THE JOURNAL OF PHYSICIAN-OWNED REAL ESTATE

Volume VIII
Presented By CMAC Partners

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COVID-19 Breaks Barriers on Lending

70 Years Later: Physicians Catch Up with NBA

There was a time when NBA teams were unable to select the best players in the draft because another team elected to use its "Territorial Pick." That allowed any team to take the best player from schools in its area, regardless of its selection order in the draft. In 1950, the NBA threw out the "Territorial Pick" and all teams suddenly had the opportunity to go after the best players in any area, not just those in their own locale.

Until 2020, most medical practices had been operating under very similar constraints. Their bank shopping consisted of whichever institutions had a brick-and-mortar presence in their area … and that resulted in limitations. CMAC Partners has witnessed borrowers of the same creditworthiness receive vastly different terms with the only differing variable being which side of a state line each one falls. With the advent of COVID, however, those geographic lines have become blurred. Bankers, in a quest to satisfy their appetite for independent medical practices, now have at their fingertips greater technology which allows them to provide services to clients outside their locale.

What was once a business that required a hands-on approach can just as easily, and oftentimes more efficiently, be serviced from afar due to virtual means. This opens a world of possibility and competition to a marketplace that has historically been regionally gridlocked.

Working the System

The real winners here are independent practices who are now seeing enhanced banking services at lower costs and banking platforms that allow greater practice efficiency. Working with advocates who can represent a practice's banking needs on a national level produces heightened competition resulting in improved terms from both local and regional lenders seeking to maintain their competitive positions in the market.

CMAC has seen the validity of this premise proved repeatedly as practices such as Olympia Orthopaedic Associates in Olympia, Washington and Cardiovascular Institute of the South in Houma, Louisiana have seen significant improvements to their operations in the past year since deciding to "cross state lines." The time has come for physician groups to improve their bottom lines by expanding their horizons when it comes to their financing needs. It may take a bit of help from those who know the landscapes unfamiliar to borrowers, but the venture will pay unexpected dividends.

5 Top Models that Never Made the Cover of Sports Illustrated

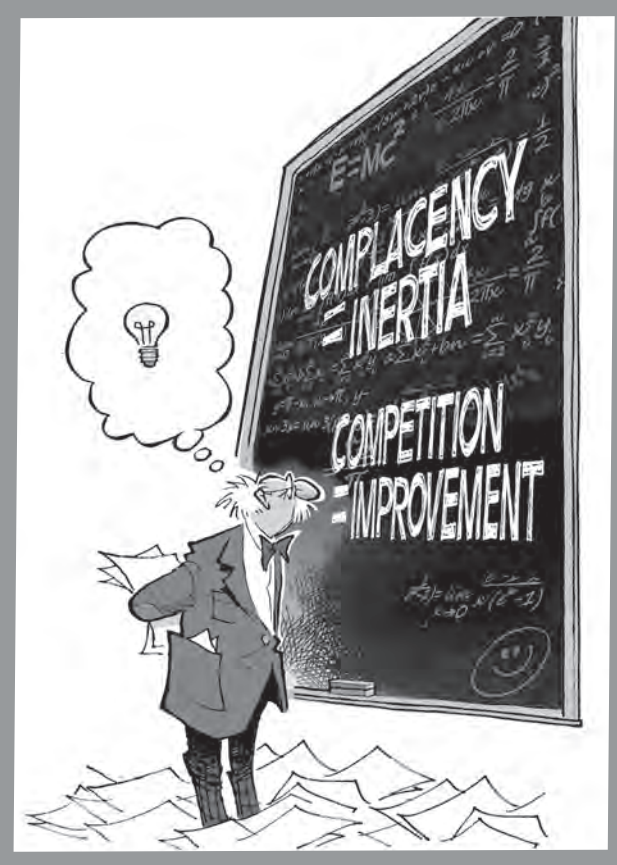
At the request of the Congress of Physician-Owned Medical Properties (CPOMP), CMAC Partners has released five of its proprietary models that have been developed and refined over the last 15 years. These can be requested from CMAC's website. They are being shared to continue CMAC's mission of making physician groups stronger through their medical real estate investment. The models provide a comprehensive range of analyses on real estate structuring and measuring investment performance. Here is a look at how the top five might assist your group. CMAC has also agreed to run a limited number of individual scenarios of each model on behalf of any group until October 31, 2021. The released models include:

TruCourse 2.0: Succession Management Tool

Allows you to model your entity's buy-in and buyout structure over a 15-year period...

(Continued on page 3)

On the Back...



On the Inside...

Why Retired Doctors in the Real Estate are a Formula for Disaster

Grant Blackhurst
Solutions Specialist

I'm a sports enthusiast. I grew up in the UK playing football (I refuse to say soccer) and came to the U.S. to play the game I loved in college. Football – either version – is most definitely a team sport and I am a firm believer in the old adage "there is no 'I' in team." Well, here's another one for you that I have learned in working with physician groups: if there is no "I" in team, there is most assuredly no "WE" in "RETIRED."

Unfortunately, I have too often witnessed doctors who have retired from the practice, taking or blocking actions that have devastating impacts upon the practice of which they no longer are a part. How can this happen? Because even though they left the practice, they continue to hold ownership in the real estate and indirectly wield substantial power over the group.

The Divergent Interests Dilemma

As long as a doctor is a partner in the practice, that doctor's self-interests should align with the best interests of the practice. As soon as that doctor leaves the practice (and stays a partner in the real estate), his or her own interests no longer align. Now they are based on what produces the most income for the real estate and not necessarily what is best for the practice. That doctor has now adopted a "landlord's mentality" and the advantages of having partners who will make beneficial real estate decisions for the practice and the property have been degraded.

The Mess In the Mountains

A perfect example of how this issue can manifest itself took place recently in a western state where a successful and growing orthopedic practice was planning a new satellite facility. The group owned an existing facility with substantial equity and planned to refinance the existing building to free up the equity for the new project. That is a sound strategy employed by many other physician groups in the same position. This group, however, had a few retired physicians who still had ownership in the original building. Hence, "A Divergent Interests Dilemma" that looked like this:

Active doctors' best interests -
Refinance and use the equity to expand the practice and build a new facility. The expansion would fuel growth and profitability.

Retired doctors' best interests -
Do not refinance. An expansion brings risk and could diminish the creditworthiness of a good tenant (the practice). Additionally, they do not believe there are any impactful investment opportunities for the money received from the refinance.

In this scenario, the retired physicians banded together to block the refinance until the physicians in the practice agreed to a set of inequitable demands. These demands created additional risk to the active physicians and reduced the risk to the retired doctors.

