the discounted available cash flow to calculate the present value of the physician practice.

B. MARKET APPROACH

The market approach measures value based on the selling price for comparable medical practices. The most common method of the market approach used for valuing medical practices is the comparative transaction method. This approach is frequently used in the appraisal of real estate. It is difficult to find comparable entities with the sale of a medical practice. Therefore, actual purchase prices paid for similar practices are evaluated, adjusted, and applied to the operating data of the seller's business to arrive at fair market value. Normal earnings from operations and cash flow levels for the practice should be determined. A risk analysis of the comparables to the practice based on factors such as size, revenue composition, payer concentration, geographic markets served, competitive position, profitability, and growth prospects must be prepared. Capital structure is also analyzed to assess comparability of debt levels.

C. COST APPROACH

The cost approach measures value by determining the value of a practice's tangible assets plus a premium representing the value of intangible assets, including goodwill. The most common cost approach for valuing a medical practice is the excess earnings approach. The first step is to value the tangible assets of the practice at the cost of reproduction or the cost to replace an asset, less an allowance for deterioration and obsolescence. Normal earnings from operations before depreciation, interest, and taxes (EBDIT) should be projected for next year. The annual cost to replace fixed assets and a normal return on the investments of the practice should be estimated. Excess earnings are then calculated as follows:

\[
\text{EBDIT} - \text{Annual cost to replace fixed assets} = \text{Excess Earnings} - \text{Normal return on investments}
\]

Excess earnings should then be adjusted for applicable income taxes. A capitalization rate should then be determined based on the risk of the purchase. The value of the intangible assets is then calculated by multiplying the capitalization rate by the excess earnings less taxes. The total value of the practice under this method is the tangible asset value added to the intangible assets.

After the valuation of the physician practice has been completed and the "fair market value" has been calculated, the value must be allocated to the practice's assets for asset-based financing, book, and tax reporting.
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