

The Sale-Leaseback Crisis

And the Rare Opportunity It Presents to the Savvy Physician: Turning a Market Shift into a Strategic Advantage

There’s an old saying that captures today’s real estate environment perfectly: **“The only constant is change.”** Another follows closely behind: **“One person’s challenge is another person’s opportunity.”** Over the past few years, we’ve seen both of these truths play out in the medical real estate market.

Real estate markets move in cycles, and recent years have delivered a powerful reminder of that fact. The same forces that drove unprecedented highs in medical property values have now swung the other way—creating new challenges for some but opening rare opportunities for others.

Not long ago, many physician groups sold their medical office buildings at peak valuations, fueled by historically low interest rates and record investor demand. Those cap rates dipped to below 4.5% in certain cases. Some walked away entirely, while others retained a stake as partial owners.

Since then, interest rates have climbed sharply, valuations have corrected (averaging more than 6.5%), and buyers—particularly those with aggressive debt or private equity funding—are facing mounting pressure to meet loan obligations and deliver investor returns.

For the physicians who sold, this reversal has created a unique position of strength. Lease agreements, especially ones approaching renewal, hold the key to the property’s value. As tenants, these physicians can directly influence that value.

This means:

- **A chance to repurchase the property** at a steep discount compared to its peak price.
- **The ability to negotiate a new lease** with more favorable terms, reduced rates, and greater control.

What began as a seller’s market has now turned into a buyer’s moment—at least for

those who know how to act quickly. For physicians, this is not just about reclaiming a building or saving on rent—it’s about turning market change into practice stability, increased equity, and long-term control over one of their most important assets.

An Advocate to Navigate the Complexities for Optimal Outcomes

Negotiations involving millions of dollars and intricate terms are admittedly difficult and require substantial expertise. That has driven the rise of advocates to represent physicians in such negotiations. Notable among such advocates is a team assembled by CMAC Partners that in-

cludes some of the most respected leaders in physician-owned real estate. The team will be headed by CMAC with the other participants being brought in based on specific needs, areas of expertise or geography.

CMAC and its experts will provide an initial opportunity assessment and develop a strategy to meet the investment parameters of the physicians with corresponding commitments of both debt and equity to provide a clear path forward. Services are purely performance based so that any group can fully assess its opportunities without financial risk.

Just as timing played an important role in selling while the market was hot, timing plays the same role in buying during a cooled market. The time to move is while the current owner is feeling the pressure. The rewards could be significant and the risk is nothing more than a bruised ego in the case of being rebuffed. That’s a fairly attractive tradeoff.

For physicians, this is not just about reclaiming a building or saving on rent—it’s about turning market change into practice stability, increased equity, and long-term control over one of their most important assets.



Malcolm Butler creates opportunity from adversity with his interception at the goal line in Super Bowl 49

Orthopedic Group Receives Over \$650K Rate Reduction on 100% Financing

In September 2024, Orthopedic & Sports Medicine Center of Oregon, a six-physician group in Portland, OR, was ready to move forward with its incumbent bank to finance its new \$17.5MM MOB/ASC under what seemed to be favorable loan terms.

However, after attending a recent CPOMP conference, the group’s CEO connected with peers who had partnered with CMAC Partners to test the market. Inspired by their success, the

CEO encouraged the doctors to meet with CMAC and, as a result, secured significantly lower rates while reducing their required cash equity contribution.

What Caused the Rate Drop?

Two factors – competition and reputation. Once engaged, CMAC issued an RFP to over 20 banks simultaneously, creating a highly competitive bidding environment. Given CMAC’s reputation and its **One Bid Policy**, banks knew they had to present their most competitive offers upfront.

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Recognizing and Preventing “Killer Clauses” in Physician-Owned Real Estate Loan Agreements

How One Covenant Violation Could Trigger a Financial Domino Effect — and How to Stop It Before It Starts



James Winchester
Principal

Imagine this: You've built your medical practice for years and own the real estate through a separate entity. You've never missed a loan payment. But one morning, you receive a notice from your lender: your loan is in default. Not because of missed payments — but because a **debt service coverage ratio (DSCR)** fell below the required covenant of 1.20x.

The bank now has the right to increase your interest rate, demand a principal pay-down, or even accelerate the entire loan. You scramble to understand how you tripped the covenant — only to learn that the bank calculated coverage not just from the rent paid by your real estate entity but also based on your operating practice's financials. This wasn't just a tripwire. It was a “killer clause.”

What Are “Killer Clauses”?

In real estate loan agreements, particularly those for physician-owned practices, financial covenants such as **DSCR** and **Fixed Charge Coverage Ratios (FCCR)** measure a borrower's ability to meet its debt obligations. However, these covenants can become dangerous when misunderstood, misapplied, or structured over-aggressively.

A big culprit that frequently causes confusion and frustration is the term “**Global**” **Pre-Distribution DSCR**. This calculation includes your operating practice.

Borrower-Only vs. Global DSCR: A Crucial Distinction

For borrowers, clearly understanding

and negotiating which DSCR will be used can have significant implications on loan approval, terms, and required guarantees.

- Borrower-Only DSCR*
- **Definition:** Measures net operating income (NOI) from the real estate entity (e.g., medical office building) divided by its debt service.
 - **Purpose:** Ensures the rent received from the operating entity covers the loan payments without relying on outside sources.

- Global DSCR*
- **Definition:** Combines the financials of both the real estate entity and the operating practice (your medical group) to determine debt coverage.
 - **Purpose:** Allows lenders to evaluate the combined risk of the two related entities.

Fixed Charge Coverage Ratio (FCCR): Another Hidden Trap

While DSCR focuses on real estate cash flow, FCCR captures a broader range of obligations, including rent, debt service, capital leases, and dividends/distributions.

If a lender applies FCCR globally (i.e., across the practice and real estate), even a one-time equipment lease or partner buy-out could trip the covenant.

- The Consequences of Tripping These Covenants**
- Violating DSCR or FCCR doesn't just lead to a stern warning. It can trigger:
- Interest rate increases (default rates 2–5% higher)
 - Principal paydown requirements (e.g., \$500,000 due in 30 days)

- Loan acceleration (entire loan balance called immediately)
- Restriction on distributions to physician-owners
- Damage to future financing due to reporting of a technical default

For most physician-owners, this is a completely avoidable crisis — if they catch it early.

How to Prevent a Killer Clause from Striking

- 1. Identify the Covenant Language Before You Sign**
- Ask your lender to clarify:
- Is the DSCR based only on the real estate entity or global?
 - Is there a FCCR? If so, which entities does it include?
 - What happens if the covenant is violated? Is there a grace or cure period?

- 2. Test the Covenant Yourself — Every Year**
- Before agreeing to terms or committing to financial projections, you must:
- Use prior year financials (tax return or CPA-prepared statements) to calculate:
 - ▶ Borrower-only DSCR
 - ▶ Global DSCR
 - ▶ FCCR (if required)
 - Model forward-looking projections based on:
 - ▶ Rent schedule
 - ▶ Operating practice P&L
 - ▶ Capital expenses or planned distributions

You're not just running math — you're

simulating whether your loan is safe.