This is NOT an isolated case and it is easy to envision many scenarios where interests may diverge between members of the practice. The divergence can lead to disagreements about matters such as lowering rent, accommodating practice cash flow issues, or affordably funding expansion projects.

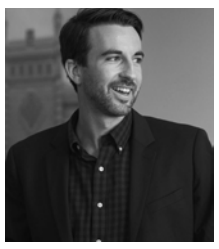
"Avoidance" is Manageable – "Correction" can be Difficult

Retired partners having a continued interest in the real estate probably do so because the group needed those doctors while they were active in the practice to make the initial real estate project happen. It's understandable. There are methods, however, to make that first investment attractive to retiring doctors without positioning the real estate to encounter problems in the future. Those might include grandfathering initial owners for a specified period following retirement and/or restricting voting rights. It can be beneficial for both sides to consider these methods.

Contact the CMAC team to view sample language from an Operating Agreement that can be shared with your own attorney for his or her consideration.

Planning for Your Exit at Your Entry

Keys to Assure a Successful Buyout



James Winchester
Principal

"If there had been fewer lifeboats on the Titanic, then more people would have been saved." - Sir Alfred Chalmers - Board of Trade

This was Sir Alfred's analysis shortly after the Titanic sank. His logic was with fewer lifeboats, more people would have rushed to those boats AND they would have been filled to capacity (which they were not). Thus, more lives would have been saved. Among all of the mistakes on that fateful day, perhaps the biggest was a lack of risk management. Very little effort had been devoted to prepare a solid exit strategy. A lesson learned for any venture: if it has a way in, it should have a tried, tested, and understandable way out.

Physician-owned real estate is no different. Too often, there is little to no strategy associated with ensuring a reliable and thoughtful exit for partners. In fact, groups often make decisions with good intentions that undermine their ability to fund a buyout at a physician's retirement. In essence, they are limiting the number of lifeboats when they are most needed. A couple of the more common, well-intended decisions that hinder buyouts are discussed below.

Debt Repayment

Many see accelerated debt repayment as a prudent step towards financial freedom. That may be absolutely true when thinking about your own home but very different when considering a real estate partnership. The partnership's ongoing success may be dependent upon leverage. As it pertains to providing physician owners surety of exit, accelerated debt repayment is like me in my weekend soccer match rushing forward from my defensive position on the pitch to have a shot on net. The opportunity feels great at the moment but quickly wanes as the player I was to guard scores an unassisted goal. The unintended consequences of my rush are not immediately apparent but can become significant and dire over time.

Paying back debt more quickly builds equity faster, making it unsustainable for the real estate entity to buy out a retiring partner. It also makes the ownership proposition less attractive for new partners to buy into the real estate because the return on equity is depressed, further exacerbating the problem.

Misalignment of the Practice & Real Estate Partners

The practice is driving the real estate value. The practice is driving the real estate value. No, that was not a typo – just driving home the point! Unless you are doing everything possible to bring the partners of the practice into the real estate, you are jeopardizing the sustainability of the investment and your own financial well-being. Keeping the real estate investment to a discrete number of owners will invariably lead to fragmentation of the partners and difficulty in realizing a desirable capitalization event. Keeping the practice partners interested in the real estate as an investment is the key to guaranteeing the viability of your own exit – to make sure your lifeboat is waiting. Going back to the first point, rapid repayment of debt will make this objective much more difficult to achieve.

Risk management is the identification, evaluation, and prioritization of risks. To fully understand the risks, it is essential to forecast and analyze them such that they can be minimized, monitored, and controlled. Planning a sustainable exit strategy is not a guessing game. It is a science and the reason that CMAC Partners has built more exit models (lifeboats) for clients than for any other sector of our consultative services. Many of these models have been made available to the Congress of Physician-Owned Medical Properties (CPOMP) Members or are available directly without charge at www.CMACPartners.com. A look at these models will point you in the right direction and help you avoid the hidden icebergs as you set up your succession plan

What is the RIGHT Time to Sell?

Greg Warren
Managing Partner

Maybe I've been watching too much daytime television but it seems like Tom Selleck is always on and telling me why, at my age, I should think about a reverse mortgage. I can take a chunk of money now and then continue to live in my home. Sound familiar? Maybe that's because the reverse mortgage concept is really not far off from that of a sale leaseback. Reverse mortgages can be the right answer at the right time – and so can sale leasebacks. There is a 9-letter word that will give you the correct answer to the question of whether you should sell or hold. The word is DIRECTION. The decision to sell or hold really isn't that difficult once you understand your ideal direction.

A sale leaseback tends to favor the physician partners who will be retiring at or before the lease term. Conversely, it becomes a detriment to those remaining in the practice when others retire. New physicians will be discouraged from joining a practice that is saddled with excess overhead stemming from a lease that enriched only their predecessors and has ballooned to over-market rates through escalators it no longer controls.

If your practice has reached that point in its lifecycle when it has stopped growing and is most likely to either be absorbed or disbanded within another lease term, it might very well be an appropriate time to consider a sale leaseback. This can produce immediate income and resolve any concern about selling or refinancing the building at a future date without a lease in place.

If the practice, however, is still in growth mode or is of a younger demographic, a sale leaseback is probably the wrong move as it would hinder growth and create excessive lease costs. There would be no commensurate benefit of rental income to the younger partners.

It is estimated that "rent rolldown" on sale leasebacks is likely to average nearly 20 percent. Rent rolldown is the amount by which a contracted rental rate must be reduced to align with market rents. Let's convert that to a real-dollar example. Take

a group that enters into a 15-year lease at a market rate of $25 with three percent annual rent escalations. By the time that lease terms, the group will be paying a premium of more than $227,000 in the last year alone and some lesser amount each year leading up to that term.

That's not to say that you couldn't enter into that same lease while owning the building but, in that scenario, those premium rents go right back to the partners.

Groups that fully understand how a sale leaseback can help them reach the goal which best identifies their DIRECTION will be in the best position to reach the right conclusion.

How Sale Leasebacks Create Hidden Partner Inequities

(Continued from back page)

The reality is this:

The Rx - Sale Leasebacks Done Right

The good news is that a model has been developed that works to identify and correct the inequities so that every partner (retiring, remaining, and new) receives his or her proper share of the proceeds and no partners end up losing their full benefit by paying a departed partner's obligation. Most importantly, it keeps the practice strong and improves the ability to recruit new physicians. Developed by CMAC Partners, the model accurately and impartially determines each partner's share by their commitment to contributing to the income stream that is being sold. Under this plan, partners who are committed to the full term of the lease will receive a full share and those committing to a partial term will receive that portion to which they commit. Provisions are made for changes in those commitments. The uncommitted portion can be managed in a manner that will assure the benefits of sale are realized by those paying the bill.

