THE JOURNAL OF
PHYSICIAN-OWNED REAL ESTATE

Volume X
Presented By CMAC Partners

CMAC PARTNERS | 399 CAROLINA AVENUE, SUITE 250, WINTER PARK, FL 32789 | OFFICE 407-264-7255 | FAX 407-588-6018 | WWW.CMACPARTNERS.COM

How to Play Full-Court Press with Property Profits

Top Executives Learning to Play Defense

In recent years, many independent practice executives are "waking up" to the value they can bring their physicians outside of the practice itself. That added value comes from better management of the practice's facilities, the single greatest expense behind staffing; more specifically, physician-owned real estate. Still, there are those executives who would find a way to pull the last nickel out of a piece of imaging equipment while nonchalantly turning their back on an opportunity to trim a million dollars of excess interest expense – dollars that could have been used to optimize their medical operations or to distribute to their physicians.

To borrow a comparison from the NBA, it's like having a great offensive player who doesn't know how to play defense. Paul George and Shareef Abdur-Rahim (now retired) have both played about the same number of games. Abdur-Rahim averaged 20.6 points per game while George averaged 20.5. Pretty comparable, at first glance. However, the opposing teams outscored Abdur-Rahim's teams by more than 1,600 points while he was on the floor, while George's team outscored the opposition by more than 3,000 points. The difference? George knows how to play defense, the same way a top administrator should figure out how to get the last nickel out of the physician-owned real estate, as well as their imaging equipment.

This article explores why and how this lack of focus on property profits is occurring and offers some solutions to make your own executive a great "two-way player" by looking at a single item: interest expense.

The 3 Primary Reasons & Their Remedies

Reason 1: It Wasn't Part of the Curriculum

True. You won't find Physician-Owned Real Estate 101 in any Healthcare Administration list of courses. Nor will those courses be found in medical schools. However, the opportunity to own the real estate where you practice, and create incremental personal cash flow or equity, is an integral part of today's independent practices.

The Remedy: Educate yourself or hire an expert to guide you in your real estate dealings. In 2019, the Congress of Physician-Owned Medical Properties (CPOMP) was formed for the specific purpose of providing a platform for doctors and executives to network and to become educated in all aspects of physician ownership in real estate. Attendance at the annual meetings and the resources available through the organization can be of great help. Information on the group is found at www.CPOMP.org.

Reason 2: It's Insidious

Sometimes, big problems start small: plaque in your arteries, a few drops of oil leaking from your car engine … or a few basis points in the rate. Who would mind paying the more familiar bank 5.95% instead of 5.75% on a $20MM loan when the monthly payment difference is only $2,500? It's no big deal. Actually, it is. That small amount of

$2,500 over a 10-year term has a Net Present Value of approximately $260,000.

The Remedy: Understand and apply "Net Present Value," the current value of a future income stream. If that same bank had offered to match the rate of the competition but charged an origination fee to be paid at closing of $260,000, would your choice still be the same?

Reason 3: Nobody's Keeping Score

It's only human nature to focus on what matters. If an executive is being judged solely on how their practice is managed, then the real estate holdings of the doctors will end up as the proverbial stepchild and not get the same attention. Most practices have no real estate performance benchmarks and, therefore, cannot really assess the performance of the administrator in that role.

The Remedy: First, establish performance objectives for the real estate. Next, broaden the responsibilities of the executive. Finally, make the executive accountable by comparing the performance of the real estate against those objectives, just as you would at the practice level. Many practices also take the step of including the executive in the real estate ownership as a way of rewarding the executive and assuring his or her interest in optimizing the outcome.

By applying the remedies outlined here, executives can have the right tools to apply their skills – and the real estate holdings of the physicians will reflect the performance standards of the practice.

Debt Free ... Until the Next Retiree

Grant Blackhurst
Senior Analyst

To all the doctors who decided you didn't want to borrow from the bank to pay partners because you wanted to build equity, here's a harsh wake-up call: You just traded cheap, long-term debt for more expensive short-term debt that will result in depressed levels of cash out and reduced profits.

Take the example of a group of gastroenterologists in Texas, who claimed they had $9MM in equity because they had a $20MM property with only $11MM of bank debt. This group failed to consider the $3MM they owed retired partners who held notes receivable.

At the end of the day, "debt is debt" regardless of to whom it is paid. The group's true equity in the property was $6MM and not $9MM. Moreover, the bank debt carried a rate of 4.50% to be paid over 25 years, while the debt to the retired docs was to be paid over 5 years at a rate of prime + 1% (9.25% at the time of writing). The annual debt service to pay the retired doctors under those current terms is approximately $750K.

If the property was leveraged up to pay off the retired partner debt, the same $3MM would have an annual payment of $200K. **(continued on page 9)**

On the Inside...

Why This Free Way Might be the Freeway to Depressed Returns

Bringing new partners into practice-owned real estate is essential to the long-term viability of a practice. To facilitate those buy-ins, many groups internally finance with attractive terms for incoming partners. Those terms often feature:

- Little to no money down
- Low interest rates

While this approach may be favorable for incoming shareholders, the unseen costs to the existing partners can be quite meaningful. But the dilemma between new and old doesn't need to prevent your practice's growth. With a little planning, you can create buy-in terms that have the same results for the new partners without the drawbacks of internal financing. Here are three factors to be considered:

1. Who's Paying for the Buy-In?

When you think about it, new partners are buying in with money that would otherwise have gone to the existing shareholders. To put this into perspective, ask yourself the following question:

Would I take my distributions and give it to a new partner such that they could give it right back to me to buy a portion of my shares?

That may seem like a silly question, but that's exactly what's happening with internally financed purchases. But wait – you say it's not free? You're getting interest? Okay, next question: is the interest at least as great as the return you would be getting in your distributions? If not, some portion of that is still free, and the "free" portion is being paid directly out of the pockets of the existing partners. This is not insignificant.

You can see an example calculation in *Table 1* below to understand the full effects, but the bottom line is that partners will typically give up hundreds of thousands of dollars in equity for approximately the same, or even less, distributions inclusive of the buy-in payment.

2. Who's Receiving the Equity Gain?

During the internal loan payment, the property should continue to build equity as the group's debt is repaid and the property appreciates. Under this structure, the existing partners are giving up the appreciation of those shares ahead of receiving the equity from the loan payment to purchase those shares. Depending upon the configuration of the partnership, that difference could amount to hundreds of thousands of dollars and is accompanied by a significant reduction in the internal rate of return (IRR) for existing partners.

3. Partner Divisiveness

If the new partner were to buy in with cash or obtain personal financing from a bank to purchase their shares, that money would typically be distributed to the existing owners to compensate them for their dilution of ownership. This money THEY received could be reinvested elsewhere to generate additional wealth.

Using the same example, a new buy-in would have been $729K, and assuming the group didn't internally finance, each partner should have received approximately $73K for their dilution of ownership. If that was reinvested at just 5%, the partner would be receiving approximately $46K over the duration of the 10-year buy-in period.

Thus, internally financing that new partner's loan could result in a substantial loss of wealth accumulation for the original partners over the duration of the internal loan.

Given these factors, it's often advantageous for the entity to receive the buy-in for a new partner up front. That said, new-buy-ins can be expensive, even after a group has leveraged to reduce the buy-in amount. In these cases, it can often make sense to obtain personal financing from a lender to help fund these buy-ins. This ensures the existing partners are fairly compensated for their equity at the time of the sale or dilution event, while enabling the new partner to use the entity's distributions to help cover the personal loan payment.

If a group wants to make the personal financing options more attractive for new partners, one alternative option may be to have the real estate entity guarantee the personal loans that new partners receive from the bank, which would improve the personal loan terms for the new partners. For more information on creating affordable and achievable buy-in options, email solutions@cmacpartners.com.

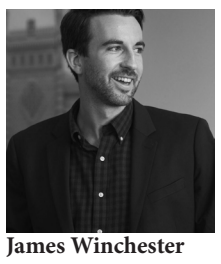
Table 1

Outcome per Existing Partner (Over 10 Years)	10 Partners (With No New Buy-Ins)	11 Partners (Buy-In Internally Financed)	Variance
Distributions Received	$1,161,453	$1,055,866	($105,587)
Internal Loan Income Received	$0	$88,687	$88,687
Equity Gain	$804,853	$658,687	($146,166)
Total 10 Year Gain	**$1,966,306**	**$1,803,241**	**($163,065)**

*Assumed $20MM project, 60% LTV, 8.5% Cap Rate, 2% rental escalator & appreciation, property loan at 3.25% with 25Y Amort. and internal loan at 4% with 10Y Amort.