- 3. Negotiate or Recast Risky Covenants**
- If your projections suggest a future covenant breach:
- Ask for a waiver or restructure before the issue arises.
 - Push for more flexible thresholds (e.g., 1.10x vs. 1.25x).
 - Include carve-outs for non-cash or one-time items (e.g., bonuses, equipment purchases).
 - Try to separate entities in financial calculations.

- 4. Build a Covenant Compliance Checklist**
- Create an internal process to:
- Review covenants quarterly
 - Update projections annually
 - Flag any major practice changes (e.g., new leases, capital expenditures)
 - Communicate with the lender proactively if needed

Final Thought: A Covenant Doesn't Have to Be a Killer

When structured clearly and monitored proactively, loan covenants protect both you and the bank. But when vague or misunderstood, they can become lethal.

For physician-owned real estate entities, especially where the practice and real estate are tied together, understanding how your lender defines “coverage” is just as important as understanding your interest rate. Before you sign — and every year after — test the numbers. Know the risk. Don't let a technicality endanger your practice or your property.

CMAC GIVES BACK

A Continued Partnership with Support our Scholars

CMAC Partners proudly collaborates with nonprofit organizations committed to strengthening communities and expanding opportunities for those who need it most. One of CMAC's most meaningful partnerships has been with Support Our Scholars (SOS), a Central Florida non-profit dedicated to empowering young women through education.

About Support Our Scholars

SOS provides financial, emotional, and professional support to high-achieving, under-resourced young women throughout their college careers. Scholars receive annual stipends, career coaching, and—perhaps most importantly—a dedicated mentor who walks with them through all four years

of college. These exceptional students, many of whom are the first in their families to attend college, come from across Central Florida.

Ongoing Commitment

CMAC continues to contribute to the SOS scholarship fund, helping cover essential expenses like tuition gaps and housing needs. This allows scholars to focus on their academics, extracurriculars, and pursue internships without the burden of financial stress.

Growing Mentorship Involvement

Mentorship is a cornerstone of the SOS model, and several members of the CMAC team have stepped up to support scholars on their journey. **Eliza-**

beth Cvercko, Principal & Director of Markeing, has been an active mentor since 2020 and recently began mentoring a Florida A&M University student, who will study biology and join the marching band.

Liz Allport, CMAC's EVP of Finance, is currently mentoring a student at Colby College who is majoring in biology and preparing to graduate this year.

Through practical advice and a steady presence, CMAC mentors help their scholars navigate challenges and celebrate successes, ensuring they feel seen, supported, and empowered from freshman year to graduation.



Orthopedic Group Receives Over \$650K Rate Reduction on 100% Financing

(continued from front page)

Ultimately, the incumbent bank retained the business—but only after lowering its original rate by 0.60%. This reduction resulted in more than \$650,000 in present value interest savings.

Overcoming an Appraisal Challenge

with an Innovative Solution

Initially, the lending bank approved an 80% loan-to-value ratio, which seemed sufficient ... until the appraisal came in substantially under the project cost. The group had expected that it's previously purchased land would cover the equity,

but the shortfall created a financing gap.

CMAC quickly devised an out-of-the-box solution, structuring a practice loan based on enterprise value to bridge the gap. This approach allowed the doctors to finance 100% of their remaining out-

of-pocket costs, ensuring their project moved forward seamlessly.

For more success stories on how independent practices are optimizing real estate financing, visit our portfolio at www.CMACPartners.com.

Swap Hidden Costs for Better Returns

Level the playing field with a swap advisor to ensure you don't lose when executing an interest rate swap



Did you use an interest rate swap to lock your interest rate? If so, do you have any idea what your swap spread was at the time of execution? Chances are ... probably not.

The reason I can say this with confidence is because the **swap spread**—the profit taken by the swap desk—is never transparent. Many borrowers don't recognize that the swap desk operates independently from your banking relationship manager. More importantly, the swap desk isn't required to disclose this spread (the profit they make). That's why you won't find it in any of your loan or swap documents. This information asymmetry puts the bank firmly in the driver's seat—while your group is taken for a ride.

Taking a quick step back—an **interest rate swap** is a method commonly used by lenders to synthetically fix your interest rate. It can be a valuable resource that allows groups to improve their interest rate. Essentially, it's a separate contract layered on top of your loan to exchange a variable interest rate for a fixed interest rate.

When reviewing your bank's proposal and, later, the loan documents, the **loan spread**—the bank's profit from the loan—is usually easy to spot. For instance, the bank may state your interest rate as Term SOFR (the floating rate index) + 2.00%, meaning their profit margin on the loan is 2%. If you choose not to enter an interest rate swap, your loan would float based on this index plus a 2% spread.

Sometimes, if you ask the right questions (or get lucky), the bank may state what the indicative interest rate would be on your proposal if you were to fix the rate with a swap. But what's never disclosed—neither in the pro-

posal nor in the final documents—is the swap spread (the profit the swap desk takes when fixing your rate).

Unless you have access to live market data—such as a Bloomberg terminal that allows you to price up the cost for a specific swap structure on a given time and day—you won't have the ability to determine this key piece of information.

Using the same example, let's say the bank quotes an indicative fixed rate of 6.00%. To uncover the hidden swap spread, you'd need to determine the cost of funds for the given swap structure—on the same day and at the same time the bank proposed. Suppose the cost of funds was 3.50% and, as mentioned above, the loan spread

and 25-year amortization, that could amount to approximately **\$759,000** in profit at execution (present value of each 0.01% = ~\$15,180 x 50).

The swap spread becomes an embedded prepayment penalty that's carried forward. The swap desk will either receive this profit over time as you pay the interest rate or, if you terminate the swap early, it will be factored into the swap unwind calculation. Either way, this ~\$759k is a sunk cost that the borrower cannot recover.

Even if you've clarified the swap spread with your lender during negotiations, there's nothing stopping the swap desk from taking additional swap profit at execution—unless you have access to live market data to verify

pertise can accurately price up the cost of funds for your given swap structure. This enables you to isolate the swap spread and ensure it's adhered to on the day of execution, removing the information asymmetry from the process.

2. Market Knowledge to Strengthen Negotiations

It's reasonable for a lender to charge a swap spread—but how much is too much? A seasoned swap advisor can benchmark your transaction against similar deals, provide a sense of what's fair, and help negotiate a more competitive spread for your group.

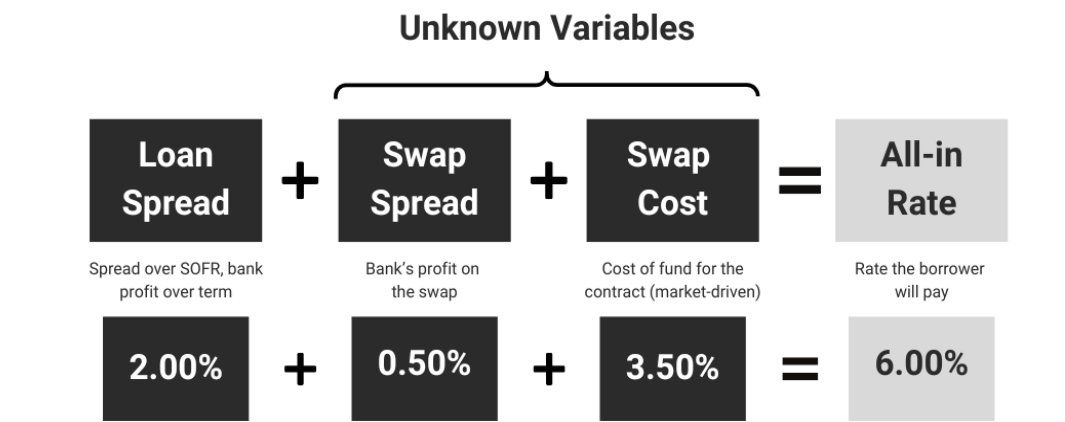
3. Expertise to Align Swap Structure with Specific Goals

Interest rate swaps are highly customizable products. There are various hedging strategies that can be adopted to match your group's objectives and philosophies.