5 Top Models that Never Made the Cover of Sports Illustrated

(Continued from front page)

Probability-based forecasting allows groups to optimize variables in their operating agreement in order to improve succession planning outcomes. Ideal for groups in the process of addressing concerns during the creation of their operating agreement or revamping an existing operating agreement.

Physician Owner Re-syndication Model

Enables a real estate entity to create an attractive investment for a new owner while assuring retiring partners of full buyout value. The re-syndication model offers a methodology for affordably diluting existing owners and realigning the interest of the real estate to the ownership of the practice.

Economic Outcomes and Equity Gain Model

Provides insight into the economic effects of differing levels of ownership in your real estate project. Most importantly, it demonstrates the inequities associated with giving up large portions of the ownership to outside partners and the impact minority ownership has on a project's IRR. It quantifies options so that partners can make informed decisions.

New Partner Equity Breakeven Model

This model applies a set of macros to the stream of cash flows produced by the real estate investment, net of taxes, to calculate how much can be borrowed personally while remaining cash flow neutral. Oftentimes, this reduces the cash required for equity by greater than 75% and the new physicians do not have to come out of pocket again. Most banks are open and willing to make such loans when negotiated alongside the entity debt.

Loan Savings Analysis

This model takes any number of bank proposals and quantifies the differences in interest rates, amortizations, loan origination fees, and debt service coverage ratios to provide both resultant net interest costs and cash flow differentials. Available with both a simple and complex version.

To find out more about these models and how they can be customized to meet your practice's needs, visit www.CMACPartners.com.

SELL VS. HOLD ASSUMPTIONS

ASSUMPTIONS - INPUTS	
Purchase Price	$18,806,214
1st Year's Rent / NOI	$1,264,399
Annual Rental Increase	2.0%
Offered Cap Rate	6.72%
Basis in Property	$16,395,161
Land Cost	$0
Current Principal Balance	$12,926,152
Depreciation Claimed	$2,411,053
Ordinary Tax Rate	40.8%
Capital Gains Tax	20.0%
Recapture Tax Rate	25.0%
Cost of Sale	3.0%
Costs of Financing	2.0%
LTV	80.0%
Bank Appraised Value	$20,763,580
Loan Amount	$16,610,864
Pre-Tax Reinvestment Rate	6.00%

Your New Project Management
Who is the Fish Out of Water?
By Steve Dobias, Principal, Somerset CPAs & Advisors

I have had the privilege of working with medical groups and hospitals on dozens of projects over nearly three decades. There isn't a code, a plan, or a budget pertaining to medical facilities that I haven't seen or written myself. Yet, there is one thing of which I am certain about – that I would probably be a miserable failure in the role of either a practice administrator or a doctor at any of those groups. I simply don't have the expertise or experience to perform adequately in either role. There is no doubt that I would be a FISH OUT OF WATER.

When the shoe is on the other foot, however, I too often witness both executives and physicians willingly (or unwillingly), without previous construction or planning experience, stepping into the role of project manager. They assume the responsibility of ensuring all elements in a multi-million-dollar investment are brought from concept to completion without a hitch, even when one mistake could cost a 10% budget bulge or a delay of a similar loss.

Would it be surprising to know that the chief underwriter of a large national bank acknowledged that banks will downgrade the credit of the do-it-yourself-ers? This is because they have determined that the distraction of leading the project negatively impacts the performance of the practice. When you stop to consider all the aspects that must be overseen to make a project successful, it becomes easier to understand why this evaluation from those banks is valid.

Here is a list of responsibilities that come with leading a project:

- Define the scope of the project
- Select and manage the development team – architect, contractor, engineers, consultants, etc.
- Review and select land – which usually involves real estate brokers
- Manage site due diligence – third party analysis, environmental, etc.
- Set and manage the budget for the project
- Review alternatives to align the budget to the resources available
- Coordinate the financing needs
- Set and monitor the calendar for the project
- Coordinate communication amongst all parties
- Mediate and resolve issues that arise during the course of a project

Of all the items on this list, there are many that are critically important but, for lack of experience, are simply overlooked. Prime examples of those can include the scope of the project, the timing of the project, and the coordinating communication between all those involved. Take scope of the project. It would be easy if you could just say that you have X number of providers and, therefore, need Y sf of space. The issue is that the design of what you build will be influenced by the site, or vice versa, and

that, in turn, will influence the costs. Do you build to a need or fit your need to a budget? How can that budget be value engineered? Who says to an architect that a curved wall is beautiful but adds unnecessary cost?

Timing can also be critical. If the project is replacement space, what kind of lead time is really needed? How do you handle your current lease? Coordination is essential and any lack thereof can be costly.

And then comes communication. Perhaps the most underrecognized, yet essential, part of a good project manager's responsibility. I did not play quarterback in high school; I played the trombone. But QB is the position I find myself playing on an almost daily basis as a project manager. Just imagine a football team taking the field with 11 players on offense and no play being called. In a successful project, each member of the team must understand how doing his or her job well and on time impacts the performance of other team members and the whole project. Understanding that flow and directing the team can be a full-time job itself.

In summary, most practices do not have a dedicated real estate professional on their staff and adding another job to the practice administrator, CEO, CFO, or COO does not seem prudent when most are already stretched to complete their jobs. Further, real estate projects for a practice are not normal recurring events. As such, the knowledge base may not be at the level needed to successfully manage a project. The credit professionals who assess risk for a living are correct to give the deals with professional project managers a higher grading. The bottom line is that both the real estate and the practice will be better off hiring a project manager to ensure a successful outcome.

SOMERSET
CPAs AND ADVISORS
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Steve Dobias is a CPA and Principal with Somerset CPAs & Advisors. He is an expert in health care real estate and assists clients in the development of medical office buildings, skilled nursing facilities, specialty hospitals, and associated ancillaries. With over 30 years' experience, Steve has a cumulative construction history of over 2.71 million square feet for medical practice construction projects with a combined project cost of $796 million (debt and equity). In the majority of those projects, Steve was involved in the formation of the entities, raising capital and the turnkey construction of the facility.

Evolvement of Hybrid GPO Model Paying Big Dividends in Financing

There is nothing new about the concept of banding together to create greater leverage in order to improve purchasing power and outcomes. The medical community has applied the Group Purchasing Organization model to everything from equipment to linens. There has never been a GPO, however, that could be applied to financing – and for good reason. Financing is highly individualized. The pricing and terms are not based on the size of the purchase but rather on an assessment of risk; every practice group must be measured independently. It's been apparent that this was a hurdle that could not be cleared; the GPO concept could really never be employed to secure improved financing. This, however, has recently changed and medical groups across the country are seeing big differences.

