Important Points in New Partner Buy-ins

An electronic report from Advisory Publications

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Important Points in New Partner Buy-ins

We’ve told readers many times how to structure an incoming partner’s stock purchase, noting that it typically carries a small price for an equal interest in the practice’s hard assets. But the capital transaction is only part of the deal. The other component relates to accounts receivable and goodwill value — probably worth at least hundreds of thousands of dollars if you sell the entire practice.

Some years ago, young doctors paid hard dollars to acquire co-owner interests in a practice’s “soft” assets. Becoming a partner meant facing the double whammy of a large out-of-pocket expense without being able to deduct the payment for income tax savings.

Pay New Partners Less

More recently, practices generally determined a dollar value for the receivables and goodwill and then had the incoming partner (whom we’ve been calling “Junior” for convenience) buy into that value by taking reduced income shares over a period of years. If, for instance, Junior was to become the third partner in a small group whose receivables and goodwill were worth a not-unusual $1,200,000, she might receive $400,000 less than her regular share of income over her first five years as a co-owner.

The current approach — one we strongly favor — gets away from the concept of “buying” a share of the soft assets at all. This approach disregards those assets’ value and simply establishes a “compensation” plan that is fair to both Junior and her seniors. It typically gives Junior a gradually increasing share of practice profits over her early years as a partner.

In the first year, determine her share as if she were a full partner and then reduce it by 40%; redistribute the reduction among her senior partners as if it were additional income.

In a five-partner group equally splitting $1 million in net profit, each co-owner would normally receive $200,000. Under this approach the first-year partner would receive $120,000 ($200,000 minus 40%). The four senior partners each would get $220,000 ($200,000 plus 25% of the $80,000 deducted from the new co-owner’s share). In succeeding years, reduce her regular share by 30%, then 20% and then 10%, after which she achieves full parity as a senior member.

[An alternative, though less intuitive, way would be to assign the new partner a 0.6 share and each of the four senior partners receive 1 share, making the formula: (0.6 / 4.6) x $1 million = $130,435. The full shares would then be (1 / 4.6) x $1 million = $217,391. This approach is more generous to the junior partner. What matters most is that you decide in advance which method your group will apply.]

This compensation approach has several advantages. For one, it cools disputes over the always difficult-to-determine value of a practice’s goodwill. Why fight that battle when the greater goal is to help bring a valuable young physician into the fold?

What’s more, valuing the assets and equivalently reducing income invites an IRS attack that the salary reductions are really a disguised purchase, making Junior’s payments nondeductible — and hence extremely difficult to afford. That IRS argument would be correct, but disregarding asset values steers away from it. Instead, it follows the perfectly proper notion that the young partner is initially less valuable to the practice than her seniors, growing in importance each of those first few co-owner years.

Why is Junior less valuable? The seniors control long-standing patient and referrer relationships, contribute group management skills and assume practice and hospital leadership responsibilities not at first expected of a young partner. She gains these responsibilities gradually over her early years as a partner.
Increasing her income as she grows in importance makes both practical and economic sense.

**Market forces**
The reduced compensation approach also lets the junior-senior salary differentials respond to changing economic circumstances. If profits fall, perhaps because of reimbursement cuts, the “buy-in” salary drops along with it. That’s fair because the declining profitability suggests the practice may not have been as valuable as previously believed. Conversely, if the practice enjoys greater-than-expected profits, the salary differentials increase, suggesting that the practice was more valuable.

Events of recent years have confirmed the wisdom of the newer approach. Scared juniors argue that, with increased managed care controls over patient populations and with falling reimbursements, they cannot justify paying for goodwill value. And yet goodwill value is not a thing of the past. Better to sidestep the issue by framing it instead as a matter of personal value to the practice.

It’s difficult for a new, young partner, probably just finishing a couple of years as an associate, to argue that she is as valuable to the practice as the seniors who continue to lead and develop it while the junior gradually assumes those roles. Full pay parity after just a couple of years’ experience is out of the question in other industries; there is no economically viable reason for it in medicine, either.