Is Your Joint Venture Partner in Your Corner?

The Hidden Conflict of Interest Rates



James Winchester
Principal

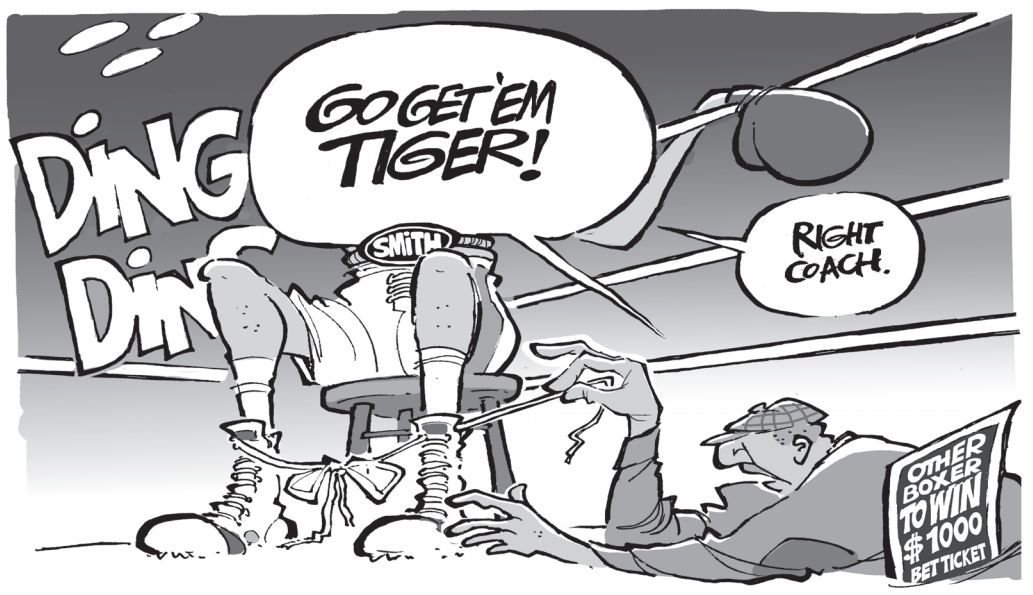
I don't profess to know a whole lot about boxing. I do know, however, that it's important to have a good coach in your corner who's not only rooting for you but also guiding you on the optimal course of action. When groups enter real estate partnerships with their development partners, it's akin to having a coach in your corner. It's not only important to have the right people in your team, but to understand when they have your best interests at heart. But to make it work, you need to recognize when and why their economic objectives may not always align with yours.

A prime example is when procuring financing for your project.

It is not uncommon for development partners to assist in procuring financing, and yet the attractiveness of those terms is likely not as vital to the developer as to the practice. Moreover, it's entirely possible that the financing terms that a developer wants conflict with the best interests of the practice. That was what one Mountain State physician group experienced when sourcing financing in a recent joint venture (JV) with their development partner.

The 50/50 JV was for a planned new construction project, in which the practice planned to lease 100% of the to-be-built space. At the project's inception, the developer outlined the intent to own the building for a few years before selling it in a sale/leaseback transaction. When procuring financing options, the developer sought a 15-year, fully amortizing loan to build equity as quickly as possible, despite the inverted yield curve resulting in shorter amortizations holding a higher interest rate cost at the time. The doctors, meanwhile, approached a couple of banks to explore other available financing options. *Table 2* represents a few of the key terms of the financing offers solicited and the resultant rents that were required to meet the debt service coverage ratio.

In essence, by looking at a 15-year repayment schedule, the developer was requiring the group to increase its lease payment by roughly 40%. On the surface it appears as though both the developer and private practice suffer from this election because of the inferior interest rate, but there is more at play when we consider the proposed future sale. At the time of writing, the market for sale/leasebacks put this building at a roughly 6% cap valuation. With starting rents of $980K, the building value would be $16.3MM. If the starting rents were $684K, the building value would be $11.4MM, roughly $5MM less, with the developer taking home $2.5MM (50%) of additional sale proceeds at the higher rents. The practice, on the other hand, would remain on the hook for an inflated 15-year lease.



This example highlights just one scenario where the desired financing terms were misaligned between partners. If the group hadn't looked for alternative financing options themselves, they could have ended up with financing terms that either significantly hindered their outcomes, or a project that was no longer deemed viable.

It is not unusual for people to act in their own best interests. Therefore, it's essential that you understand your partner's best interests so that you can effectively continue to look after your own and those of your practice. One excellent way to do this is by having a coach in your corner with years of experience in procuring financing specially designed to meet the objectives of your real estate investments and your practice. One such group that comes to mind is CMAC! Please reach out to solutions@cmacpartners.com if you'd like to better understand what alternative motives might be at play, what financing options could be available, and which of those make the most sense for you and your partners.

Table 2

	Developer Sourced Financing	*Practice Sourced Financing*
Amortization	15 Years	25 Years
Interest Rate	5.50%	4.75%
Debt Service Coverage Ratio (DSCR)	1.25x Pre DSCR	1.25x Pre DSCR
Minimum Lease to Meet DSCR	$980,000	$684,000

Responding to Adverse Market Conditions: Is Your Bank Clutch?

Chris Tollinchi
Principal

When your team is down one point in the NBA playoffs with three seconds left on the clock, to whom do you give the ball to win the game? If you're the '89 Chicago Bulls, that answer is easy: it's Michael Jordan.

My point isn't to praise MJ as the G.O.A.T. (though I'd argue he is), but rather to pose a question: Who do you turn to when you need debt but the financial markets are facing adversity? The recent collapse of regional lenders like SVB, First Republic, and Signature; a tightening cycle unheard of since the Volcker-led Fed of the 1980's; and an anticipated global recession in the coming months have created an atmosphere of uncertainty among banks, making it hard to know where to turn for financing. The choice for you may not be as easy as it was for Phil Jackson (Bulls Head Coach, '89).

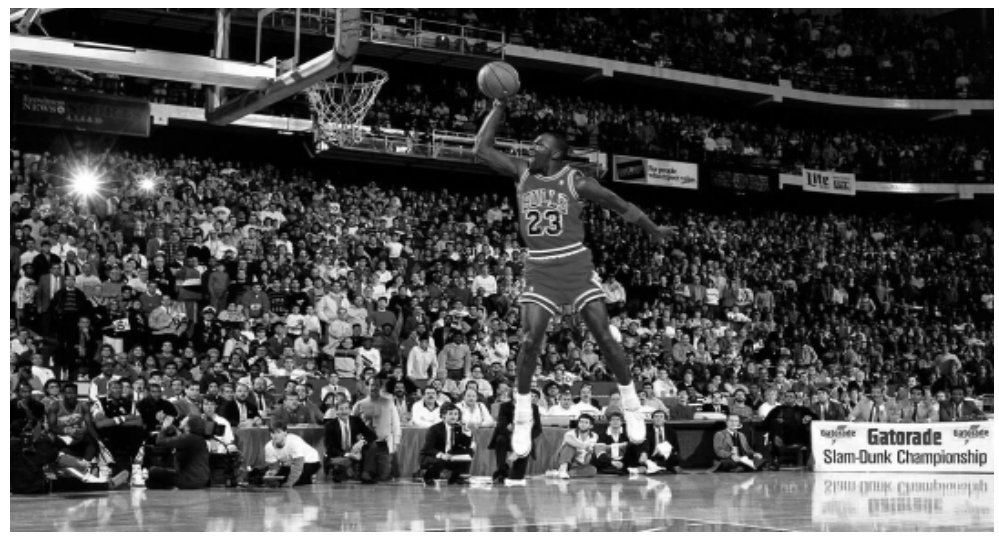
Consider one of our clients, a leading multi-specialty practice with revenues exceeding $250MM. Last year, they received an indicative fixed-rate offer of 3% for a 7-year term loan for a new building project. This year, that same lender proposed a bid of just over 9% on a similarly sized project. Another group specializing in orthopedics in the Pacific Northwest had a similar experience. They were accustomed to loan pricing at 0.95% over their floating rate index, only to be blindsided when their lender provided indicative pricing on their new project that had doubled.

These lenders, or rather their credit officers, were responding to adverse market conditions by increasing their portfolio returns, so they widened their loan spreads based on the bank's pricing strategy. It is worth noting, however, that not all banks had this knee-jerk reaction. In fact, some lenders became more competitive with their pricing for higher quality credit sectors such as medical.