A few years ago, the team at CMAC Partners began to realize that the value in the GPO model went beyond the most obvious benefit of size. What seemed to get buried behind the biggest advantage of volume was the benefit of data and the knowledge it brought. While that may be a minor item in linen, it could play a big role in financing and here's why.

Borrowers operate either in a complete vacuum or at best in a rarefied atmosphere. Because banks and borrowers keep each other's information confidential, none of that is shared and the only basis to get a semblance of the market is through an RFP process generally limited to a few lenders servicing the local area. For all intents and purposes, borrowing is like the lay person buying a diamond, it is a blind item.

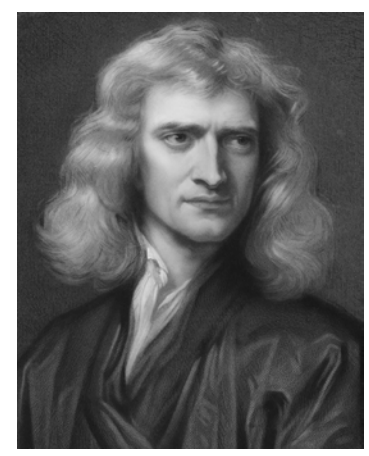
Because CMAC Partners has access to data gained through thousands of proposals it has received in responses to hundreds of RFPs, it has accumulated data that can be used on behalf of its clients to gain optimal responses based upon known data.

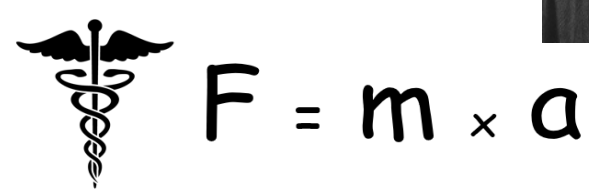
In its simplest concept, CMAC acts as a GPO for groups seeking financing. CMAC Partners secures more than $500 million annually for medical groups and that number carries as much leverage as can be found in any type of GPO. It's like applying Sir Isaac Newton's Second Law of Motion - that $500 million "Mass" combined with the expertise of CMAC as the "Accelerant" produces a "Force" that results in terms and conditions that are rarely matched by those seeking financing independently. The Financial GPO improvements include:

- Lower Rates
- Higher Loan to Value
- Elimination of Personal Guarantees
- Lower Bank Origination Fees
- Higher Distributions Through Lower Debt Service Coverage Ratios

Perhaps the most outstanding feature of this particular GPO is that the only cost is based upon a fraction of savings whenever bank terms are in place or have been proposed and only if the group decides to make use of the GPO outcome.

More information about the "pay from savings" approach is available at www.CMACPartners.com.





"In medicine, Force equals Mass times Acceleration."

Tanner Clinic

Headquarters: Layton, Utah

Multi-Specialty Clinic

$44,100,000

OrthoCarolina

Headquarters: Charlotte, NC

Orthopedic Group

$43,400,000

Virginia Eye Institute

Richmond, Virginia

Ophthalmology Group

$24,100,000

Alyeska Vascular Surgery

Anchorage, Alaska

Surgical Center

$5,000,000

Fort Worth Heart

Fort Worth, Texas

Cardiovascular Group

$13,900,000

ENT & Allergy Partners

Charleston, South Carolina

Ear, Nose & Throat Group

$20,700,000

Metrolina Nephrology Associates

Charlotte, North Carolina

Nephrology Practice

$16,300,000

Coastal Orthopedic & Sports Medicine of Southwest Florida

Bradenton, Florida

Orthopedic Group

$36,400,000

Why Low Leverage on Real Estate Can Kill a Practice

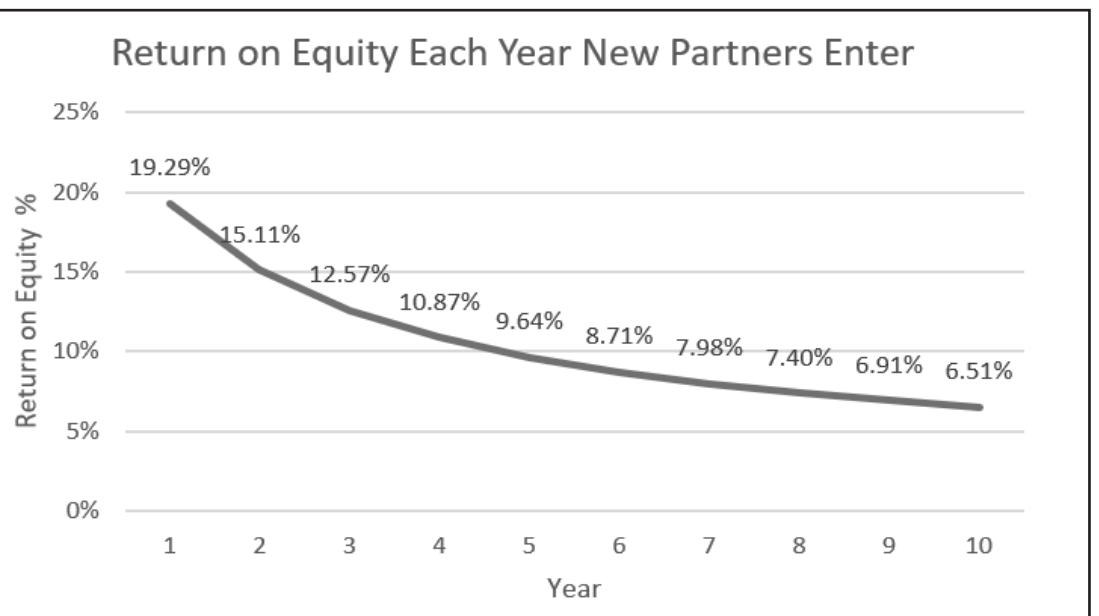
Peter Kokins
Principal

Enzo Ferrari once said, "Aerodynamics are for people who can't build engines." He understood that it was the engines that made his Ferraris the fastest in the world. Similar to Enzo Ferrari, it's important for physicians to understand what's driving their real estate investment. The engine is the medical practice and its ability to pay rent. But what does that have to do with leveraging your real estate?