**Do some math**
Don’t accept the suggested 60% to 70% to 80% to 90% progression as the only formula just because we suggest it. Develop your percentages by reasonably projecting practice income over the buy-in years. The purpose is to promote Junior fairly, not to extract a “price.” Bring in your consultants, accountants or attorneys to help with such projections.

Sometimes income reductions may take Junior below what she earned before becoming a co-owner — perhaps even below a fair salary. To avoid this, Bernick suggests guaranteeing Junior a minimum income. Don’t make it too high, though, for, “How can Junior assert her right to ‘partnership’ without being willing to bear some of the financial risks of being a co-owner?”

Remember that a buy-in’s primary importance is creating a fair and rational way for new physicians to become your long-term partners. You will earn far more by having the right physicians on board and committed than by extracting a “price” for them to join.

**Goodwill Value**
Any time you add a partner, you’ll need good information to calculate a buy-in amount that’s fair to the group as well as to the new co-owner. The same goes for departing partner payouts. While placing a value on your tangible assets in these situations remains fairly straightforward, estimating the intangibles that constitute goodwill value doesn’t come so easily. Still, you’ll have to make the effort. Comparing your estimate to published benchmarks may help produce the best possible answer.

Ohio health care attorney Peter A. Pavarini casually defines goodwill as the amount the purchase price exceeds the identifiable assets, net of assumed liabilities. Goodwill represents the likelihood that patients will continue to return to a medical practice because it has all the right business and operational systems in place. Attorney Sandra E. D. McGraw and consultant Michael J. Parshall offer examples such as:

- A trained work force including physicians and support staff
- Effective billing, information, collecting and scheduling systems
- Non-compete covenants with member physicians
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*Practice* goodwill implicitly includes the value of having an established patient base and current and transferable referral patterns from which to establish immediate and substantial cash flow, *regardless of what specific physicians are doing the work*. Keep reading for a simplified example of this kind of “going concern” value.

**One example of goodwill calculations**

Publisher and ex-consultant Leif Beck offers the following example illustrating real dollar value arising from *practice* goodwill. Suppose the following:

In ABCD Urology Group, each of the four urologists receives $240,000 in annual salary plus a $30,000 retirement contribution. In their well-integrated practice, patients and referrers know that any of the four doctors can expertly handle their concerns.

With this kind of group strength, ABCD Urology’s gross income will probably remain about the same even if Dr. A retires and is replaced by “Dr. New.” The group would probably pay Dr. New a $120,000 starting salary (with no first-year retirement contribution), leaving Drs. B, C and D with an extra $150,000 of profit the first year. In the second year, Dr. New’s salary might typically become $160,000 (plus $30,000 to retirement), leaving the seniors an extra $80,000; and so on for several more years.

What, asks Beck, are those extra earnings if not from the practice’s goodwill value?

**So what’s it worth?**

“*Personal*” goodwill — future income that depends on an individual physician’s reputation and continued practice — is a different story. If a particular physician’s departure will decimate the patient base, his/her personal goodwill adds no salable value.

Goodwill reflects somewhat the cost of putting a practice together from scratch. A brand new practice can’t generate the same revenue as an established one, so goodwill includes the difference between actual and potential revenue during the start-up period. The intangible factors making your practice a “going concern” certainly contribute to its worth, just like hard assets (equipment, for instance) do. After all, you know there’s value to the group’s good name and to the general strength of its business operations. Your satisfied regular patients, referring doctor relationships, trained work force and familiar office location represent parts of the practice’s worth, too. And your non-compete covenants with member physicians help increase the likelihood that patients won’t leave your group with a departing doctor.

Still, hanging a price on goodwill continues to puzzle experts. Few agree completely on how to handle the challenge, and yet it’s critical to a departing partner’s payout, says attorney Janice Cunningham. And it’s best determined with good data.

Cunningham’s firm, The Health Care Group (HCG), provides a compendium reporting goodwill values of buy-ins, pay-outs, practice sales and appraisal reports across the country. HCG’s annual *Goodwill Registry* expresses each reported practice’s agreed or determined goodwill value as a percentage of gross revenue (before expenses) and breaks the data out by medical specialty. The report also lists practice goodwill values by region. We’ve included a table on the next page showing the ranges of goodwill values for several specialties.