Our group, CMAC Partners, specializes in medical owner-occupied real estate and operates on the cutting edge of commercial real estate lending. We source approximately $500MM of commercial real estate loans a year and engage in constant negotiations with 100-150 bankers nationwide. If you find yourself facing sticker shock from your lender, don't take it personally. Banks are large institutions driven by policy and will often overlook good credit opportunities. To help mitigate the impact of an adverse lending environment, we suggest the following strategies:

1. **"Sell" your loan (and your story) to the bank –** A compelling pitch can improve your chances of securing a good deal. Write a detailed request for proposal ("RFP") outlining your request, and include financials, tax returns, leases, and proformas. Anticipate the questions a credit officer might ask. Offer to meet with bankers in person and give them a tour of your property. Yes, applying the personal touch takes time, but it reaps dividends when your financing is on the verge of an increased credit rating.

2. **Offer a "relationship" –** Most banks these days consider themselves "relationship lenders." This means they don't just want to have a loan with you; they want to have a depository and treasury management services agreement with you. The more of a "relationship" the bank can hold, instead of just a loan "transaction", the higher the likelihood the lender will get their deal approved internally by credit at the most competitive terms.



3. **Offer additional security –** Generally, banks will require either personal guarantees or the practice guarantee for a medical real estate loan. Most borrowers prefer the practice (tenant) to guarantee instead of requiring the doctors to personally guarantee. In the case of the former, a guarantee of an additional entity owned by the same doctors, like an ASC operating entity or equipment leasing company, could add value and improve the loan terms. Or, personal guarantees might be offered as additional security, with future burn-offs. And if the practice has some equipment owned free and clear, could that perhaps be provided as additional collateral? Think of what you have that you feel comfortable pledging which could help get you the best offers possible in this tight credit environment.

4. **Cast a wide net –** Your financing RFP should go to as many banks as possible. You likely won't know which banks are picky and which are competitive until you get your results. And don't forget credit unions, which often have very different lending parameters than traditional banks. Use networks you may already have (Boards of Directors, club memberships, fellow alumni, neighbors) to form personal relationships with bankers who will advocate for you.

5. **Have an exit strategy –** Begin with the end in mind. Economic downturns happen, but they're a natural part of the cycle and they don't last forever. If you find yourself with a loan proposal with unfavorable terms and don't have any alternatives, think about your exit strategy. Focus on short-term financing to structure the loan with minimal or no prepayment penalty today and refinance tomorrow when the market conditions become more favorable.

It is likely that banks will continue to operate conservatively in the foreseeable future, at least until the Federal Reserve gets its arms around inflation and the pendulum swings back in favor of the borrower. We recently closed a $10MM refinance loan in the Southeast with rates in the mid-4% range. We are slated to close a $13MM new construction loan in the Midwest, with an indicative interest rate at the time of this writing in the high-4% range. In any lending environment, there is always someone willing to step up and deliver in the clutch. If you don't have your own banking "Michael Jordan," consider passing the ball to CMAC.

Mentes360: A Medical GPS

Mariela Araujo
Client Advisor

Imagine going on a road trip in your brand-new electric car. Would you risk starting a 12-hour drive, hoping there are charging stations along the way? Or would you plan ahead and pinpoint the necessary stops?

When embarking on a journey that involves potential heavy traffic, road closures, or unexpected weather conditions, it's best to assess the alternative routes and expected rest stops to ensure battery charging and service plazas are available where needed. Having a well-prepared plan before going on an adventure like this increases the odds that you'll successfully and comfortably reach your destination.

Now, this type of "trip planning" is available for your physician-owned real estate investments. Having a structure that aligns with the partners' long-term objectives is like having a compass that guides you through unfamiliar terrain, helping you avoid potential pitfalls and take the most efficient path towards your destination.

The year 2023 marks the introduction of Mentes360, a program designed specifically to optimize the physician ownership of medical properties. Google Maps provides you with the best route options based on traffic conditions, distance, and estimated travel time. It also suggests alternative routes if there are any road closures or traffic jams along your intended path.

Similarly, Mentes360 guides physicians through every step in the ownership process. It provides physician partners with the best route to structure their investment based on expected distributions, equity build-up, and eventual buyouts. And when things don't go exactly as planned, it helps physicians get back on course.

Mentes360 includes:

- **An Operating Agreement Decision Guide.** We laid out over 75 provisions that are exclusive for physician-owned real estate. This interactive form serves as a detailed map with alternate routes that would ensure the bylaws align with the group's long-term objectives.

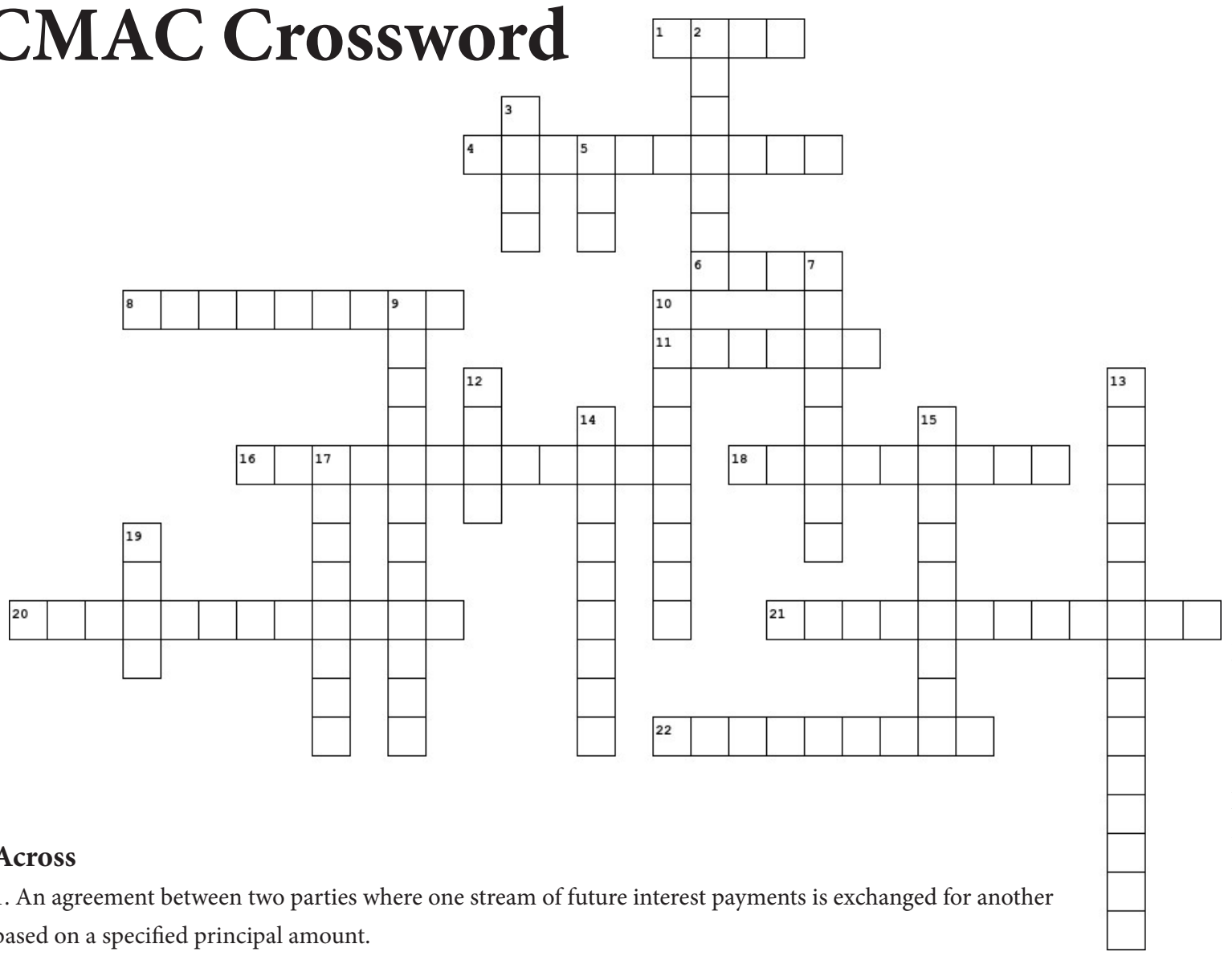
- **A 30-Year Economic Model.** Different philosophies and provisions have varying economic impacts. This model tests the covenants of the Operating Agreement to ensure the sustainability of the investment from both the individual and group perspective.