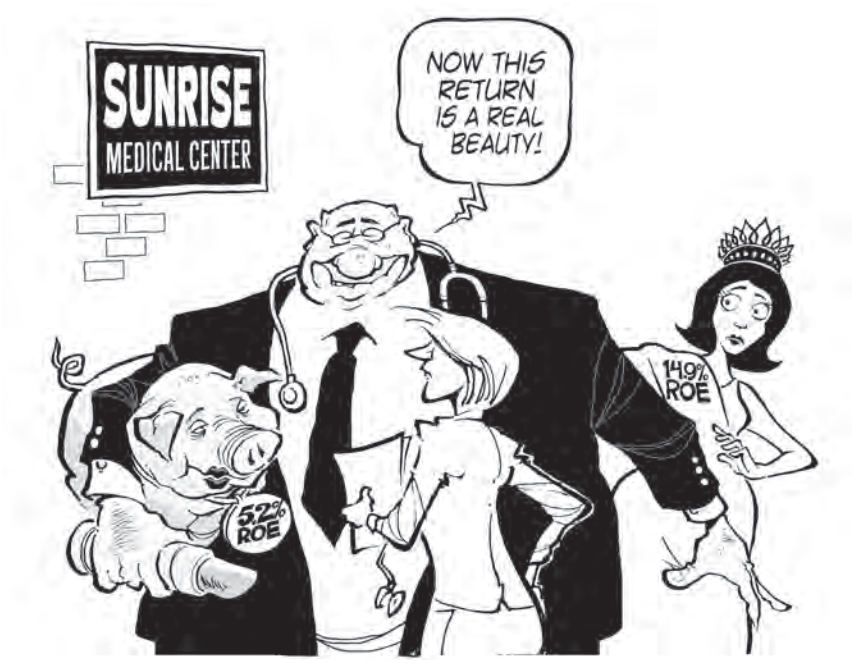
Onboarding new physicians into the real estate investment could be likened to oiling your engine. It keeps the investment protected and adds to its longevity. Aligning real estate ownership with practice ownership also aligns the objectives of the practice with the interests of the real estate, and this, in effect, removes real estate investment risk. In this scenario, the real estate investment is enhanced because it is a further investment in the practice.

While most growing and progressive practices fully understand the importance of attracting new physicians into their property company, many struggle in finding a way to keep the investment attractive. Too many of those groups, however, fail to understand that "attractive" is not the same as "affordable" and, therefore, opt for solutions that don't really address the full issue. The practice end up falling short of their objectives.

There are a number of ways to help fund buy-ins, including having the practice act as the bank and lend the money. But making a poor investment affordable doesn't improve an unattractive investment. It only masks the issue – like putting lipstick on a pig. The real challenge is for the current ownership to make the buy-in as attractive as it was when the initial group invested.



The graph assumes an 8% ROI (Capitalization Rate) with financing at 3.5%, a 25-year amortization and 85% initial leverage. The equity buy in appreciates each year by applying a 3% appreciation and through repayment of the loan. With these assumptions applied, by year 10 the real estate is at 56% LTV.



We often ask groups the following question: "If you were to buy this building again today, would you use 50% of your own money and only leverage the remaining 50%?"

Invariably, the answer is "No, why would we when we could get a much better return by leveraging?" The groups often remind us that this is a business investment and not their individual homes. This is exactly what is being asked, however, when a new physician comes on board an investment with reduced debt and high equity ... regardless of affordability!

The impact that leverage can have upon returns on equity is demonstrated in the graph above. While the "first-ins" borrowed 85% and saw an immediate return of nearly 20% cash-on-cash, the latecomers with 56% leverage show a cash-on-cash return that is about 1/3rd of their predecessors' return. Chances are those doctors will take a pass or look to another practice with a more appealing investment opportunity.

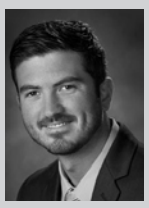
Allowing leverage to wane can be the single greatest cause of investor apathy, growth of tension between the practice and the real estate entities, and greater difficulty in funding buyouts. By looking at your investment as something new and fresh and maintaining reasonable leverage, it will truly remain attractive and benefit the practice and all of its partners.

What CMAC Clients Have to Say...

We needed our appraisal to be accurate to get this done; thank you for going back to the bank and highlighting the areas for improvement, we were able to get a much more accurate appraisal. That saved the entire project.

Dr. James Tucker
OrthoArkansas

Thanks to the CMAC team. We appreciate the guidance and effort throughout the process.



Nick Frain, CFO
Orthopedic Associates of Lancaster

We are so appreciative of the education and guidance that you all have provided. This has been a very favorable experience for us and I've been raving to all my nephrology friends across the country.

Jennifer Huneycutt, CEO
Metrolina Nephrology Associates

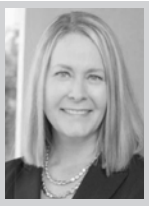
CMAC was always available to help us with any questions after our deal closed. I can't say enough about the availability and readiness of communication.

Dr. Tom Bertuccini
Lafayette Surgical Specialty Hospital

CMAC was a key team member on our Newberg project in 2017-2018. We were incredibly impressed with their expertise and we couldn't have navigated the complicated loan document process without them.

Barbara Tauscher, Director of Operations
The Oregon Clinic - Gastroenterology South

I would like to thank you for everything you and the CMAC team has done for this project. We appreciate your expertise and guidance through this entire process!



Paige LeMay, CEO
Coastal Orthopedic & Sports Medicine of Southwest Florida

Thanks for assisting us with the refinance – you did a great job!

Jeff Baird, Administrator
Willamette ENT

We were so happy with your help on our last project that we are coming back for assistance with a refinance and cash out. That speaks volumes of our confidence in your team.

Dr. Vijay Kalaria
Forth Worth Heart

Thank you for all of your work seeing this transaction through. I've valued your insights, efforts, and guidance greatly and have enjoyed working with you all as well!

Eric Olson, CFO
Orthopedic Physicians Anchorage

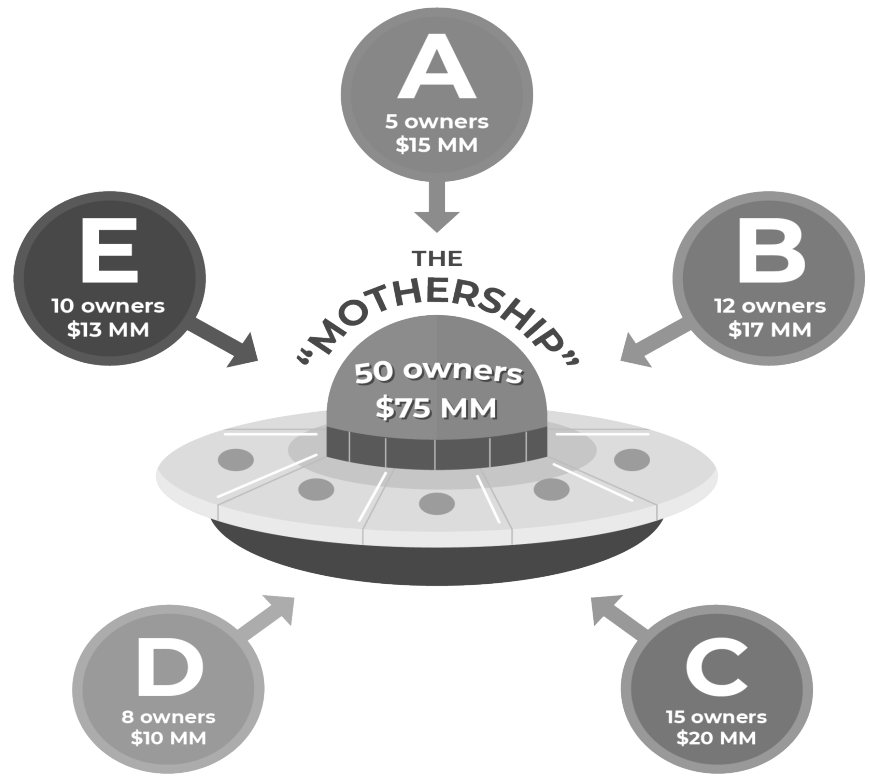
We are very pleased with CMAC and will speak favorably to anyone about the service provided and the outcome.