The benchmarks in the *Registry* provide nothing more than a starting point. Don’t simply refer to the data and assume your practice is worth the top of the reported range for your specialty. Too many individual factors greatly affect actual value. Factors that can make a huge difference include:

- **Overall profitability and economic soundness**
- **Practice location**
- **Competition**
- **Managed care success**
Important Points in New Partner Buy-ins

- Ancillary revenue and service diversity
- Local population and economic trends
- Referral patterns (for specialty practices)
- Payor mix
- Non-compete covenants

Since the Registry reports each transaction separately, you can look for specific practices similar to your own and compare those values. The effort may help you make your own hard calculations so you’ll end with more than just a casual estimate. It’s dangerous to assign — or let anyone else assign — an arbitrary number to your goodwill without some such reference points.

Even with this data, it’s often terribly difficult to determine or agree on a practice’s goodwill value, especially when group members may have different interests in the figure. That’s why you may need outside experts’ help in fixing the figure for your purposes. In any event, insist on a thorough evaluation in setting your figure and revisit it from time to time, especially when the shape or scope of your practice changes substantially.

General Benchmarks for Goodwill Values

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Goodwill</th>
<th>No Goodwill</th>
<th>Mean</th>
<th>Median</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>1225</td>
<td>148</td>
<td>35.94%</td>
<td>31.97%</td>
<td>0.63%</td>
<td>405.69%</td>
</tr>
<tr>
<td>OB/Gyn</td>
<td>211</td>
<td>34</td>
<td>31.72%</td>
<td>28.63%</td>
<td>0.40%</td>
<td>103.69%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>173</td>
<td>21</td>
<td>35.89%</td>
<td>32.74%</td>
<td>1.18%</td>
<td>140.08%</td>
</tr>
<tr>
<td>Otolaryngological surgery</td>
<td>50</td>
<td>17</td>
<td>27.76%</td>
<td>25.00%</td>
<td>0.11%</td>
<td>105.50%</td>
</tr>
<tr>
<td>Internal medicine subspecialties</td>
<td>172</td>
<td>57</td>
<td>32.59%</td>
<td>29.10%</td>
<td>1.04%</td>
<td>220.98%</td>
</tr>
<tr>
<td>Surgical practices</td>
<td>262</td>
<td>83</td>
<td>28.91%</td>
<td>25.00%</td>
<td>0.08%</td>
<td>89.43%</td>
</tr>
<tr>
<td>Hospital based</td>
<td>77</td>
<td>24</td>
<td>33.94%</td>
<td>29.11%</td>
<td>0.14%</td>
<td>181.22%</td>
</tr>
</tbody>
</table>

Figures reflect average values from 1992 – 2002 and illustrate a percentage of the practice’s gross revenue. HCG drops the “zero” values and averages all those reported in a given specialty. Call HCG at (800) 473-0032 or e-mail publications@healthcaregroup.com to obtain the full Registry ($395).

Structuring the Buy-in to a High-Value Practice

Arrangements for young physicians to become partners in small and mid-sized groups were fairly standard in the past. The associate spends one, two or three years as an employed (non-partner) doctor and then, if acceptable to the seniors, is offered co-shareholder status. For it, he or she pays a moderate amount for an equal stock interest and then takes reduced income shares for the following three to five years to complete the buy-in.

With some reservations about the “new economy” including heavy malpractice insurance and stagnant reimbursements, this approach continues to make sense for many groups. Sometimes, though, it runs into seemingly insurmountable problems because the desired new member just can’t afford it.

Consultant and attorney Daniel M. Bernick, J.D. says that’s often the case with “large” practices. By large he means either that they have very substantial and expensive amounts of equipment on hand (like many ophthalmology practices) or that they continue to produce unusually generous income shares for the senior members. Sometimes associates expected to
buy into these valuable groups have not yet built up their production capacities to earn incomes that will support the expensive buy-in payments.

**High Initial Salaries a Problem**
The problem is often compounded because too high a salary was paid to attract the young doctor in the first place. That starting salary (possibly augmented with generous incentive bonuses) may make it impossible to structure an income give-up that will not severely cut into his or her take-home pay. Perhaps you think the associate still has plenty of income to live on, but try to sell a pay cut to your increasingly productive partnership candidate!