It can also answer questions such as the impact of different valuation methodologies, expected return for each physician's investment horizon, the impact of buy-ins and buyouts, and leveraging up vs. paying down debt scenarios.

Investment tools like Mentes360 allow users to navigate physician-owned real estate challenges more effectively. Just as important, they enable physicians to make more informed decisions along the way to support the practice's growth, just like a traveler who carefully plans their route before setting off and makes adjustments as needed.

Reach out to support@mentes360.com for information on how to access this tool for your practice needs.

CMAC Crossword



Across

1. An agreement between two parties where one stream of future interest payments is exchanged for another based on a specified principal amount.
4. Properties or assets that are offered to secure a loan or other credit.
6. Period over which a loan agreement is in force.
8. A valuation of property (ie. real estate, a business) by the estimate of an authorized person.
11. The difference between the current market value of the property and the amount the owner still owes on the mortgage.
16. Arrangement in which two or more parties (e.g. a physician practice and a developer) agree to pool their resources for the purpose of accomplishing a task such as a new project. (2 wds)
18. The amount borrowed or the amount still owed on a loan, separate from interest.
20. Interest that changes periodically, moving up and down with economic or financial market conditions. (2 wds)
21. Disbursement of assets to an investor.
22. When a loan is issued and supported only by the borrower's creditworthiness, rather than by collateral.

Down

2. Casting this by sending your financing RFP to as many banks as possible creates competition to secure the best rates and terms. (2 wds)
3. Benchmark index for U.S. loans that replaced LIBOR in June 2023.
5. A financial ratio that compares the amount of money being borrowed to the market price of the collateral asset.
7. Date on which the life of a transaction or financial instrument ends, after which it must either be renewed or it will cease to exist.
9. The process of paying off a debt (often from a loan or mortgage) through regular payments including principal and interest.
10. A program designed specifically to optimize physician ownership of medical properties, including a 30-year economic model and an operating agreement decision guide.
12. A right to keep possession of property belonging to another entity until a debt owed by that entity is discharged.
13. Analytical process of determining the current (or projected) worth of an asset. (2 wds)
14. A person who pledges to pay for someone else's debt if they should default on a loan obligation.
15. Interest that does not fluctuate during period of loan. (2 wds)
17. The charge for the privilege of borrowing money, typically expressed as an annual percentage.
19. The act of giving money, property, or other material goods to another party in exchange for future repayment of the principal amount along with interest or other finance charges.

Crossword solution on page 10

Doctors Waking Up to Added Dollars in Real Estate Joint Ventures

It is not unusual for a medical group that is building a new facility for its practice to partner with the developer on the project. In those cases, the developer and the doctors generally take ownership interests proportional to the equity contributed. However, the developer will also charge development fees for its services while the doctors charge nothing for the brokerage fees saved by bringing the lease. Those days may soon be ending as CMAC and other physician-advocates become involved early in the joint venture formation.

Let's put this in context. A development company ("DC") and a practice group ("PG") decide to build a $20 million medical facility. It is agreed that the DC will act in the role of a developer and charge a 4% development fee, or $800,000. That is the same fee that would have to be paid to any other developer for its services. The PG agrees that it will sign a 10-year lease having a value of $1.2 million and would routinely incur a broker's fee of 5%, or $600,000. However, historically, the PG has not received credit for the broker's fee that it just saved the joint venture (JV) on bringing the lease. The fact is that the value created by the PG should carry the same weight as the services brought by the DC.

In this case, the respective equity for services from each partner should be accounted for and the project cost for the PG will have been reduced from $400,000 to $100,000.

- **Development fees only**
  $800,000 @ 50% = $400,000 cost to PG
- **Development fees, less credit given for saved Broker Fees**
  ($800,000 less $600,000) = $200,000 @ 50% interest = $100,000 cost to PG

When Larry Page and Sergey Brin founded Google in 1998 it was completely free. They focused on delivering accurate and relevant search results. At the time, only 3.6% of the world's population were internet users and therefore, it was initially more of a computer science project. They really hadn't considered if or how they would create revenue from their idea. The current method of monetizing the value, Google AdWords, hadn't been invented yet. Once Google AdWords was launched in October 2000, it allowed businesses to promote their services in a way that was incomprehensible at the inception of the internet age and provided Larry and Sergey their first monetization opportunity.

The point being, the Google founders spent a long period of time providing a valuable service, for free, before 1. Recognizing the value and 2. Creating a structure to harness it. Physician practices across the country are following in Larry and Sergey's footsteps. They are creating significant value without the tools to monetize and harness that value which the following scenario aims to outline.

When landlords and developers have vacant space in existing or to-be-built locations, they often seek the services of a real estate broker to fill that space. As part of this service, the standard commission rate for a commercial lease is 4-6% of the total lease expense. Let's do some quick math to quantify the broker fee on a $10MM building.

For new construction projects, the inaugural lease usually carries a length of at least 10 years. With a starting ROI of 8% ($800,000 of annual rent), assuming no escalators, a 10-year lease and a 5% broker commission, the fee to the broker would be $400,000. A 15-year lease with 2% escalators increases that fee to $691,000.

In these kinds of joint ventures, it is very standard for a developer to include its development fee as part of the equity contribution. A typical development fee is anywhere from 4 – 6% of the construction budget. On a $10MM building, that is roughly $500,000 (5%). In consideration that the physician practice is bringing a long-term lease and the developer is bringing development services, of almost equivalent value, it would seemingly make sense that these two services roughly cancel one another out. But they typically don't!

What often happens is the value which the physician practice brings through its own lease is not recognized and results in the physicians sourcing a disproportionate amount of cash equity to the deal. Ultimately, the long-term lease a physician group signs carries significant value and should always be part of the negotiation to ensure a more equitable deal with its development partner. Like when Google created AdWords, the broker fee argument aims to provide a tool to 1. recognize the value and 2. monetize that value. To discuss the best methods of navigating that negotiation, send an email to solutions@cmacpartners.com.

The Orthopedic Clinic of Daytona Beach

Daytona Beach, FL

Orthopedics

$18,150,000

Audubon Medical Building

Colorado Springs, CO

Multi-specialty

$11,775,000

Eye Surgeons Associates

Bettendorf, IA

Ophthalmology

$9,300,000

Kennedy-White Orthopedic Clinic

Sarasota, FL

Orthopedics

$19,000,000

The Oregon Clinic GI South Division

Portland, OR

Gastroenterology

$6,600,000

Orthopedic Physicians Alaska

Anchorage, AK

Orthopedics

$8,700,000

Premiere Bone & Joint Centers

Laramie, WY

Orthopedics

$7,100,000

North Atlanta Vascular Clinic

Suwanee, GA

Vascular

$10,400,000

CMAC Partners

WE KNOW MEDICAL

Urology

Arkansas Urology* Little Rock, AR
Central Ohio Urology Group Gahanna, OH
Idaho Urologic Institute* Meridian, ID
Michigan Institute of Urology Saint Clair Shores, MI
Southeastern Urological Center Tallahassee, FL
Urology Associates, P.C. Nashville, TN
Urology Associates of Southern Arizona Tucson, AZ
UroPartners Westchester, IL
Urology San Antonio San Antonio, TX
Wisconsin Institute of Urology* Neenah, WI

Ophthalmology

Bay Eyes Cataract and Laser Center Fairhope, AL
BoozmanHof Regional Eye Clinic Rogers, AR
California Eye Institute* Fresno, CA
Emerald Coast Eye Institute* Fort Walton Beach, FL
Eye Associates of Boca Raton Boca Raton, FL
Eye Associates of Colorado Springs Colorado Springs, CO
Eye Surgeons Associates* Bettendorf, IA
EYE-Q Vision Care Fresno, CA
Eye Center of North Florida Panama City, FL
Eye Institute of West Florida* Largo, FL
Eye Specialists of Mid-Florida* Winter Haven, FL
Heaton Eye Tyler, TX
Huntsville Laser Center Huntsville, AL
Laser & Surgery Center of the Palm Beaches Palm Beach Gardens, FL
LaserVue* Orlando, FL
Medical Eye Specialists Bozeman, MT
Ocala Eye Ocala, FL
Ophthalmology Consultants St. Louis, MO
Pacific Cataract & Laser Institute Chehalis, WA
Retina Consultants of Southern Colorado Colorado Springs, CO
St. Louis Eye Surgery and Laser Center St. Louis, MO
The Eye Clinic of Florida Zephyrhills, FL
Tower Clock Eye Center Green Bay, WI
Virginia Eye Institute* Richmond, VA