- ▶ Have a greater risk tolerance, or confident that short-term rates will fall? You might want to fix a portion of the debt and leave some floating to take advantage of a potentially lower rate.
- ▶ Expecting to refinance before the term of the loan? You might consider swapping for a shorter term.

An advisor can help you navigate the different options and find one best suited for your needs.

To put it in perspective: if you were involved in a multi-million dollar lawsuit, would you represent yourself in court? You can execute a swap on your own—but that doesn't mean you should. Regardless of whether or not you choose to use CMAC Partners, we strongly recommend working with an experienced swap expert to avoid unnecessary, hidden costs and ensure your structure is aligned with your best interests.



was 2%. That would imply a 50 basis point (bps) swap spread.

A 50 bps swap spread would be considered an excessive level of profit for a swap desk to take on a transaction—yet it's often hidden from borrowers throughout the entire process. What's more, this swap spread is arguably more impactful than the loan spread. That's because the swap desk recognizes this profit immediately, on the day the swap is executed.

Here's how it works: the swap desk takes the 0.50% interest per annum, multiplies it over the life of the swap, and present values it back to day 1 to capture it as an upfront fee. On a \$20 million swap with a 10-year term

the swap spread they're taking on the stated fixed rate. We've been on swap execution calls with clients where the swap desk attempted to slip in an **extra 10 bps above the agreed-upon swap spread**. In the prior example, that would have quietly added **\$150,000 in hidden costs** to the borrower—had it not been caught. I hesitate to imagine what they might have added if a swap advisor wasn't present to hold them accountable.

So how does having a swap advisor help alleviate this problem?

1. Pricing Transparency to Uncover Hidden Costs

A swap advisor with access to live market data, the right tools, and ex-

Cardiology Practice Achieves Superior Financing On Their Terms

The Heart Group in Fresno, CA was on the verge of closing a deal when the bank introduced a last-minute covenant requiring audited financials—which the physicians were unwilling to accept. The group turned to CMAC who initiated a comprehensive RFP process to vet the market and secure superior financing options.

The new financing eliminated the need for CPA-audited financials and pro-

vided flexible personal guarantees, which will be released if the group decides to opt for reviewed financials. Understanding the group's preference for minimizing debt and enhancing cash flow, CMAC worked with the lender to design a repayment structure that aligned with their objectives.

Ultimately, the physicians chose to maintain two separate facilities: a primary construction loan and a tenant

improvement note. The real estate loan closed on a 10x25 term with early repayment options, while the tenant improvement loan was structured with a 10x15 term and similar prepayment flexibility.

The doctors were pleased that CMAC successfully identified better financing solutions and structured the loans according to the physicians' goals and preferences.



To Include or Not to Include: A Discourse on Swaps and Valuation

A Shakespearean-style tale of finance, fair dealing, and physician partnerships

Written in the spirit of Master Shakespeare, where boardrooms are the new courtrooms, and spreadsheets the stage. This tale, though modern in subject, is told in the voice of a wiser age, when logic wore doublets and balance sheets bore smudged ink. Imagine, if you will, a cast of physician-partners grappling not with daggers and destiny, but with cap rates and swaps, in a valuation far more subtle than it seems...

In a fair state, not far nor near, stood a house - not of royal lineage, but of real estate. Its keepers were physicians, partners in both practice and property. Their bond was forged in stone and steel, their wealth measured in rent and repayment. Yet lo! A time came when one partner sought to join, and another to depart. And thus was summoned the age-old question: **How shall we value the keep?**

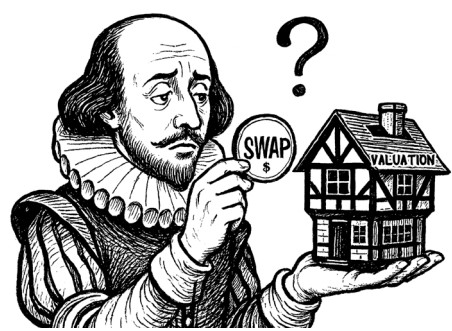
Not merely the bricks and mortar, nay, but also a shadowy thing, unseen and oft misunderstood: **an interest rate swap**. It lurked in the margins of financial statements, carried a value both real

and fluctuating, and now demanded judgment.

“Shall it be included in the buy-in? Or the buyout?” Thus spoke the chorus of accountants and counselors. Two schools of thought emerged, as ever they do.

The First: The Appraiser’s Path

Here enters the certified, the credentialed, the licensed Seer of Value, who, with charts and comps and market whispers, declares: “Behold, thy building is worth X!” But what drives his hand? What stirs his ink? Interest rates, my lord, and nothing else so greatly.



As rates fall, the building’s value rises; as rates climb, so do appraiser’s concerns. And here lies the truth: the swap and the appraised value are of the same blood. Both respond to the same force. To include one and not the other is folly - to include both is wisdom.

Therefore, if thou dost use an **appraisal** to divine thy building’s worth, thou **must include** the swap’s value, be it blessing or burden. Else, thy judgment is flawed, and thy fairness in doubt.

The Second: The Formulaic Path

This method, favored by the cautious and the consistent, heeds not the market’s whims. It says simply: “Value shall be NOI divided by cap rate.” Here, interest rates play no part. The cap rate is chosen, not discovered; it is fixed, not floating. The building’s value depends only on the income it brings.

And thus, if interest rates are not in the formula, then the swap - being a creature of rates - has no rightful place.

To include it would be to bring thunder to a play about silence, to mix tempests with taxes.

So what, then, shall be done?

Let thy valuation method be thy compass:

- If thou employest an appraisal, include the swap.
- If thou usest a formula, exclude it.

Consistency, dear reader, is the very soul of equity. To veer from it is to invite suspicion, quarrel, and perhaps litigation—a fate more tragic than even Hamlet’s own.

Thus ends our tale.

Let it be read aloud in boardrooms and break rooms, pondered by partners and paraprofessionals alike. For though the tools are modern, the truth is timeless: **Fair value must follow fair method.**

How MSO Structures Can Affect Borrowing & Guarantees for Medical Practices



Ha Tran
Principal

As independent medical practices face rising expenses, staffing shortages, and growing administrative demands, many are turning to Management Services Organizations (MSOs) for support. MSOs can streamline non-clinical operations such as billing, human resources, and compliance—but their structure can also have a significant impact on a practice’s ability to borrow funds or guarantee debt.