The more valuable “state-of-the-art” equipment you have, the more expensive the buy-in becomes. The stock purchase price, based on equipment values, can be quite pricey even if paid over a number of years. Those payments are typically paid out of after-tax dollars with a reasonable rate of interest added on. The combination makes the stock payments hard to handle without suffering a decline in take-home pay.

As one solution, you could simply reduce or eliminate the buy-in. Some senior physicians even give equal stock shares to younger doctors “for free.” This approach does not easily relate to economic logic, and some seniors have been stung later on when they sought to buy their younger partners out at the same bargain prices.

**A Better Approach**
Here’s another, possibly better solution. Make the buy-in process depend on the associate’s achieving a pre-set level of production in comparison to the senior’s or seniors’ production. It might not begin, for instance, until the young doctor’s productivity level reaches 80% of an equal share of all physicians’ production. In a two-doctor practice the newer member would have to produce 40% of the group’s receipts for the buy-in to begin; for a four-physician group the starting point becomes 20%.

The approach has merit because the new member will not take an income hit until (presumably) able to afford paying fair value. It also sends an appropriate signal to the young physician that he or she must justify partnership by “pulling one’s weight” in terms of revenue production.

**No Hurry to Promote to Shareholder**
The system contemplates an automatic buy-in when the associate’s production hits the target point. Yet it need not mean that the senior partner(s) must automatically sell shares in the practice corporation and thereby give up control. You may limit the automatic mechanism so it only makes one eligible to share group income and accrue rights in a pay-out upon retirement, death or other departure. Whether to sell stock in the practice corporation may and should remain a separate decision depending on your evaluation of the young doctor’s entrepreneurial and management interests and skills, even beyond good clinical ability.

These days, you might be able to hold on to a good young physician even if you do not offer partner status right on schedule. Opportunities are fewer than a few years ago, and an attractive salary progression — but not as attractive as a full partner’s share without reduction for a buy-in — may be extremely appealing.

Here is an important caveat. Some practices make it nearly impossible for a new associate to produce like the senior(s) by the way they allocate duties. A new surgeon may handle most of the in-office medical work while all or most of the surgical patients go to the senior partner. Or the new internist may see more low-fee Medicaid or capitated patients while the seniors stick with their old full-fee visits.

Perhaps practices like these cannot expect incoming physicians to buy in so heavily when their modest productivity-based incomes make it difficult. It may be a reason for considering a compensation formula based in whole or in part on equal division of receipts when productivity does not alone fairly measure relative contributions to group success.
**Decouple Your Buy-in Financial Arrangements**

While deals vary widely, early year income reductions and stock purchase will both likely be part of your buy-in. We suggest decoupling these two main parts of your agreement. It helps insulate against the IRS possibly claiming that taking less pay as part of a buy-in deal is really a disguised part of the stock purchase.

Conversely, it rebuts an IRS argument that the group cannot tax deduct the “separation pay” upon a retiring member’s departure because the payments are instead part of buying back the stock. Decoupling also makes sense because you should have different criteria for becoming a co-owner than for sharing in a compensation pool.

**The IRS factor**

Back in the early 1990s, a new tax provision alerted medical practice advisors to a possible IRS attack on new member buy-ins to co-ownership. That law, Code section 1060, required reporting any change in ownership involving at least a 10% interest. Unless you have 11 or more partners, bringing in a new partner or buying out a retiring, deceased or withdrawing partner became a reportable event.

Section 1060 didn’t change the law, but having to report a buy-in’s details opens your new partner’s deal to closer review. It could lead the IRS to treat his/her typical first few years of income reductions as disguised parts of a capital purchase, thus changing the intended tax treatment. Perhaps worse, it could suggest to the IRS that a senior member’s payout doesn’t deserve tax treatment that is extremely important to the ongoing group.