Hospitals

Arkansas Surgical Hospital Little Rock, AR
Ascension St. Vincent Orthopedic Hospital Evansville, IN
Catholic Health/St. Francis Hospital* Colorado Springs, CO
Heritage Park Surgical Hospital Sherman, TX
Lafayette Surgical Specialty Hospital Lafayette, LA
North Carolina Specialty Hospital Durham, NC
Springhill Medical Center Mobile, AL
The Breast Cancer Center at Physicians Medical Center Houma, LA
The Spine Hospital of Louisiana at the NeuroMedical Center Baton Rouge, LA
Western Reserve Hospital* Cuyahoga Falls, OH

Cardiology

Abilene Cardiology Abilene, TX
Alabama Heart & Vascular Medicine Tuscaloosa, AL
Cardiovascular Associates* Birmingham, AL
Cardiovascular Institute of Orlando Orlando, FL
Cardiovascular Institute of the South Houma, LA
Clearwater Cardiovascular Clearwater, FL
Florida Heart Group* Orlando, FL
Fort Worth Heart Fort Worth, TX
Northeast Georgia Heart Gainesville, GA
Orlando Heart Orlando, FL
Pima Heart Tucson, AZ
Savannah Cardiology Savannah, GA
South Denver Cardiology Littleton, CO
Southern Cardiovascular Gadsden, AL
Sutherland Cardiology Clinic Memphis, TN

Other Specialties

Advanced ENT & Allergy Louisville, KY
Alyeska Vascular Surgery Anchorage, AK
Audubon Medical Building* Colorado Springs, CO
Austin Diagnostic Clinic Austin, TX
Austin Regional Clinic Austin, TX
Central Park Ear, Nose & Throat Arlington, TX
Cancer Specialists of North Florida* Jacksonville, FL
Canyon View Medical Group Springville, UT
Cascade Brain & Spine Bellingham, WA
Dallas Nephrology Associates Dallas, TX
Charleston ENT Charleston, SC
Endoscopy Center of Ocala* Ocala, FL
ENT Center of Utah Salt Lake City, UT
Gastroenterology Institute of Orlando Kissimmee, FL
Granger Medical Clinic West Valley City, UT
Mayfield Brain & Spine Cinciannati, OH
Metrolina Nephrology Associates Charlotte, NC
Nephrology Associates Nashville, TN
North Atlanta Vascular Clinic & Vein Center Suwanee, GA
North Carolina Eye, Ear, Nose & Throat* Durham, NC
Northeast Georgia Diagnostic Clinic Gainesville, GA
Ogden Clinic Ogden, UT
Ohio ENT & Allergy Physicians Columbus, OH
Orlando Aesthetic Institute Orlando, FL
Piedmont Ear, Nose, & Throat Associates Winston-Salem, NC
Premier Family Medical Pleasant Grove, UT
Sagis Diagnostics Houston, TX
Signature Medical Group St. Louis, MO
Southern Oregon Neurosurgical & Spine Associates Medford, OR
Tanner Clinic Layton, UT
The Doctors' Clinic Salem, OR
The Iowa Clinic West Des Moines, IA
The Lexington Clinic Lexington, KY
The Oregon Clinic Portland, OR
Transformations Treatment Center Mahtomedi, MN
Utah Cancer Specialists Salt Lake City, UT
Valley Medical Center Lewiston, ID
Wake Internal Medicine Consultants Raleigh, NC
Wasatch Dermatology South Ogden, UT
Willamette ENT Salem, OR
Women's Healthcare Associates Portland, OR

Surgery Centers

Blue Water Surgery Center* Port St. Lucie, FL
Carolinas Center for Surgery* Morehead City, NC
Hilton Head Surgical Hilton Head, SC
Bend Surgery Center Bend, OR
Hollywood Surgical Center* Hollywood, FL
Palmetto Surgery Center* Columbia, SC
Southpoint Surgery Center Jacksonville, FL
Surgery Center of Southern Oregon Medford, OR

*** Returning Clients**

Real Estate Implications in the Sale of Your Practice to a Private Equity Group

Millions Gained Through Lease Extension at Closing

Oftentimes, we have witnessed all the focus of a private equity sale being cast onto the practice, with no consideration of the real estate investment which is usually the same set of owners. Let's look at the following example as to why that can be economically disadvantageous.

In 2022, an Orthopedic practice in Michigan had four years left on its current leases. Those leases were producing roughly $3MM in Net Operating Income. At a 6 cap (their anticipated building value), the portfolio was worth $50MM. Luckily, before they closed the sale of the practice, they engaged a local real estate broker who had told them that based on the short length of their current leases, their portfolio would be valued at only $35MM. MOB and ASC Properties are primarily valued on the amount, length and reliability of the rental income produced. That reduction in value came as a shock to the group and as a result, they negotiated new 12-year leases (at the same starting Net Operating Income) to be put in place prior to the sale occurring. This resulted in a $15MM enhancement in value, which far outweighed any negotiated enhancement they had received during the practice sale and did not cause any loss in value as part of the PE sale.

Non-Owner-Occupied Structure

In addition to the negotiation of a lease extension, the real estate ownership provisions should be re-evaluated during a private equity sale. When a practice private equity sale occurs, the buildings are no longer considered owner-occupied. Not only does this have implications for the current or future financing (practice guarantee removed, rates adjusted & generally cash flow reduced), it also has long-term effects on the value of the investment.

Most private practices that own real estate are best suited to ownership structures that mirror the underlying practice. When physicians join the practice, they generally can join the real estate investment and when they retire there are provisions to be bought out. In addition, most groups will adopt a real estate valuation approach that is consistent over time to enable the ingress and egress of partners. Typically, that valuation is derived from the anticipation of a perpetual lease obligation being applied to the building.

But suddenly, as part of the private equity sale, the lease renewal is no longer guaranteed. At the end of the current lease there is a significantly greater possibility that the practice lease will not be renewed. The destiny of the practice is no longer in the physicians' hands, and the real estate owners will need to find a new reliable tenant. That creates risks to income and a possible deterioration in value that makes it problematic to continue the buy in and buy out of partners based on the owner-occupied structure that was originally adopted. There is much more volatility in the building value which will now be a function of the remaining lease length. This should be considered as part of any entry or exit to the investment.

We believe the most important question to ask is the following: If you were repurchasing the building, under what valuation and structure would you do so? Having a real estate advocate on your side can be essential to help navigate the many moving parts that need to be addressed during a PE sale, with the real estate being one component that should be given the care and attention it needs.

Debt Free ... Until the Next Retiree

(Continued from front page)

That's a cash flow improvement back to the current doctors of $550K per year for 5 years. The interest expense savings in the first year alone is more than $100K. But this raises a bigger question.

Are physician-owned real estate investments ever free and clear of debt? The answer is typically NO.

If there is a future obligation to buy out partners at retirement, the debt gets transferred from the bank to the partners at retirement in a 1:1 exchange, and as we highlighted above, the cheaper cost of capital is usually to the bank. This elusive goal of being free and clear on physician-owned real estate investments is often misguided and usually results in underwhelming cash flows and distributions that are significantly reduced by partner buyouts.

The best way to truly know an entity's best long-term debt structure is to create a model that forecasts planned buyouts, and use that forecast to make an assessment. CMAC utilizes its Mentes360 program (read more on page 3) to assess the best debt strategies specific to each group's operating agreement, and partner succession plans, enabling our clients to better manage cash flows and maximize returns.

What CMAC Clients Have to Say...

Thank you for your continued support with our recent index conversion. You went above and beyond to help us on a deal for which CMAC had already been paid. Grateful for your expertise and continued partnership.

Eric Olson, CFO
Orthopedic Physicians Alaska

CMAC helped us get financing that was 100% leveraged, so there was no money out of pocket to get started. We secured lower rates, stayed with the local bank, and saved about $1.9 million over a ten-year note.

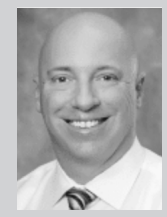
Jimmy Tucker, MD & Co-President
OrthoArkansas

With the engagement of CMAC, we were able to utilize a group that has very specific expertise in helping practices such as ours navigate those waters. It turned out to be an amazing experience. CMAC did everything they could do to make sure that the process was facilitated.

Karl VanBenthuysen, MD
South Denver Cardiology

Thanks for all the hard work from CMAC. Your team has been very patient in dealing with myself and the bank. We really appreciate your help in getting the best deal we were looking to get.