With lenders focusing more closely on cash flow, collateral, and borrower identity, joining an MSO introduces financial complexities that many physicians may not fully anticipate.

Ownership and Structure: Key Drivers of Lending Risk

The effect of an MSO on borrowing capacity depends largely on who owns the MSO and how much operational and financial control it assumes.

- **Physician-Owned MSOs** typically have minimal impact on borrowing. Since the practice keeps control over its tax ID, bank accounts, and revenue streams, lenders usually continue to view it as the primary borrower and guarantor. These

arrangements generally preserve eligibility for loans tied to real estate or equipment.

- **Hospital-Owned MSOs** can vary in their effect. If the hospital provides only administrative support—without controlling revenue—the impact is often limited. But more comprehensive arrangements, such as global professional services agreements (PSAs) where the hospital takes over accounts receivable, can trigger loan covenant reviews or force the restructuring of existing debt. In such cases, the practice may lose the legal standing to act as a guarantor.
- **Private Equity-Backed MSOs** tend to involve the most complex restructuring. These entities often take over billing, payer contracts, and assets, reducing the original practice to a shell entity. This set-up can nullify existing collateral agreements and disqualify the practice from serving as borrower or guarantor. Accessing new financing may require substantial renegotiation with lenders.
- **Independent Third-Party MSOs** generally function like vendors. They offer contracted services while allowing the practice to maintain full control over financ-

es and operations. These models typically do not interfere with the practice’s borrowing ability or its role as a guarantor.

What Banks Look For: It’s Not Just About Revenue

When evaluating a medical practice’s lending viability, banks assess several key factors:

- **Receivables Ownership:** If the MSO controls collections, pledged receivables may no longer be accessible as collateral.
- **Loan Covenants:** Many financing agreements contain clauses requiring disclosure of changes in ownership or financial structure. Undisclosed MSO relationships can lead to technical default.
- **Debt Service Coverage:** MSO fees—especially those based on a percentage of revenue—can reduce net income, potentially weakening the practice’s ability to meet debt obligations.
- **Legal Borrower Identity:** If the practice’s legal structure changes significantly or is dissolved, it may no longer qualify as a borrower or guarantor.

Steps Practice Owners Should Take

Before entering an MSO arrangement, it’s essential for practice owners

to perform thorough due diligence:

- Review all existing loan agreements for change-of-control or receivables-related clauses.
- Clarify whether the MSO will control billing, collections, or own any key assets.
- Request a detailed financial forecast that includes MSO fees and their impact on margins.
- Engage with current lenders early to disclose potential changes and assess implications.
- Consult legal and financial advisors to ensure compliance with loan terms and maintain financial flexibility.

A Strategic, Long-Term Decision

While MSOs can provide substantial operational benefits, they also introduce legal and financial complexities that affect a practice’s borrowing power. For practices that currently hold or anticipate needing loans, maintaining financial independence is essential.

When structured carefully, MSO partnerships can support long-term growth without undermining access to capital. The most lending-friendly arrangements allow practices to retain full ownership and control of their financial operations—ensuring continued eligibility as borrowers and guarantors.



WE KNOW MEDICAL

Multispecialty

Audubon Medical Building* Colorado Springs, CO	Austin Regional Clinic Austin, TX	Boice-Willis Clinic, PA Rocky Mount, NC	Canyon View Medical Group* Springville, UT	Catalyst Medical Group Lewiston, ID
Granger Medical Clinic West Valley City, UT	Hutchinson Clinic Hutchinson, KS	Kansas Medical Center Andover, KS	Signature Medical Group St. Louis, MO	Sierra Nevada Specialty Care Reno, NV
Tanner Clinic Layton, UT	The Doctors’ Clinic Salem, OR	The Lexington Clinic Lexington, KY	The Oregon Clinic Portland, OR	The Portland Clinic Portland, OR

Orthopedics

Advanced Bone & Joint St. Peters, MO		Alabama Orthopaedic Clinic Mobile, AL		Athens Orthopaedic Clinic* Athens, GA		Azalea Orthopedics Tyler, TX							
Baldwin Bone & Joint Daphne, AL		Bayside Orthopedics Mobile, AL		Bridger Orthopedic Bozeman, MT		Carolina Orthopedics & Sports Medicine Center New Bern, NC		Coastal Orthopedics Bradenton, FL					
Columbia Orthopaedic Group Columbia, MO		Connecticut Orthopaedic Specialists* Branford, CT				Desert Orthopedics Bend, OR		Ellis & Badenhausen Orthopaedics Louisville, KY					
EmergeOrtho Durham, NC		First Settlement Orthopaedics Marietta, OH		First State Orthopaedics* Newark, DE		Flagstaff Bone & Joint* Flagstaff, AZ		Fox Valley Orthopaedics* Geneva, IL					
Georgia Carolina Orthopedics* Augusta, GA		Georgia Hand, Shoulder, & Elbow Atlanta, GA		Hope Orthopedics of Oregon* Salem, OR		Kansas City Bone & Joint Clinic Overland Park, KS							
Kennedy-White Orthopedic Center* Sarasota, FL		Legacy Orthopedics & Sports Medicine* Plano, TX				Lewiston Orthopedics Lewiston, ID		Louisiana Orthopaedic Specialists Lafayette, LA					
Lowcountry Orthopaedics & Sports Medicine Charleston, SC			Michigan Orthopaedic Surgeons Southfield, MI			Missoula Bone & Joint Missoula, MT		Moore Orthopedic Clinic Lexington, SC					
Nebraska Orthopaedic Center Lincoln, NE		New England Orthopedic Surgeons Springfield, MA		OAK Orthopedics Bradley, IL		Olympia Orthopaedic Associates* Olympia, WA		ORA Orthopedics* Bettendorf, IA					
OrthoAlaska* Anchorage, AK		OrthoArkansas* Little Rock, AR		OrthoCarolina* Charlotte, NC		OrthoIllinois Rockford, IL		OrthoLoneStar* Austin, TX		OrthoMontana Billings, MT		OrthoTennessee* Knoxville, TN	
OrthoTexas Plano, TX		Orthopaedic Associates* Fort Walton Beach, FL		Orthopaedic Associates Albany, GA		Orthopedic Associates St. Louis, MO		Orthopaedic Associates of Central Maryland Baltimore, MD					
Orthopaedic Associates of Michigan Grand Rapids, MI		Orthopaedic Associates of Muskegon Muskegon, MI				Orthopaedic Associates USA Plantation, FL		Orthopedic Associates of Lancaster Lancaster, PA					
Orthopedics Center of Florida Fort Myers, FL		OIBortho Manasquan, NJ		Orthopaedic Associates of Wisconsin Pewaukee, WI				Orthopaedic Specialists of the Carolinas Winston-Salem, NC					
Orthopaedic Specialists of Southwest Florida Fort Myers, FL			Orthopedic & Sports Medicine Center Elkhart, IN				Orthopedic & Sports Medicine Center of Oregon* Portland, OR						
OSS Health* York, PA		Parkview Orthopaedic Group Palos Heights, IL			Palm Beach Orthopaedic Institute Palm Beach, FL			Precision Bone & Joint Surgery Center Stuart, FL					
Premier Bone & Joint Centers* Laramie, WY		Princeton Orthopaedic Associates* Princeton, NJ				Puget Sound Orthopaedics Tacoma, WA		Raleigh Orthopaedic Clinic* Raleigh, NC					
Regenerative Orthopedic Center Oregon City, Oregon		Reno Orthopedic Center Reno, NV		Rothman Orthopaedic Institute Philadelphia, PA		Sierra Pacific Orthopedics* Fresno, CA		Shoreline Orthopaedics Holland, MI					
Slocum Center for Orthopedics & Sports Medicine* Eugene, OR				South Florida Orthopedics & Sports Medicine Stuart, FL				Southern Oregon Orthopedics* Medford, OR					
Spectrum Healthcare Partners Portland, ME		Syracuse Orthopedic Specialists Liverpool, NY		Tallahassee Orthopaedic Clinic* Tallahassee, FL		Tampa Bay Orthopaedics St. Petersburg, FL		The Bone and Joint Group* Clarksville, TN					
The Foot & Ankle Group Fort Myers, FL		Tennessee Orthopaedic Alliance Nashville, TN				The Orthopedic Clinic Daytona Beach, FL		The San Antonio Orthopaedic Group San Antonio, TX					
Tri-State Orthopaedics Evansville, IN		Tulsa Bone and Joint* Tulsa, OK		University Orthopaedic Associates Somerset, NJ			Wooster Orthopaedics & Sports Medicine Center Wooster, OH						