To forestall the problem of the buy-in, the advice goes, just separate the date when the young doctor purchases stock in the practice corporation from when s/he starts receiving reduced shares of group income. Then report under section 1060 the stock purchase on its own terms without reporting the income reduction. You could similarly provide for a two-part payout structure, perhaps requiring a senior to sell back his/her stock upon reaching a stated age (perhaps 62 or 65) but not starting the income payout (usually called “separation pay” or “deferred compensation”) until s/he actually retires.

**The two-step process**

We still recommend a traditional six-month time differential between the start of income sharing and stock co-ownership. Offer stock ownership to recognize certain factors like:

- Attaining board certification
- Satisfying the board of directors (the other partners) about the physician’s reliability as a co-owner to be trusted in the practice’s business management.
- Helping make the practice grow more profitable by various work and/or business attributes

On the other hand, perhaps a young doctor should not yet become a co-owner but still share in the group income for reasons unrelated to those for stock purchase, such as:

- Having completed satisfactory employment for a stated time period, thus deserving pay higher than that of just an associate
- Achieving an agreed-to productivity level
- Satisfying the board that s/he merits “senior” status based on factors like developing new referral patterns and taking on important clinical responsibilities

Put the arrangements in different contracts. When the buy-in time approaches, put the stock purchase terms into one document and the income sharing arrangements into another. They actually belong separately anyway — in the Shareholders’ Agreement and the Employment Agreement, respectively (assuming a professional corporation).
**Owner versus worker status**

Besides, decoupling furthers the philosophy that there is a difference between being a good physician and being a good “partner.” Ownership should be based at least partly on certain entrepreneurial skills, not just on treating patients.

It is more difficult to separate the capital (stock) and income (compensation) elements in a payout when a partner retires. Still, having a member resell his/her stock upon reaching, say, age 65 whether or not the doctor retires at that age has some logic. The senior physician thus — at least technically — leaves major decisions up to the younger partners who will be affected by them for years to come. In doing so, s/he strengthens the argument that later separation pay (starting upon actual retirement) has no relation to capital values.

### Five Key Financial ‘Details’

Beyond the basics, here’s how to handle five special considerations that may become extremely important if you don’t face them up front.

- **Senior partner rights.** A sole practitioner taking on a first partner may rightfully be concerned about losing control over practice decisions when the new member (we’ll call her “Junior” again) comes into equal ownership. And yet, to make her a less-than-equal partner flies against the concept of professionals equally involved in a joint enterprise; Junior will probably refuse such lesser status. The problem becomes even worse if Dr. Senior takes on a second young partner, for then he could clearly be outvoted — or even voted out!

  Protect your financial stake (and decision-making control) by reserving “senior partner’s rights” in buy-in documents. That could mean an option letting you at any time repurchase a junior partner’s stock at the agreed pricing formula. Thus the two doctors can work as 50-50 “partners” — sharing in decisions as professional equals — while the senior member is protected in case they encounter a split-up situation. If it comes to that, Junior must leave and the practice stays with Dr. Senior.

  And keep in mind that even senior rights may not deserve to go on forever. Somewhere along the line, Junior has probably earned the same protection as her senior partner. Consider, therefore, calling for the option to expire when the buy-in period ends (typically four years).

- **Semi-personal assets.** It’s fine to have an incoming partner pay for her stock in the practice according to the balance sheet’s recital of equipment, cash on hand and other productive assets. But small corporations often hold what we call “semi-personal assets,” like partners’ cars, personal computers used by their families at home and perhaps even art collections. Though corporate-owned, the partners consider them personal to themselves.

  How should you handle these assets? Calculate Junior’s buy-in stock price without including those assets. Also carve out that portion from what she would receive if she later sells out. Provide in the seniors’ documents for a correspondingly higher price and include distribution of those special assets to satisfy the extra price. Such an approach avoids adverse tax consequences the senior doctor would face if he simply removed the items from the corporation.

- **Permanent restrictive covenant.** During her time as an associate, Junior was in all likelihood subject to a “covenant not to com-
important points in new partner buy-Ins

emple — a contract provision that, if she leaves your employ, she will not practice in your service area (not compete) for several years. In states where legal, a restrictive covenant protects you from her taking away patients, referring doctor relations, hospital staff membership and even managed care panels that contribute to your revenue base.