Uthan Vivek, MD
North Atlanta Vascular Clinic & Vein Center



It wasn't until I engaged CMAC that I realized that they could do so much better than we could. I'm amazed at the rates that CMAC has been able to get us by going into multiple banks and using their expertise. I keep going back to CMAC because each time I do, they're able to meet my needs.

Kayo Elliott, CEO
Athens Orthopedic Clinic

We worked with CMAC to refinance five real-estate properties and two leasing companies. It was a very successful transaction. To this day, we continue to have an excellent relationship with the new bank.

Bill Hyncik, CEO
Princeton Orthopaedic Associates

Little did I know that when you bring experts like CMAC in the equation, it really changes the dynamics of the discussion with the banks and with the other options avaliable to us for financing.

Scot Davis, CEO
Arkansas Urology

There are always things that come up that are unexpected or unforeseen, and in dealing with CMAC, I have always felt a partnership. So, I've never hesitated to text or call, and they've always been very prompt to return my call.

Steven Meek, MD
Tanner Clinic

A Comparison of the Sources of Backfill Equity

When independent medical groups enter into a real estate project, it is not uncommon that some practice partners cannot afford to fund their full portion of the equity. That is, a portion that would create equality of ownership among all the partners.

In such cases, there are several sources that may be accessed to backfill the individual or aggregate equity needed. These equity sources should only be used after accessing traditional sources of real estate financing to fund the bulk of the investment, assuming the terms of repayment allow for reasonable, sustainable cash flow and do not contain unusual loan covenants that could negatively impact other sources of income or the partners personally.

These backfill equity sources include:

I. Bank loans to the individual doctors,
II. Other doctors within the practice taking on greater ownership in the real estate,
III. Loans (internal financing) from the real estate entity,
IV. Injection of equity by the CPOMP Physicians' Equity Fund, and
V. Injection of equity by other outside investors (e.g., developers).

I. Bank Loans to the Individual Doctors

Personal bank loans to individuals with equity shortfalls may be the easiest and most efficient method of solving the shortfall so long as the doctors individually and collectively are able to accept the disadvantages which may accompany this source. Those disadvantages may include:

1. An outcome where all doctors may not receive loan approval or favorable terms because each must be underwritten personally in accordance with their own creditworthiness. Should that occur, this method will not have fully resolved the shortfall and may create some discomfort among the partners.

2. Personal loans may impact the borrowing doctors' personal financial statements and credit ratings, which, in turn, might negatively affect other planned borrowing or purchases.

3. The borrowing doctors wishing to pay back their personal loans from real estate investment disbursements may need to limit their loan amounts so that after-tax disbursement income will fully cover the personal loan principal and interest payments. Any borrowing in excess of that amount will create an initial negative cash flow.

4. That cash now obligated for personal loan payments may otherwise have been deployed personally in other investments (opportunity cost).

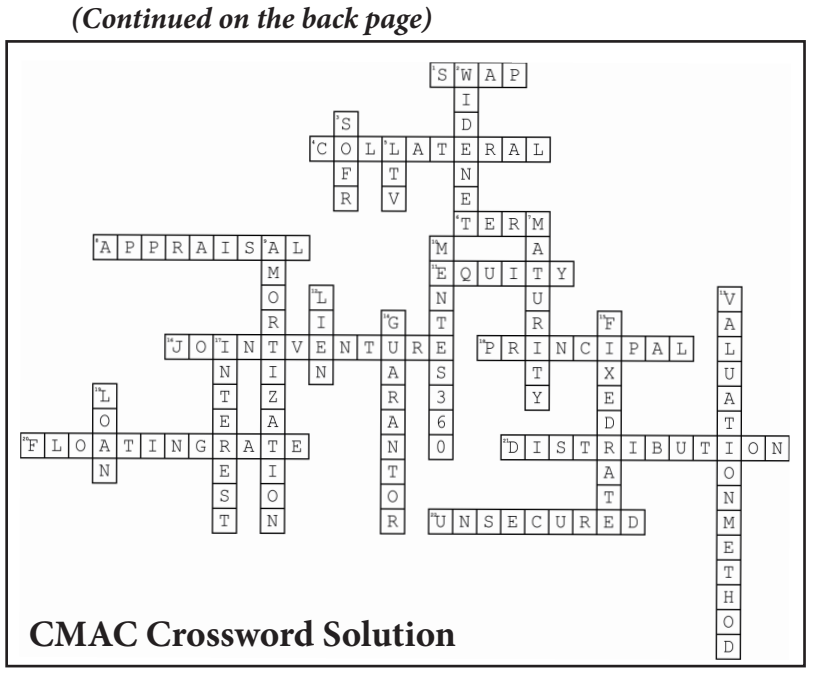
II. Other Doctors Within the Practice Taking on Greater Ownership in the Real Estate

The advantage to this method, assuming the other doctors within the practice have sufficient capital, is that the wealth stays within the practice and those doctors who can afford a greater investment stand to make a greater return. However, this method also creates its own set of disadvantages, which are likely to grow and will impede sustained growth and an alignment of objectives between the partners. Those include:

1. *A Creation of "Haves and Have Nots" in the Partnership.* Since the Haves get a larger share of the disbursements and equity gain, there may be no clear path for those receiving a smaller share to later purchase their way to equality.

2. *An Inability to Fund Partner Buyouts at a Later Date.* This buyout problem can be exacerbated and remain concealed for years, only becoming apparent when those having a larger interest reach retirement.

(Continued on the back page)



CMAC Crossword Solution

The Appraisal Boycott: Partner Buy-ins & Buyouts

Ha Tran
Finance Project Manager

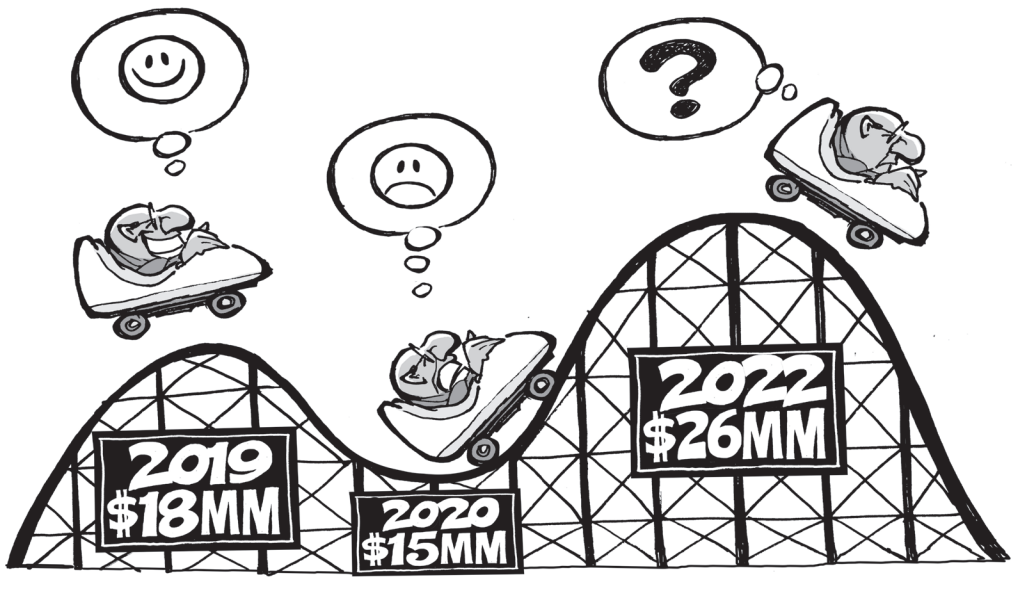
Like when teenagers stopped wearing Crocs in the late 2000s (thanks, Justin Bieber, for bringing back that trend), change is sometimes for the better. Another example of this has occurred in recent years: a consistent and justifiable movement away from using appraisals to value partner buy-ins and buyouts of real estate entities. Unlike Crocs, the primary reason for the "appraisal boycott" trend is inconsistency (because Crocs are consistently bad, obviously).

Appraisals are, by definition, a single individual's opinion of value. Yes, there are some numbers (comps) that are used to support the claim, but we have seen deviations of >25% caused merely by which comps are picked (or disregarded). Take the example of Midwest Orthopedics. Their real estate went from an $18MM valuation in 2019 to a $15MM valuation in 2020 before finally receiving an appraised value at $26MM in 2022. With the debt included, each partner in the group went from $300,000 of equity in 2019 to $0 in 2020 to $800,000 in 2022. The only thing that changed was the appraiser's opinion of value.

But that begs a bigger question. What cheap and consistent valuation methodologies would allow us to achieve a sustainable partner succession plan without creating inequities? Let's explore the primary alternative.