* Returning Clients



**Boice-Willis
Clinic**

Rocky Mount, NC

Multispecialty

\$12,900,000



**Center for
Neurosciences**

Tucson, AZ

Neurology & Spine

\$10,500,000



**Eye Guys – Eye Physicians &
Surgeons of Augusta**

Augusta, GA

Ophthalmology

\$13,000,000



OrthoLoneStar

Austin, TX

Orthopedics

\$24,800,000



Five Points Surgery Center

Greenfield, IN

Dental

\$8,700,000



ORA Orthopedics

Bettendorf, IA

Orthopedics

\$40,000,000



Eugene Gastroenterology Consultants, PC

Eugene, OR

Gastroenterology

\$27,500,000



The Heart Group

Fresno, CA

Cardiology

\$28,800,000



WE KNOW MEDICAL

Urology

Arkansas Urology* Little Rock, AR	Central Ohio Urology Group Gahanna, OH	Idaho Urologic Institute* Meridian, ID	Orange County Urology Associates Laguna Hills, CA	
Southeastern Urological Center Tallahassee, FL	Urology Associates, P.C. Nashville, TN	Urology San Antonio San Antonio, TX	UroPartners Westchester, IL	Wisconsin Institute of Urology* Neenah, WI

Ophthalmology

BoozmanHof 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 Center of North Florida Panama City, FL	Eye Guys Augusta, GA	Eye Specialists of Mid-Florida* Winter Haven, FL	Eye Surgeons Associates* Bettendorf, IA	EYE-Q Vision Care Fresno, CA	Florida Retina Institute Lake Mary, FL
Heaton Eye Associates Tyler, TX	Huntsville Laser Center Huntsville, AL	Laser & Surgery Center of the Palm Beaches Palm Beach Gardens, FL		Magruder Laser Vision* Orlando, FL	Medical Eye Specialists Bozeman, MT
Ocala Eye Ocala, FL	Ophthalmology Consultants St. Louis, MO	Pacific Cataract & Laser Institute Chehalis, WA	Retina Associates of Cleveland Akron, OH	Retina Consultants of Southern Colorado Colorado Springs, CO	
Retina-Vitreous Surgeons of CNY Liverpool, NY	St. Louis Eye Surgery & 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	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	VINO Physicians Group LLC Lima, OH	

Cardiology

Abilene Cardiology Abilene, TX		Alabama Heart & Vascular Medicine Tuscaloosa, AL		Alaska Heart & Vascular Institute Anchorage, AK		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		The Heart Group Fresno, CA	

Surgery Centers

Bend Surgery Center Bend, OR	Blue Water Surgery Center* Port St. Lucie, FL	Carolinas Center for Surgery* Morehead City, NC	Five Points Surgery Center Greenfield, IN	Palmetto Surgery Center* Columbia, SC	
Piedmont Outpatient Surgery Center Winston-Salem, NC	Plastic Surgery Specialists of South Florida* Hollywood, FL		Southpoint Surgery Center Jacksonville, FL	Surgery Center of Southern Oregon Medford, OR	

Other Specialties

Alyeska Vascular Surgery Anchorage, AK	Austin Diagnostic Clinic Austin, TX	Balboa Nephrology La Jolla, CA	Cancer Specialists of North Florida* Jacksonville, FL	Cascade Brain & Spine Bellingham, WA	
Center for Neurosciences Tucson, AZ	Central Park Ear, Nose & Throat* Arlington, TX	Charleston ENT Charleston, SC	Charleston GI Charleston, SC	Dallas Nephrology Associates Dallas, TX	
Endoscopy Center of Ocala* Ocala, FL	Eugene Gastroenterology Consultants, PC Springfield, OR		ENT Center of Utah Salt Lake City, UT	Gulf Coast Plastic Surgery Pensacola, FL	
Mayfield Brain & Spine Cincinnati, 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	Premier Family Medical Pleasant Grove, UT		Southern Oregon Neurosurgery Medford, OR	Texoma ENT & Allergy Wichita Falls, TX	
Utah Cancer Specialists Salt Lake City, UT	Wake Internal Medicine Consultants Raleigh, NC		Willamette ENT Salem, OR	Women's Healthcare Associates Portland, OR	* Returning Clients

Tailored Lending: Why Physician Real Estate Financing Deserves a Better Fit



Chris Tollinchi
Principal

Getting a custom suit made takes time—and the right expert who knows how to measure precisely and make adjustments that matter. Commercial real estate financing isn’t much different, especially when the borrower is owned by a group of physicians.

Sure, you can walk into a bank and get something “off the rack”: standard rates, predictable terms, and a generic structure built for the average borrower.

But here’s the thing—you’re not average. And neither are your goals.

We’ve seen too many physician-owned practices boxed into financing that “technically” works, but functionally falls short. It restricts cash flow, adds unnecessary costs, and most importantly, limits your ability to grow strategically.

That’s where customization makes all the difference. At CMAC, we’ve structured physician real estate deals across the country where just a few key adjustments made all the difference. Here are just a few examples:

1. Loose in the Collar: Covenants That Don’t Restrict

If you’ve ever had a commercial real estate loan, you know banks want to test business strength with covenants and ratios. But sometimes, those covenants can feel like a starched collar three sizes too small.

That’s exactly what happened to a client in Arizona. The initial terms proposed by the bank were way too tight—think high-pitched, short-on-oxygen tight. CMAC stepped in and negotiated more forgiving terms on their behalf, including a 1.00x post-distribution debt service coverage ratio (DSCR).

The result? Breathing room. The physicians could now distribute the majority of their excess cash—just as they should.

2. Smart Structuring: Going Beyond Mediocre Terms

For a cardiology group in California, the interest rate and equity weren’t the problem. Their real headache? The time, cost, and hassle of audited financials.