But should that restriction end when she becomes your partner? No. Insist on continuing the restriction even into Junior’s years as a partner. A departing doctor can do far more damage if she leaves later. Hopefully, your initial employment contract specifically says the restriction continues into co-ownership years; you may find it difficult to insist on this vital financial protection when working out the buy-in later.

Bernick and many other advisors urge all groups to restrict their members, so perhaps Junior’s entry will prod you to face the issue for yourselves. But if one or more seniors refuse, we still suggest restricting Junior. There’s too much at stake not to.

❑ Phase up sick, vacation and meeting pay.

It’s not unusual for group documents to phase up vacation, sick pay and professional meeting absence, starting only slightly more generously than for an associate.

For vacation time, you might give a first-year partner four weeks of paid absence if she was entitled to three in her last employee year; then perhaps five weeks a year in her next few co-owner years, and thereafter six weeks or whatever the regular partners get. Apply the same concept to meetings and sick pay allowances, phasing up to equal rights over three to five years as a member.

❑ Sell-out protection. What if you bring Junior into equal co-ownership, and soon thereafter you sell the practice for a hefty sum? As an equal owner, Junior would share in that apparent bonanza despite her short tenure compared to her seniors who served many years. We urge inserting special provisions phasing up a young member’s share of any such pay-out price. Failure to so provide caused terrible problems a few years ago when PPMCs and hospitals were buying practices right and left; who knows when such phenomena might arise again?

Real Estate Ownership Issues

Even though most likely your real estate venture technically comes under the umbrella of a separate partnership or an LLC or LLP taxed like a partnership, we still stress you follow a basic, proven premise of equal ownership. Numerous problems can crop up when some group members own practice real estate and others don’t. We’ve seen plenty of examples — reluctance to expand or move on the part of physician-owner(s), divisiveness over setting “fair rent,” and a host of buy-in and payout issues — to name a few.

You might regard new members of your group as “savvy” business people, with an eye for investment potential. However, real estate ownership is subject to different market pressures than other investments. Pure economics of your practice, however, point to owning practice space rather than leasing. This fact adds to the complication when both become intertwined. That’s why it’s important to discuss how you’ll handle future issues like buy-in of new partners and payout of senior partners.

Protect your current holdings

Work now to revise your arrangements to bring all practice owner-physicians into the real estate ownership if you can. Meanwhile, establish a few safeguards to prevent some sticky situations. First, en-
Make sure that the owning partners offer fair rent value to the practice entity (and thus to the doctors who own the practice but not the real estate). Even if the building owners feel the rent they charge is fair and competitive, non-owners often perceive otherwise. Obtain an unbiased appraisal, perhaps by averaging values from appraisers chosen by each respective group and an unbiased third party.

Your location may hold great value for the continued success of your practice. If the building owner(s) retires, dies or decides to sell the building, the practice could face serious harm. Non-real estate owner physicians should require a provision in their documents that the ongoing practice can continue to rent the building for at least one year after the owner’s death or departure. Provide also that the non-owners hold first option to purchase the property upon any such event or decision to sell. Again, use several appraisers to determine a fair selling price.

**Deal with unequal office ownership**

Take calculated and specific steps to involve third parties in setting fair market value. No matter how “healthy” your inter-partner relationships, unexpected situations or changes of heart can crop up later. Unfortunately, determining “fair rental value” for a single-use medical office is far from an exact science. Even some professional appraisers give you little more than educated guesses. Still, hiring an independent expert remains your best approach.

Even if estimates differ, conscientious appraisers help remove a potentially divisive issue. Most lease terms run for five years, so we recommend getting a new appraisal every few years. If you set rent on a yearly basis, make the new appraisal part of your annual planning routine. And to put the issue at further arm’s length, let the expert set the fair rent each year for you.

**Go beyond base rent**

Do more than just set a fair base rent. Deal with other important parts of your lease agreement as well. Beyond monthly rent, consider a fair amount charged for other costs normally paid in any lease — like those that cover insurance, taxes, maintenance and upkeep of common areas. These costs typically spread across tenants.