Craig Kilgore, CEO
ENT & Allergy Partners

Real Estate Roll-Ups

Bringing Disparate Ownership Together for the Sake of Practice Unity

THIS ARTICLE ORIGINALLY APPEARED IN AN EARLIER EDITION AND HAS BEEN BROUGHT BACK BECAUSE OF ITS TIMELY IMPORTANCE.



There is an issue that is growing more and more common – "How do we roll up properties that have diverse ownerships so that all of the partners in the practice have an opportunity to own all the real estate?" This action would create unity rather than discord. Sometimes the disparate ownership is a result of the development of multiple locations within a single practice, while sometimes it is generated by the merger or acquisition of practices that have pre-established ownership in their real estate.

There is good reason for these groups to seek common ownership – the benefits are immense. Primarily, it allows the practice to make office utilization decisions based solely on what is good for the whole without concern that the decision may have an economic benefit for one set of doctors while disadvantaging another.

Moreover, it provides an opportunity for all partners in the practice to equally share the fiscal benefits of ownership, since each are already contributing to the real estate income through practice rent. Full partner participation also unifies the practice. It eliminates any "have vs. have not" issues or perceived inequity from those who feel the rent is too high. The practice becomes one-minded (at least, as far as its rental rates go).

Admittedly, the WHY is easy. It's the HOW that takes a little more work. The biggest challenge is finding a way in which each subset of owners feels that they have received appropriate value for their respective properties in the process of this amalgamation. Once that is addressed, the tax considerations of the different methodologies must be considered.

Fortunately, those seeking solutions do not have to reinvent the wheel. There are others that have come before; utilizing those experiences can go a long way in deciding which methodologies will best fit the situation. There is no "one plan fits all." But there are a number of now-estabished protocols where at least one of many should fit.

This very issue hit the CPOMP (Congress of Physician-Owned Medical Properties) agenda at its 2019 conference in Orlando. With CMAC Partners citing examples from case studies of its own clients, physicians discussed the pluses and minuses of various approaches. The takeaway here is that a practice faced with this issue is far from alone. The way has been paved and you need only reach out through organizations like CPOMP to connect with others who have traveled this road or visit CMAC's website (under the Common Ownership solution) to find models that can be utilized by those with interest.

How Inclusion of Practice Partners Reduces Real Estate Investment Risk

Mariela Araujo
Solutions Specialist

"Bad locations, negative cash flow, high vacancies, and problem tenants" are Investopedia's four most substantial real estate investment risks. For physician investors owning their own medical building, all these risks can be eliminated – assuming one simple guideline is followed. The ownership of the practice should be aligned with the ownership of the real estate. Whenever that guideline is not followed, the objectives of the tenant and landlord begin to diverge and the aforementioned risks are given a foothold to fester.

Optimal alignment of the real estate and the practice has two consequential components – the involvement of all the practice partners and a balance of ownership among those partners. There are several benefits to achieving both goals. To easily understand the concept, consider the following potential advantages.

Credit Enhancement / Elimination of Personal Guarantees

An equally-owned real estate entity allows for the practice to provide a corporate guarantee of the debt. This is huge. It can improve the rate, increase amortization, remove personal risk (through the elimination of personal guarantees), and enhance flexibility from covenants. Without equal ownership, utilizing a corporate guarantee can be a challenging proposition and typically requires negotiation and indemnity agreements among partners.

Facilitation of Physician Buyouts

Generally, unequal ownership is driven by the financial ability or inability of owners to invest. Because of this, in unequal structures, we see that the senior physicians are more likely to have a larger ownership position. This exacerbates the issue of buying out physician owners because now the partners closest to retirement are the ones with the largest buyout. To make matters worse, this buyout needs to be funded by younger physicians with a lower equity position and less capital available.

Favorable Lease Negotiations

Every owner has a different opinion on what constitutes fair market rent in their building. Even with outside impartial rental data, negotiations can be a contentious issue that can be avoided through equalization. In fact, equalization allows the opportunity to manipulate rents in order to maximize returns and improve tax efficiencies.

Tenant Improvement Considerations

Why do I have to contribute as much as my partner to improve a building in which he or she has triple the ownership? The disparity between practice and real estate ownership can be a divisive issue when improving an existing building, particularly with the rising cost of MOB and ASC build-out. This can lead to a delay of plans, poor ongoing maintenance, or complete avoidance leading to disrepair.

The Ties That Bind

This all comes down to the relationship between the real estate entity and the practice. By creating a structure that enforces this relationship, you can add to its sustainability and longevity. Such a structure creates an improvement in return, reduction in cost, mitigation of risk, and an all-around healthier proposition.

Key to Buying Out Your JV Partner

Don't Give Up Your Leverage

Chris Tollinchi
Principal

There are many lessons to be learned from the Bible, but there is one in particular that is applicable to every physician group that ever thought about buying out its Joint Venture Partner's interest. It goes something like this: Esau and Jacob were brothers. Esau, being the older brother, had the birthright entitling him to a double portion of the inheritance. One day, Esau returned from hunting and found his brother cooking a "mess of pottage" - a bean stew. Famished, he asked Jacob for a bowl. Jacob agreed on the condition that Esau give up his birthright in exchange. Bad deal … but not unlike the physician group that enters into a new lease and THEN tries to negotiate a favorable deal to buy out its partners.

With the signing of that lease, the group substantially enhanced the value of the real estate. When subsequently trying to negotiate with its partner, the group negotiates against the inflated value that the practice itself just created. The practice emulated Esau and sold its birthright for a mess of pottage. Practices must recognize the potency of the lease value and then leverage that value to bend negotiations in its favor. Once that lease is signed, the leverage has disappeared.