After hitting roadblocks elsewhere, they turned to CMAC. We got to work and structured a deal that reduced their



reporting requirement from a full audit to a CPA review—and eliminated personal guarantees entirely.

Simpler reporting. Lower cost. Less risk. Oh, and while interest savings weren’t their top concern, it was ours. They still walked away with more than \$635,000 saved in interest expense.

3. Refitting the Suit: Working with the Incumbent Lender

Sometimes the problem isn’t the lender—it’s the fit. Maybe it’s post-holiday weight, maybe it’s a New Year’s resolution. Either way, the old suit doesn’t wear like it used to.

That was the case for a Midwest client. Their existing structure wasn’t bad,

but it no longer aligned with their needs. With CMAC’s guidance, we extended their interest-only period, increased loan proceeds across both real estate and equipment draw-down facilities, and improved their spread by over 100 basis points.

The bank kept a valuable relationship. The borrower got a smarter, more strategic structure. Win-win.

There’s no one-size-fits-all solution for physician real estate financing—nor should there be. With the right structure and the right advocate, your loan can do more than just fit. It can flex with your goals. It supports strategic growth. It moves your group forward—on your terms.

Redefining The Way Independent Practices View New Projects

How Private Equity-Backed Practices View Real Estate and Tenant Improvements — And What Independent Groups Can Learn



Peter Kokins
Principal

In today’s evolving healthcare landscape, private equity (PE) firms which have yet to complete a secondary sale are often looking for alternative methods of enterprise value creation. One particularly insightful example of this approach is how PE-backed healthcare companies sometimes handle tenant improvements (TI) when physicians own the real estate in which their practice operates.

The PE Perspective on Tenant Improvements

When a physician-owned real estate entity constructs or purchases a new building for their practice, traditional practice management would call for a split of tenant improvement costs between the landlord (physician-owned real estate company) and the tenant (physician-owned practice company). This dynamic changes significantly under PE ownership.

- Here's how:
- PE companies often contribute 100% of the TI dollars, removing the burden from the physicians’ real estate entity, while continuing to increase the value of the real estate investment.
 - These costs are not treated as operating expenses, which would otherwise reduce physician compensation or impact practice profitability.
 - Instead, the TI investment is treated as a capital expenditure by the parent company, outside the scope of normal overhead.

Why this structure? Because private equity views the opening of new offices as a revenue-enhancing strategy. New facilities help attract additional physicians and increase procedural volume, both of which directly drive EBITDA, a key metric for company valuation. The PE company will pay for EBITDA at inception, why not provide more capital to grow EBITDA as long as the ROI is attractive?

Capital Spending as a Value Driver

For PE-backed entities, boosting EBITDA is the name of the game. Every dollar spent on growth that results in a recurring increase in revenue and profitability adds to the valuation multiple of the overall enterprise. Tenant improvements, while costly up front, are seen as a high-ROI investment if they lead to expansion and scale.

This value-driven approach to growth incentivizes investment in new space, even when physicians own the building, because it aligns with the PE firm’s long-term objective: to maximize the exit value of the platform.

What Independent Groups Should Consider

Independent physician groups, especially those who own their real estate, can adopt a similar lens when evaluating expansion opportunities:

- View tenant improvements not as a drag on profits, but as an in-

- vestment in enterprise value, especially if they lead to increased EBITDA.
- When modeling the economics of a new project, consider isolating the TI investment from traditional overhead to get a clearer picture of ROI.
 - If projected EBITDA is increasing (exclusive of the tenant improvement cap ex), the practice is likely creating meaningful value, just as a PE firm would see it.

Conclusion: Adopt a Growth-Minded Framework

By reclassifying tenant improvements as capital investments and focusing on EBITDA growth, private practice groups can build more valuable enterprises. Prioritizing smart growth and evaluating projects through a value-creation lens can build sustainable, physician-led organizations. Physician groups need to look beyond expenses and start viewing capital expenditures as having a measurable return on investment.

More Risk Without the Reward

Why you shouldn't secure construction-only financing!

Would you buy a house without knowing what your monthly payments would be—or if you could even afford it? Would you purchase a house without knowing the financing options? Probably not. These unknowns are examples of what some groups encounter when they secure construction-only financing for their real estate projects.

While construction-only financing might initially seem like a flexible way to fund your building project, it comes with risk that can jeopardize your investment.

Here are just **three primary risks** you could be facing with construction-only financing:

1. Changes in the Economic Landscape

Unlike construction-to-permanent loans, construction-only financing covers only the build phase—leaving you to secure permanent financing once construction is complete. By that time, you may be facing a completely different economic landscape. If interest rates have risen or lending standards have tightened, you could find yourself unable to secure favorable (or even sufficient) terms. This uncertainty adds unnecessary stress and financial strain just when you expect to be settling into your newly completed property.

To put this into perspective, imagine securing construction-only financing that matured in mid-2008, or during the height of COVID, and consider how hard it would have been to secure permanent financing during this period of uncertainty.

2. Appraisal Conundrums

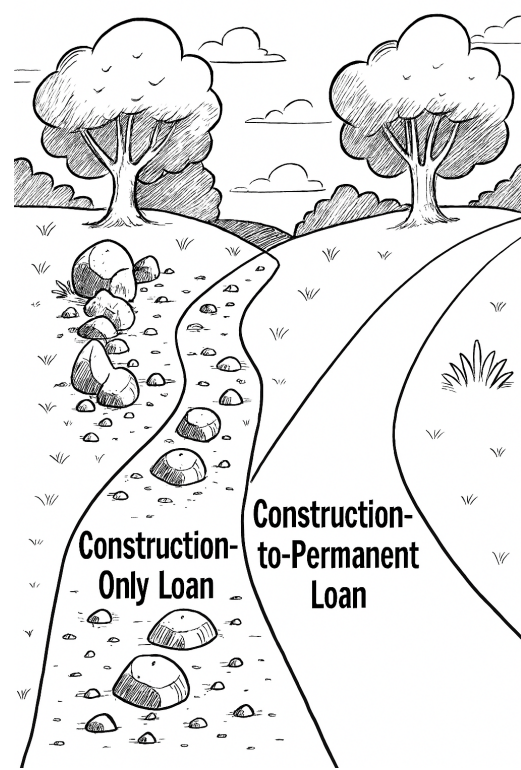
Construction-only financing requires a second appraisal at the end of the project to qualify for permanent financing. If the second appraisal comes in lower than expected—whether due to market shifts, valuation discrepancies, or simply a change in one appraiser's opinion of the value—you may be forced to come up with a larger down payment or adjust your financing strategy entirely.

For example, suppose you secured an 85% LTV construction-only loan for a \$20MM project. The initial “as-complete” appraisal matched the project cost, allowing you to borrow \$17MM. However, upon completion of the property, the new “as-is” appraisal comes in at just \$18MM. If lenders were unable to offer a higher LTV option, this caps the maximum loan amount to \$15.3MM—leaving a \$1.7MM shortfall that would need to be funded by the practice partners.