Income Capitalization: The Leading Alternative

Since commercial properties are income producing, their value is ultimately derived from the amount, consistency, and longevity of the income produced. Therefore, a vast majority of the building's value can be found in the lease agreement. That said, it is possible to create a consistent and reliable valuation by applying a multiple of the base rent. Let's explore an example: Say a building is producing $1MM of annual rental income. If you apply a multiple of 12.5x, you end up with a building valuation of 12.5MM. For those readers familiar with cap rates, that is the same as applying an 8% capitalization rate to the building ($1MM divided by 8% = $12.5MM).



This methodology is particularly enticing for a couple of reasons. First, it utilizes the same mechanism that third parties adopt when acquiring a medical office building in a sale/leaseback transaction, which allows for market-driven examples of how outside parties value the income the building creates. Second, and perhaps most impactful, it creates predictable, stable buyout values and consistent returns. Because the real estate valuation is directly proportional to the lease income, as the leases escalate, so does the value of the building, therefore, maintaining the same return on investment.

Now for the tricky part. What capitalization rate makes sense for a specific building or set of buildings? In our experience, there are no hard and fast rules surrounding the exact number; however, there are a few variables that should be considered before deciding on an outcome.

Generally, the easiest place to start is by understanding the value at which a third party would be willing to purchase the building under a long-term lease arrangement (between 10-12 years). Let's say that the buyer asks for a 6% capitalization rate, meaning the purchase price equals the annual rental income divided by 6%. With that in mind, there are two factors one should consider when determining a number relative to a third-party calculation.

1. You are assessing the value of an individual's share and not that of an entity. Because no single individual has controlling rights, there is typically a discount applied for the lack of marketability associated with that non-controlling interest.

2. The third-party sale valuation described above takes into consideration that the practice will maintain a long-term obligation that is driving the value – an obligation that a partner being bought out is not contributing to. Therefore, it would be nonsensical to buy out a partner based on a valuation that the partner has not contributed to creating.

With these two points in mind, we typically see that a discount is applied relative to a third-party market valuation of anywhere between 1% - 3% (in cap rate terms). This means that the ascribed building valuation in the example above would result in a valuation of anywhere between a 7% - 9% cap rate ($14.29MM - $11.11MM).

So, now that you have a valuation methodology that is measurable and consistent, we advise that you put together a long-term model to test, report, and manage the investment. Mentes360, an interactive program created by CMAC Partners, does just that. Based on your group's demographics and defined structure, Mentes360 creates a model that allows you to understand the following variables:

- The impact of different capitalization rates
- The expected return for each partner (inclusive of buyout)
- The effect of buy-ins and buyout notes
- The impact of completing periodic cash-out refinances vs. paying down the debt
- The implications of a minimum investment horizon

For more information, reach out to support@mentes360.com.

Opposing Joint Venture Objectives Creating Unfavorable Outcomes for Doctors

How to Recognize the Conflicts and Protect Your Practice by Using the 3 Cs

Every partner in a joint venture (JV) wants the project to succeed. How they define success and the paths they take to get there, however, can be very different. Let's look at three real examples to demonstrate this point and discuss what physician groups can do to ensure a clear path to their own success.

The Alabama Orthopedic Group

This group built its facility as a 50/50 partnership with its developer. After some years, debt paydown and property appreciation caused a substantial growth in equity. As the buy-ins for new partners grew more expensive, many of the practice partners could not afford to become real estate partners. Therefore, the practice asked the developer to agree to a loan refinance so the property could be leveraged up to reduce equity and allow new practice partners to buy in.

Unfortunately, the developer refused, telling them that his priority was to pay down debt and leave a free and clear property for his estate. The problem worsened over the years, but the developer never relented. As a result, more and more practice partners were left out of the real estate and its enticing ancillary revenue stream. They lost control over major building decisions. And because the doctors owning the real estate no longer controlled the practice, they lost the ability to arrange a sale/leaseback of the property.

The Utah Multi-Specialty Group

This 50/50 JV was created to build a new medical office building (MOB). In the minds of the physician group, this building would become a long-term part of its expanding real estate portfolio. Within months of occupancy, however, the developer partner sought and received an LOI for the purchase of the building. Although the medical group had desired to hold it, and maintained the right of first refusal, the group had no choice but to sell. It was not able to afford to pay the developer what had been offered by a third-party buyer.

As a result, the developer took 50% of the gain without any ongoing responsibilities while the practice group will be paying its rent to an outside party for the next decade.

The Washington Orthopedic Group

This group sought a piece of desirable land to construct a new MOB/ASC that was owned by a local developer. They subsequently entered a 50/50 JV partnership that relinquished control and the financing procurement to their development partner.

The terms of the contract, however, stipulated that the developer required a set return on investment. The financing terms had basically no impact on the developer. Even if the interest rate paid was higher, the leases would be increased proportionately by the practice to ensure the return on investment was met. In some ways, the developer was even incentivized to procure worse financing terms, because doing so would result in higher starting rents, and a subsequent sale or refinance would only improve the outcomes for the development partner!

In the end, the projected rents became unfeasible for the practice, and the project didn't move forward.

Using the Three Cs to Ensure Success on YOUR Terms

The Three Cs are very simple. They are Control, Control, and Control! When entering into a JV partnership:

1. Do not give de facto **Control** to a JV partner by agreeing to conditions that you may not be able to meet (e.g. first right provisions).
2. Do not cede **Control** of project financing to a JV partner if that partner's return is not tied to the interest expense (and thus rent) which the practice pays.
3. Wherever possible, maintain unilateral **Control** over major issues. (Remember, this project won't happen without your group. Your partner should not object so long as their economic interests are protected.)

OK, so really there's only one C, but it's so important we should repeat it three times. (Think Dorothy chanting "There's no place like home" in Oz). Keep shouting "control" or you may quickly find yourself going in the wrong direction.

Physicians' Equity Fund Used to Create Equal Ownership in Real Estate Investments

Like Ozempic, the drug developed to aid diabetics but found to have great benefits in weight loss, the CPOMP Physicians' Equity Fund, capitalized by physicians, was developed with one purpose in mind but has been found to have other very useful applications. Chief among those is the creation of equality among physician partners in a real estate venture.

Until now, whenever some partners within a group could not afford to fund their full equity portion, the most common remedy would be for other partners to take on a larger portion of the ownership. That would mark the start of the immediate creation of the "have and have not" classes. Other issues would then arise and exacerbate with the disproportionate division of distributions and an enlarged buyout of those partners at retirement that could stress the remaining cash flow.

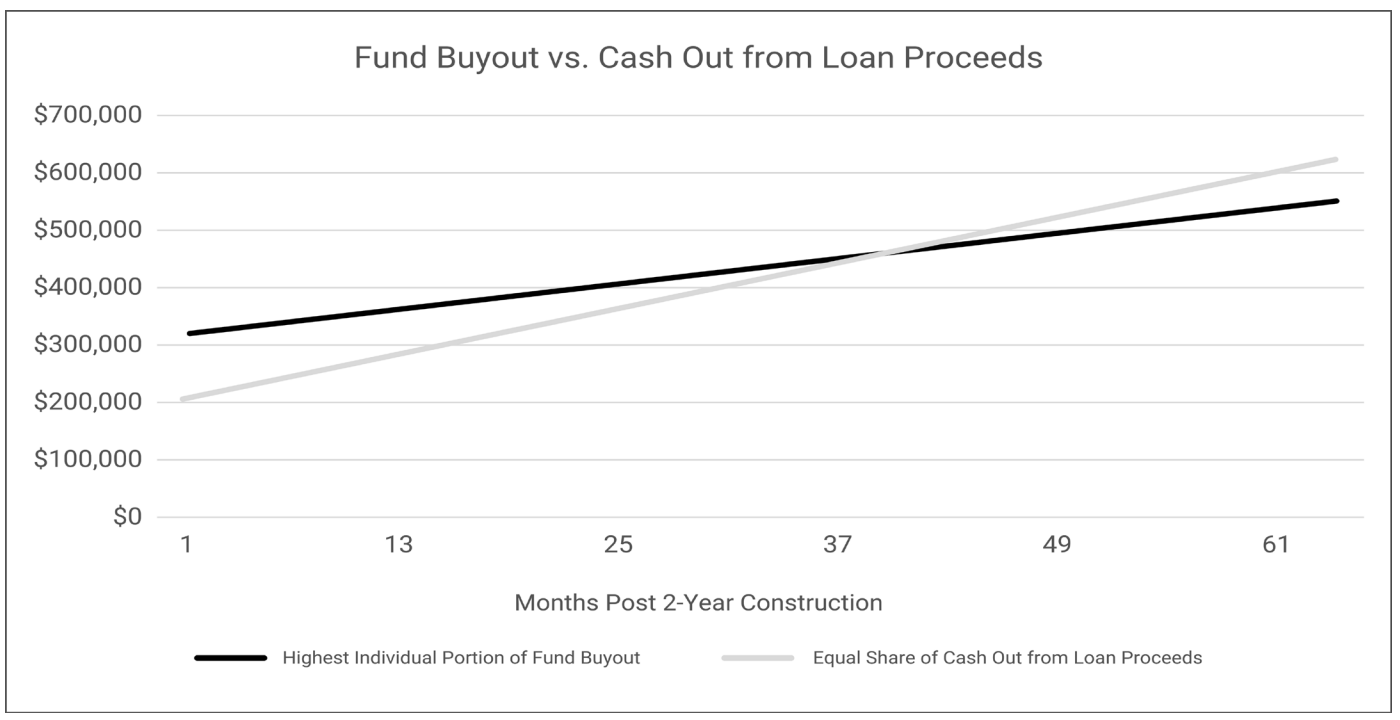
By way of example, let's assume that there are 10 partners building a $20 million MOB that has an equity need of $4 million (20%). For the doctors to have equal ownership, each would have to contribute $400,000. In this case, four of the doctors have only $200,000 each to contribute between cash on-hand and personal loans, creating an aggregate shortfall of $800,000.