Timing is Everything

It is important to understand that it is the possibility that the group may not sign a new lease which creates the leverage. The practice should be in a position to evidence a credible alternative to the JV partner, creating some degree of concern to the JV partner that the practice could find or build a replacement or move its doctors into other facilities. Additionally, the doctors need to be in a position to imply that the economic benefits that could come from the alternative(s) may reasonably outweigh the lease up risk in replacing themselves. To accomplish that, a practice needs time. It would be difficult for a JV partner to believe that a practice would consider a new facility six months before a lease expiration. A practice that starts these discussions three years from lease expiration will have better credibility with its JV partner.

CMAC Partners has had the good fortune of representing multiple clients in the negotiation of a JV partner buyout. While our expertise can help with the discussions, it is the position created by the practice itself, through its lease standing, which will substantially impact the eventual outcome. So, start early and don't lose that leverage!

Peyton Manning and Hedging Your Loan

By JP Conklin, Founder & President, Pensford

Trying to determine the most effective and economic way to hedge (or not hedge) your real estate loan is something like determining the order of the NFL draft. Sometimes it's really easy and you can't make a mistake. Like 1998, how about starting with Peyton Manning. Or even the last time my Philadelphia Eagles had a number one pick. That was 1949 and even my grandfather was too young to remember Chuck Bednarik. Other times, it's mind boggling. Like forecasting the order of the QBs drafted in 2021. Well, it's not much different in the financial markets. Not too long ago, rates had flattened to such a degree that there was virtually no difference between 5-year and 10-year rates. Heck, even Mel Kiper couldn't go wrong. Well, that was then and this is now and, wow, have things ever changed. Chances of getting it just right are about the same as scoring a perfect bracket for 2021 March Madness.

With all that said, many of my clients are gluttons for punishment and profess a sincere interest in understanding the forces that move the markets in order to make informed decisions. To those so dedicated, I will do my best to provide some insight. Deciding when and how to hedge with market conditions shifting rapidly as we exit the pandemic, borrowers face challenges in their interest rate decisions that haven't been apparent since the previous recession. As long-term rates rise and the yield curve steepens, borrowers should also consider the market's current rate expectations and the impact going fixed will have on future prepayment decisions. Alternatively, primarily fixed-rate borrowers could diversify their risk, taking advantage of the current rate environment by floating below fixed.

During the pandemic, lower rates made fixed-rate decisions easier. It's hard to argue with locking in your rate for the next decade when Treasury yields are sub-1.00%. As long-term yields began to rise, however, it became more challenging to identify the best option for your rate.

Today, the 10T has climbed back substantially as vaccine deployment, fiscal and monetary stimulus measures, and positive economic indicators have sent yields higher. Floating rates, however, are firmly anchored near 0% with a Fed committed to no rate hikes through at least 2023. This begs the question, "How much of a premium is the right premium to pay in securing a fixed-rate?"

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JP graduated from the University of North Carolina—Chapel Hill with a degree in economics and spent three years in the US Army's 1st Ranger Battalion. He lives in Charlotte, NC with his wife, five children, and two dogs. He is a member of the ULI Capital Markets Committee, an avid sports fan, and has been a private pilot since 2006.

During the last rate hiking cycle, the Fed hiked every other meeting, 0.25% each time. Assuming a 10-year rate of even 1.50%, a similar pattern would require 18 months or more of hikes before floating rates matched the 10-year fixed-rate. Given the Fed has indicated it is on hold for at least three years, that makes the inflection point about five years from today to reach even 1.50%. But that doesn't account for the savings along the way, meaning the Fed would have to continue hiking to 3.00% before you really reach your point of indifference. It has been 13 years since LIBOR hit 3.00%.

Compounding this is the prepayment language frequently found in fixed-rate deals. Many borrowers fail to appreciate that, when they lock in, the steepness of the yield curve will drive their future penalty. The greater the difference between short-term and long-term rates, the more you need rates to increase to get back to a $0 penalty. Because the yield curve has steepened recently, accounting for potential prepayment penalties has become more critical.

For example, if you were to enter into a 10-year fixed loan today at 3.50% and wanted to refi five years from now, you would need the Five-Year Treasury to climb to 3.50% by 2026 to have a $0 prepayment penalty. The Five-Year Treasury hasn't hit 3.50% since 2008 and is considerably less than that today.

Even if the Five-Year Treasury climbs to 1.50% over the next five years, a $20million loan would still have a $2 million penalty, which means you really paid 5.50% instead of 3.50%. Would you have chosen a deal with a 5.50% fixed-rate?

That is the hidden cost of fixed-rate debt. Many borrowers are uncomfortable with the idea of floating rate exposure for ten years, but don't really consider how expensive fixed-rate debt can be.

Historically, markets consistently overestimate the future path of rates, especially as the economy exits a recession. Following the financial crisis, the Fed's forward guidance was similar to today and they ultimately waited almost seven years before hiking again. If this recovery looks anything like the last few, floating rate borrowers could expect to float below current projections for some time.

There are many ways to mitigate rate exposure while managing a potential prepayment penalty in the future. If you may sell or refinance within the next 10 years, you might choose a shorter-term fixed-rate. Or choose a floating rate, knowing there is a lot of cushion to absorb higher rate movements once you account for the prepayment penalty. Use hedges to diversify your rate risk. There are a lot of ways to customize a rate strategy specific to your unique situation.

Ultimately, you may still choose a 10-year fixed-rate deal, but do so with your eyes wide open about potential penalties and the impact it has on the effective interest rate you pay.

CMAC Gives Back

Every year, CMAC Partners collaborates with nonprofit organizations that are working to build a stronger and supportive community. The CMAC team has participated with a local Central Florida organization called Support Our Scholars (SOS) for multiple years.

About SOS

SOS is a non-profit organization that provides financial and emotional support to disadvantaged young women with extraordinary potential during their college journeys. Each scholar receives a yearly stipend along with dorm essentials, financial and leadership guidance, business contacts and professional opportunities, and a trained mentor who remains with her through her college career. The incoming freshman all hail from Central Florida, and while most stay in the state at attend school, some make the journey out of state as well.

SOS SUPPORT OUR SCHOLARS
Changing Women's Lives One Degree at a Time

Scholarship Contribution

CMAC contributes to the SOS fund which is allocated for scholarships, dorm needs, and other resources for these young women as they begin an important new step in their lives. Without SOS, these resources would not be easily accessible to them. The support from donors allows them to focus on their studies and extracurricular opportunities that will help them excel towards graduation.