3. Weaker Negotiating Position

Another major concern is the shift in negotiating power during construction. With construction-only loans, the lender controls the draw schedules and disburses funds incrementally. This puts you in a vulnerable position: if the lender disputes or delays a draw request, it can stall your project and cause expensive delays. Do you really want to be negotiating with your lender on a permanent loan while they have this level of control over your project?

You might be thinking, “What if I believe long-term rates will decrease during construction and want to take advantage of that?” If that's the case, the good news is—you can have your cake and eat it too:



- **Wait to lock your interest rate** – Assuming your loan proposal doesn't include a hedging requirement, you have the option to float your interest rate during the construction phase and lock it in after the project is complete—or even later. The key advantage is that you still have a permanent loan in place from the onset, which specifies the loan spread you'll pay. This means there's no need to renegotiate with lenders or obtain another appraisal.
- **Limit your prepayment penalty** – If you're able to negotiate a reduced prepayment penalty, you'll have greater flexibility to refinance at a more favorable time with minimal costs—but keep in mind, you may be giving up a better rate to receive this benefit.
- **Lock your rate for a shorter term** – If you anticipate rates will

decline, you might structure a long-term loan with a shorter fixed-rate period—for example, fixing the rate for just 3 years on a 10-year loan. After that period, the remaining 7 years would either float or give you the option to re-lock the rate at that time, hopefully in a more favorable interest rate environment.

The obvious drawback with these strategies is the unpredictability of interest rates. While rates could decline, there's also a very real possibility they'll rise by the time construction is complete or when you're ready to adjust your rate. If you have a higher risk tolerance, these options may offer potential upside without taking on the aforementioned risks. That said, in our experience, many clients prefer the certainty of a “bird in the hand” rather than gambling on “two in the bush.”

Groups that lock in their interest rate at the start of construction have the advantage of knowing exactly what their monthly payments will be for the 7 to 10 years following project completion. This certainty allows them to accurately forecast cash flow and project returns—providing peace of mind. Just as importantly, it eliminates ambiguity around investor expectations.

In short, construction-only financing leaves too many critical variables out of your control. Opting for a construction-to-permanent loan instead provides greater predictability, simplifies the process, and shields your project from financial turbulence at a critical time.

Strategic Refinance with a Low Fixed Rate Unlocks \$7MM in Cash & Lowers Partner Buy-ins

A South Carolina GI group approached CMAC Partners to conduct an analysis in support of its buy-in and buyout strategy. With some physicians considering a potential sale of the real estate, the group wanted a comprehensive evaluation of its current portfolio and available options.

The resulting analysis helped the group enhance returns, buy out a partner, and significantly reduce the buy-in for new physician partners. Although

the group already had favorable terms with its incumbent lender, CMAC successfully negotiated an extension of the loan term by six years and secured nearly \$7 million in cash out—all without changing lenders. All four of the practice's properties were fixed at 4.85% for 10 years (**at closing, the 10 Year Treasury was at 4.24%**), with no personal guarantees.

By leveraging strong existing relationships and market expertise, CMAC

delivered a strategic solution that improved liquidity, supported succession planning, and locked in long-term sta-

bility. A win-win for both the practice and its incumbent lender.



The Forgotten Fortune

How Retiring Physician Partners Could Be Overlooking a Goldmine in Interest Rate Swaps

Retirement: the golden years of golf, grandkids, and, hopefully, a well-earned windfall from your real estate partnership buyout. But for many physician partners, there’s a part of their real estate investment that’s often left out of the spotlight ... and out of their retirement check. We’re talking about the interest rate swap, the financial equivalent of that dusty Picasso in the attic which no one realized was worth millions.

Wait, What’s an Interest Rate Swap Again?

Think of an interest rate swap like a financial handshake between your group and a bank. It’s a contract that exchanges floating-rate interest payments for fixed rate payments - kind of like trading Johnny Manziel for Tom Brady. Floating interest rates aka Johnny Manziel ... in his prime hype years. Electrifying, yes. Capable of brilliance, absolutely. But with unpredictability baked in. One game, he’s dazzling with off-script plays; the next, he’s throwing interceptions or missing practice. There’s a chance for greatness, but also a risk of chaos.

Fixed Rates aka Tom Brady, the football equivalent of a Swiss watch. Predictable. Steady. Week after week, year after year, you know what you’re getting;

smart decisions, consistent execution, and dependable leadership. He may not always be flashy, but you can build a game plan around him with confidence.

So, why do banks and borrowers use swaps? Swaps are frequently used by banks to offload risk, which can often-times allow them to provide more attractive rates to the borrower. Depending on interest rate movements, swaps can either be “out of the money” or “in the money.” For those groups that were fortunate enough to lock in a swap before rates rose, it is more than likely the latter, and it could be a sizeable asset.

Here’s the Problem: Everyone Forgets the Swap

When physician partners retire and go through the buyout process, the operating agreements rarely account for interest rate swaps. Yet as we’ve established, they can be a significant asset or liability at the time of retirement. You may remember an article that we wrote previously, when rates were at all time lows, which highlighted that retiring physicians were running off without footing the bill when they had significant swap unwinds that were underwritten and being left for remaining partners to bear. Now the tables have turned, and

the physicians who are close to retirement could be missing out.

If the swap is “in the money” (i.e., it has a positive value) it’s an asset. And if the group doesn’t include it in the valuation or doesn’t unwind it before the partner leaves, the retiring physician could be walking away from tens or even hundreds of thousands of dollars.

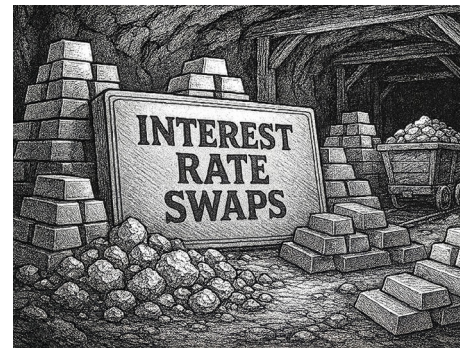
The \$100,000 Oversight

Imagine this: Dr. Smith retires from a real estate partnership of 10 doctors in July. The group’s interest rate swap, signed years ago at a 3% fixed rate, is now worth \$1,000,000 because rates have climbed. If the group doesn’t adjust the buyout formula to account for that asset, Dr. Smith gets nothing from it. Come January, the remaining partners unwind the swap, pocket the gain, and ... oops, sorry, Dr. Smith.

How to Avoid the Swap Snafu

Get a valuation – Before retiring, ask for a fair market valuation of the swap. It may be more than you think. If it’s worth further discussion, there are two avenues to be explored:

1. Include it in the buyout formula – If it’s an asset, shouldn’t it be



- treated like one?
2. Unwind it pre-retirement – If you want your fair share, consider re-financing to close out the swap while you’re still there to receive the gain.

In Conclusion: Don’t Forget About Your Swap

In our experience, there’s not necessarily a right answer on how to handle interest rate swaps. But if you’re nearing retirement, you probably at least want to check to see if you have an interest rate swap that’s in the money. That interest rate swap might just be your hidden retirement bonus. Don’t let your final gift to the group be your unclaimed, unnoticed, or uncelebrated share of a six-figure asset.

After all, you took the risk when you signed on for the swap.