The Old Way

Typically, you might have a couple of the more senior doctors step in and take on an additional $400,000 each to cover the $800,000 shortfall. The division between the doctors would then have two doctors owning 20% each, five doctors owning 10% each and four doctors owning 5% each. Moreover, there may be no clear path back toward equalization. And the eventual buyout of the two doctors, who together now own 40% of the total shares, may require more cash than the others then have available.

With the Fund

Rather than have other doctors stepping in to fund the shortfall, the CPOMP Physicians Equity Fund could be brought in as a joint venture (JV) partner with shares proportionate to the equity contributed. Under the JV Agreement, the Fund would have its voting rights flow through to the doctors whose equity it is replacing subject to certain protective provisions. The JV Agreement would call for a buyout of the Fund within six years. The JV is structured so that the buyout should be able to be funded by a refinance within two or three years from completion of construction or acquisition. When that happens, the doctors who fully funded their shares will receive 100% of the cash out from the refinance. The Fund will receive its proportional share capped by the predetermined buyout, and any residual over and above that buyout will go to the doctors. Those doctors would also be responsible for any shortfall. At the completion of the refinance and buyout, all partners will own equal shares as shown in the graph.



Year 6	Initial Contribution	Cash Out from Loan Proceeds	Fund Buyout	Partner Balance	Starting Shares	Shares Purchased	Ending Shares
Dr. A	$400,000	$526,972	$0	$526,972	10.00%	0.00%	10.00%
Dr. G	$200,000	$263,486	($231,253)	$32,233	5.00%	5.00%	10.00%

The CPOMP Physicians' Equity Fund provides an alternative that keeps the fabric of the partnership united rather than pulling it apart. For more information, contact the Fund General Manager Andy Johnson at andy@cpompfund.com.

A Comparison of the Sources of Backfill Equity

(Continued from page 10)

When those retiring partners seek their buyout, many groups realize the entity doesn't have the cash flow necessary, and the remaining partners don't have the equity to facilitate the buyout. Even with a refinance, there is often not enough cash out to the remaining shareholders to fund the buyout of the retired partners having the largest shares.

3. Partner Divisiveness

Unequal ownership positions lead to unequal outcomes for owners; decisions made by the group will impact owners differently. This misalignment can result in contentious issues, as doctors with larger ownership may be incentivized to capitalize on the lease through a sale, or increase rents to increase real estate entity distributions, while those with less ownership request lower rents to benefit from reduced practice expenses.

Either way, even partners with the best of intentions may have their motives questioned. It is recommended that if this option is selected, it be paired with a well-validated, long-term agreement that would allow or require buy-ups down the road. For example, partners may be required to use any future distributions from the real estate, from operating profits or cash out from loan proceeds during a refinance transaction, to dilute owners with a larger share until all have identical ownership.

Without having some sort of equalization plan in place, the challenges of unequal ownership are likely to amplify and result in an unsustainable ownership model that triggers fractures among the group.

III. Loans (Internal Financing) from the Real Estate Entity

Some groups admit new partners by internally financing the new shareholders' purchases. This approach may be favorable for incoming shareholders but quite costly for those already invested. The cost to existing shareholders is not readily apparent and, for that reason, overlooked. However, it can be significant and will occur in two forms:

- Assuming the cash-on-cash returns are in excess of the interest rate charged to the purchasing partner, that difference is lost to the other owners who are redirecting a portion of what would be their distributions in exchange for some lesser interest income, and
- The appreciation of the shares the other owners are giving up ahead of receiving the equity from the loan payment to purchase those shares.

Depending upon the configuration of the partnership, the difference can amount to hundreds of thousands of dollars and is accompanied by a significant reduction in the ROE (Return on Equity).

IV. Injection of Equity by the CPOMP Physicians' Equity Fund

The CPOMP Physicians' Equity Fund (PEF) differs from most traditional equity sources in that it acts as a placeholder with an agreed sale of its shares back to the doctors within two to six years from the initial injection of equity. The buyout return is set at the time of the investment and approximates what the typical buyout might be for any other physician partner at termination. It is structured with the anticipation that a refinancing within six years of the initial equity injection would produce sufficient cash out to fund PEF's buyout.

The risk is that a downturn in the market would result in a value not able to produce enough cash out and the shareholders would need to come out of pocket or find other sources to replace that portion of the equity not paid for in the refinance.

The advantages of the PEF source are:

- The pre-set buyout assures a capping of the payout to PEF in the case of a sale or other liquidity event with 100% of the remaining upside going to the doctors.
- The doctors maintain control of all major decisions (sale, refinance, etc).
- It allows new partners to buy in more affordably and not forego distributions to repay personal loans, because the subsequent refinancing should buy out PEF and bring all physicians to a position of full and equal partnership.
- Upon buyback from PEF, shareholders will see 100% of distributions from operations and liquidity events.

The disadvantage of the PEF source is:

- Risk that a refinancing will not produce sufficient cash to fund a full PEF buyout and that partners will have to negotiate an extension, come out of pocket or seek other equity sources to fund the remaining portion.

VI. Injection of Equity by Other Outside Investors (e.g. Developers)

Consideration of other outside equity sources should be weighed against what is received or given up in the JV agreement. The typical JV Agreement calls for a proportionate level of risk / reward for the investment partners. If a JV partner puts in 50% of the equity, they expect 50% of the upside and downside.

The differences between this source and the PEF mentioned above are: 1) the PEF lets the physicians keep the upside in exchange for limiting downside risk with an agreed takeout, 2) the PEF agrees to give up its ownership in the buyout, and 3) all control stays with the physicians.

Often, a JV Agreement with someone like a developer is a requirement rather than an option. As an example, a developer might own the land and only agree to sell it if it can be an equity partner with the doctors. Under those circumstances, it is important to recognize that an equity partner may have different objectives that are averse to the sustainability of the investment.

The practice group should keep these suggestions in mind when negotiating the JV agreement and seek to:

- Attribute Fair Market Value, not an inflated value, to any non-cash contribution such as land or development fees.
- Receive additional equity for the value of the brokerage fees that would have been due for bringing in any other but your own lease.
- Maintain control over decisions of financing or sale/leaseback.
- Limit the payment to the equity partner of the incremental value created in a sale/leaseback, since that extra value is solely attributable to the practice's lease and ongoing payment obligation.

If there is no consideration (such as control of the land) that would tie a group to this category of equity, it is recommended that other sources be considered first, because the negatives are less detrimental. For additional information on equity sources, reach out to solutions@cmacpartners.com.

The CMAC Team would like to thank its readers and contributers. We hope this newspaper serves as a valuable resource to you and your physician-owned practice.

From left to right: Liz Allport , Peter Kokins, Chris Tollinchi, Mariela Araujo, Greg Warren, Elizabeth Cvercko, Grant Blackhurst, James Winchester, and Ha Tran

Published by:
CMAC Partners
399 Carolina Ave. Suite 250
Winter Park, FL 32789
407-264-7255
solutions@cmacpartners.com

CMAC Partners