Even if your practice has sole tenancy, set a fair and typical monthly amount the practice pays toward these costs. Again, keep these arrangements at arm’s length. Outline the details in your rental agreement. Involve your attorney and a real estate advisor to make sure you cover all bases — and cover them fairly.

When only some group members own your building, seek your attorney’s advice on formal arrangements to include in your practice agreements. Wording regarding fair market value requirements, the opportunity for the practice to continue using the building upon the owner’s departure, and the like should go into your practice agreements at the outset.

Disparate ownership can lead to too many damaging practice issues and to potentially divisive inter-partner problems. Remember your biggest investment is your successful medical practice. Don’t let the real estate investment take precedence over that. Your best approach to owning your building should be the same as your practice ownership — with equal shares whenever possible.
When doctors own the building where they practice, promoting an associate to shareholder status often involves two buy-in deals. The new partner buys into the practice and, separately, into the real estate. Generally, they’re separate legal entities for tax and liability reasons.

For the practice buy-in, we usually recommend a stock purchase to cover the new partner’s share of the practice’s hard assets, and paying the partner a reduced income share for the first three to five years of partnership. That split approach addresses the tangible assets the practice owns, intangible values such as A/R and goodwill, and the likelihood that a new partner has a lesser immediate value to a group than a long-standing member.

But how should you handle the separate real estate transaction?

Two approaches
Presuming that both the current shareholders and the young associate agree that all parties will join the real estate partnership, they usually complete the transaction one of two ways:

1. Refinance the current mortgage with as close to 100% financing as possible and adding the new doctor to the mortgage. This approach lets current co-owners take the mortgage proceeds and requires little or no up-front cash from the new partner.

2. Finance the new partner’s share of the real estate equity. The doctor signs a note agreeing to pay the current owners, with interest, over time. The new physician is also added as guarantor to the existing mortgage.

Those options may seem familiar to you. How doctors handle practice real estate transactions hasn’t changed much in recent years, says Healthcare attorney Jeffrey B. Sansweet, JD, LLM. The terms of the real estate buy-in usually aren’t a contentious part of bringing on a new partner, he adds. If everyone agrees the young doctor should be a shareholder in both the practice and the real estate, the interest rates and lending climate usually drive the details.

“Refinancing is the most common way it’s done,” Sansweet says “The current owners pull out their equity and the now-larger group takes on a new mortgage. If interest rates are down, they may shorten the term and build equity faster.”

Promissory note
If interest rates are high, or the owners have recently refinanced the mortgage, the doctors might be reluctant to do it again. In that event, the new partner pays the owners what would be his/her share of the equity and is added as a guarantor to the existing mortgage. Rather than paying cash, the new partner usually signs a note to pay the others over time, including interest.

Terms and timing
The parties must also agree on the payment term and interest. Sansweet says that if there is significant equity in the property, the note could call for payments for as long as 10 years.

Sometimes the partnership seeks an immediate lump sum buy-in, expecting the incoming partner to obtain the cash through a bank loan. The real estate partners will often help the new co-owner arrange the financing through the practice’s bank — sometimes even guaranteeing the loan.

Written agreements
Protect everyone’s interest in the deal by defining the mechanism for determining the price, the length of repayment and how interest will be calculated.

Whether the new doctor truly buys in or just signs to a new mortgage, any changes obviously must be reflected in the partnership agreements (or operating agreements in an LLC). Make sure your attorney participates in revising these documents.
Will partners who retire or leave the practice be obligated to sell their real estate interest? Will the remaining doctors be obligated to buy back a departing doctor’s interest? At what price? With payments over how many years? Those future buy-out terms are the key issues to settle.

The most common way of setting the price uses independent appraisals. Sansweet offers this typical approach: Each side obtains an appraisal and the average of the two determines the price. If the difference between the two is greater than, say, 10 percent, the appraisers bring in a third opinion and the average of the three determines the buy-out price — less any mortgage liability, of course.

**Stress and buy-in**

Usually the young doctor buys into the practice and the group at the same time, but sometimes groups may stagger those commitments a few years to lessen the financial burden on the young doctor. While Sansweet hasn’t studied the matter specifically, he hasn’t seen that the struggling economy and medical economic climate have greatly affected how practices handle their real estate arrangements.