Risk in Medical Real Estate: Myth vs. Reality

Why the Danger Isn’t Where You Think It Is



Shannon Stocker
Physician Liaison

When someone says, “we’re breaking ground on a new building,” most people hear “risky business ahead.” And sure, in most real estate circles, new construction conjures images of cost overruns, permitting nightmares, and sleepless nights spent wondering if moving forward with the project was the right decision.

But in the world of *100% owner-occupied medical real estate*, particularly for groups with multiple partners, the story is surprisingly different. In fact, if you’re a physician partner embarking on a shiny new development for your group’s clinic, you may be less exposed to risk than you think.

Why? Because You Have Surety of Your Lease!

When a medical group builds a new facility for itself, there’s usually one thing locked in tighter than a vault at Fort Knox—a long-term lease. That means the “tenant” (you) is al-

ready guaranteed. There’s no waiting around to see if someone will show up and rent the space. The occupant is in place, the rent is likely pre-determined, and everyone knows exactly who’s paying the bills and whether the practice can afford it.

So, while it feels risky, it’s actually one of the few times in commercial real estate where the lease, occupancy, and business model are already nailed down before the first brick is laid.

Now, Here’s Where the Real Risk Comes In...

Fast forward a few years. The building is up, the walls are painted a soothing shade of taupe, and new partners have joined the practice partnership. These new docs are invited to “buy into the real estate”— here’s where things get murky.

Unlike the physicians who were involved from the inception of the build, the new partners are stepping into a situation with less certainty. The group might outgrow the space, decide to merge with another practice, or switch locations entirely. Suddenly,



that rock-solid “owner-occupied” status starts to look less stable.

Will the group renew the lease in 10 years? Will the building need expensive renovations? Will the remaining partners be left holding the bag on a vacant property with an MRI-shaped hole in the wall?

These are real risks—ones that the original partners had to worry about to a lesser extent when construction began.

Moral of the Story: The Risk Isn’t in the Dirt—It’s in the Handoff

If you’re a physician thinking about building your group’s next medical office building, don’t let the construction sticker shock blind you to the relative

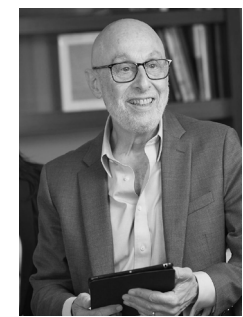
security you actually have. If you’re an existing partner looking at bringing in new partners, don’t assume the risk you took at the building’s inception is more than the incoming partners. And if you’re a new partner looking to buy into the real estate—ask the tough questions:

- How long is left on the lease?
- Are there renewal plans?
- What’s the succession strategy for the real estate if the group moves?

Because in this world of owner-occupied real estate, it turns out that laying the foundation is the easy part—it’s what happens after the ribbon-cutting that could cause the real heartburn.

Independent Physician Groups Investing Millions of Inadequately Managed Dollars

Recognizing the Problem and Taking the Steps



Greg Warren
Managing Partner

Over the past couple of decades, there has been a substantial move for medical groups to create additional ancillary income streams by investing in their owner-occupied real estate rather than paying rent to third-party landlords. Unfortunately, in most cases, the reality often falls short, and these multi-million-dollar investments:

- Deliver below-market returns, substantially reducing physician distributions,
- lack sustainable structures for partner buy-ins and buyouts, and
- create divisiveness rather than unity within the group, applying conventional operating agreement provisions that don't align with the unique dynamics of physician-owned practices.

Why This is Happening

The core issue is a lack of clear ownership and accountability. Unlike the clinical side of the practice—where leaders are evaluated based on outcomes—there's rarely anyone specifically tasked with overseeing the real estate investment.

In addition, most practices don't have someone on the executive team with the specialized expertise needed to properly structure the investment, negotiate optimal financing, or manage the evolving ownership of the real estate entity in alignment with a changing partnership.

How Serious is the Issue?

At the 2024 CPOMP meeting (Congress of Physician-Owned Medical Properties), a group of approximately 100 physicians and executives took part in a 10-question multiple-choice assessment designed to gauge their preparedness to face real estate scenarios they're likely to encounter over the term of their tenure. The results were telling: the average score was just 66.7%. Even a single misstep on the test could represent a costly error in an actual situation—and many participants missed more than one.

Neither medical schools nor health-care administration programs offer real estate training in their curricula. Yet, these same professionals are routinely making high-stakes real estate decisions with significant long-term financial implications—often without the tools or knowledge they need.

3 Steps to Creating Better Outcomes

1. Accountability

Without a clear person or group responsible for the performance of your real estate investment, and held accountable for its outcomes, it will drift like a rudderless vessel—staying afloat, but with no real direction. To optimize your investments, achievable goals must be defined and actively pursued. Many practices have now appointed a Chief Property Officer—an owner in the real estate specifically charged with overseeing the real estate investment's performance.

2. Education

Fortunately, physicians and practices leaders have access to CPOMP, a dedicated forum where peers come together to share challenges, outcomes, and solutions related to owner-occupied medical real estate. CPOMP offers targeted sessions on timely issues and foundational education through its Real Estate 101 course. First-time attendees often walk away saying, "I didn't even know what I didn't know."

3. Expert Advocates

Even with greater knowledge, physicians can't be expected to be real estate experts. That's where seasoned advocates come in. Today, a number of firms specialize specifically in **owner-occupied medical real estate**—bringing expertise and strategic guidance. Regular contributors at CPOMP include **CMAC Partners**, **CBIZ**, and **Eide Bailly**, all of whom are committed to exclusively representing the interests of physicians.

The Bottom Line

It all starts with **recognition**—recognizing that dollars are being left on the table. Recognizing that sustainable models now exist to support long-term buy-ins and buyouts.

But most importantly, it's about recognizing that **you have the power to change the trajectory**. With the right structure, the right support, and the right mindset, an untapped level of improved performance can come through your actions. **Start now.**



Physician-Owned Real Estate 101: A Breakout Hit at CPOMP Conferences

Colorado Springs, CO — At the annual CPOMP (Congress of Physician-Owned Medical Properties) meeting, one breakout session has emerged as a standout: Real Estate 101, a crash course designed to equip physicians and practice leaders with the knowledge to turn one of their largest

expenses—real estate—into a strategic asset.

Billed as "the most important course you never took in medical school," Real Estate 101 first debuted at CPOMP 2024 and quickly became one of the most requested offerings. Due to its popularity, the session returned in 2025 and will continue as a featured breakout at the CPOMP Annual Meetings.

The Real Estate 101 agenda offers a deep dive into several practical modules—from understanding the benefits of physician-owned real estate to navi-

gating leases, financing, and exit strategies.

"The younger docs don't understand the benefits of ownership just yet. This session will help start to pass that baton."

Bruce Cohen, MD, OrthoCarolina

Targeted at physician leaders and practice executives, Real Estate 101 fills a critical education gap, providing a powerful foundation for practice growth and sustainability. As physician-owned practices seek to take control of their future, Real Estate 101 is more than a course—it's become a cor-

nerstone of CPOMP's mission to support independence and ownership.

Join the conversation and sign up for updates on our next annual meeting by using the QR code below.



Your CMAC Team



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

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