Mentoring

A couple of CMAC team members have recently become part of the Mentorship Program with SOS. CMAC's Marketing Director Elizabeth Cvercko was paired in 2020 with her mentee, a motivated and hard-working young woman who entered Florida State University to study Criminal Psychology. Elizabeth will follow her mentee's journey through her four years of college, making sure she has the support and resources to succeed during her classes and reach her career goals. Oftentimes, it is just the extra support, motivating words, and attention that gets these young women over any challenges they face at school and allows them to focus on their very bright future.

CMAC Partners' Elizabeth Cvercko, left, and her SOS mentee, second left, class of 2024.

Will You Let Inertia or Improvement Define Your Practice?

In Portland, Oregon, The Gastroenterology South division of The Oregon Clinic was seeking financing for its new project and received a pretty decent proposal from its previous lender. Yet, that same lender subsequently threw out its original pricing in favor of much lower rates when a new RFP hit its desk.

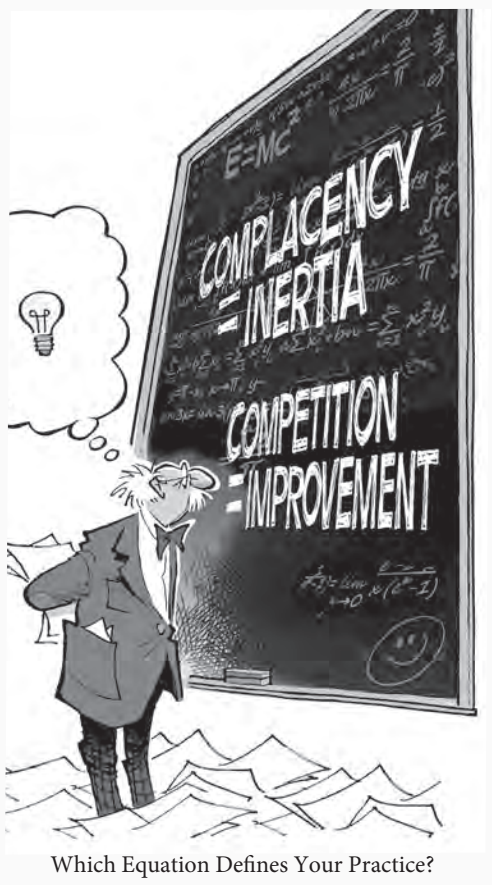
In Olympia, Washington, Olympia Orthopaedic Associates negotiated with its incumbent bank to improve the terms of its real estate financing without any discernable movement. When the group advised the incumbent bank of its decision to move to another bank, the rate suddenly got a lot lower (but a bit too late).

In Houma, Louisiana, Cardiovascular Institute of the South (CIS) tried unsuccessfully to negotiate with its incumbent lender. The lender figured no other Louisiana bank could knock them off their throne. That lender did not expect two other banks from outside the state showing CIS some real love.

In Boulder, Colorado, BoulderCentre for Orthopedics had been given its last and best offer to finance its real estate by the lender that had handled the practice banking for the last six years. Two months later, that same bank dropped its pricing drastically after not immediately winning the RFP.

And, near Salt Lake City, Utah, Tanner Clinic's Chief Medical Officer was assured by the President of its incumbent bank that Tanner would be given the best pricing, only to learn that the bank's VERY best pricing was offered only after it didn't win the bidding.

What happened in these cases is typical of what CMAC Partners sees across the country and is fueled by one single cause COMPETITION. Had any one of these practices settled for what their friendly bankers had offered as favored-client pricing, they would be seeing a lot less on the bottom line. Every physician partner would have less money in his or her pockets.



Which Equation Defines Your Practice?

Historically, there has been a reluctance to change banking relationships. While everything from insurance coverage to equipment is bid out, banks have enjoyed a special immunity from close scrutiny. Well, things are changing. Practices are growing businesses, and the best outcomes demand the best business practices. As these examples bear out, COMPETITION is at the heart of those optimal economic outcomes.

And, while COMPETITION has always been a great motivator in and of itself, the recent advances in technology have produced even greater improvements for those ready to move outside of their comfort zones.

Olympia Orthopaedic Associates reports that it has seen better service from its new Atlanta-based bank than it saw from the bank having a branch five minutes away. Cardiovascular Institute of the South has been presented with operational advancements from non-Louisiana competitors that it is excited to institute.

So, consider the question once again, "Which equation defines your practice?"

How Sale Leasebacks Create Hidden Partner Inequities

Problem Identified. Solution Found.


Liz Allport
Executive Vice President

FACT: Sale leasebacks enrich those doctors retiring before the term of the lease at the expense of every other doctor.

Could you imagine a world in which you could sell what isn't yours and keep the money? How about an orthopedic surgeon who gets paid in advance to perform 20 knee replacements a year for the next 10 years and retires after five years, keeping the money while another surgeon takes those cases for free? It may seem ridiculous, but that is exactly what happens in almost every sale leaseback.

You need only ask yourself one simple question: If a partner retired from the practice and was bought out of the real estate, would the real estate entity continue to pay the retired partner distributions? If the answer is "no," then read on.

How it Happens

For the sake of simplicity and this example, we will assume that the same doctors have equal ownership in the practice and the real estate. In a sale leaseback, the buyer pays the owners a specified sum in exchange for a series of monthly payments from the practice as agreed in a lease. The purchase price for that income stream is significantly more than what would otherwise be paid for the building without a lease. With equal ownership, the additional value created by the lease is received by each physician partner proportionate to their share of the ownership. The practice now has an obligation to make that stream of payments over the lease term. That arrangement is fair and equitable, so long as each partner who received the payment from the buyer is a part of the group making those payments over the lease term. Once a partner retires after receiving payment (or other benefits) for the full term of the lease, they are no longer contributing to the monthly rental payments for which they received compensation. They are also not entitled to their share of the premium received for the remaining period.

It may be easier to envision if one looks at this as debt. Think about a practice partner receiving a distribution from a loan that the practice has to repay and then leaves the practice early with the remaining partners responsible for the outstanding payments.

The Adverse Impact

In a sale leaseback, the retired partner(s)' share of the burden has now fallen upon the remaining members who have not and will not be compensated for their new share of the payment. For the doctors remaining in the practice, it means that they have not received the commensurate premium due. This leads to a direct and possibly substantial economic loss. The reason is because if the building had not been sold and a doctor had retired, the portion of the rent received that would have gone to the retired doctor now goes to the remaining partners. That takes us back to the doctor who was prepaid for surgeries and left the practice early, leaving other surgeons to perform the work. A simplified example shows a group of 11 partners who enter into a sale leaseback with a 15-year lease. Five of the original partners leave at the end of five years and five new partners replace them.

(Continued on page 3)

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

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

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