Setting Up & Operating

# Specialty Practices

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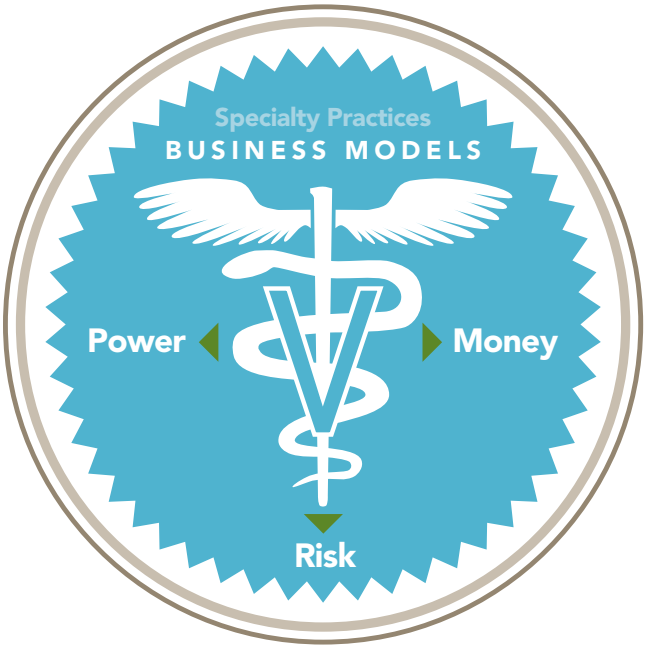



## Which structure will work best for you?

**Multi-specialty practices—or specialty practices for short—do not all follow a single business model. Specialty practices operate under different models, based on the priorities, interests and relative bargaining power of the partners.**

So if you are an owner of a specialty practice, or if you're thinking about forming one with or without another specialist colleague, you need to be aware of these facts:

1. Several business models do exist.
2. Operating under the correct model will reduce management stress and increase the chances of long term success.

# Winging It.

**Most specialty practice owners, of course, don't start by studying business models and choosing the right one. They just "wing it," as illustrated in the following story.**

A surgeon, internist and ophthalmologist decide to form a specialty practice somewhere in the northeast. They agree to be equal owners and decide not to hire an appraiser at the outset to determine the value of their individual practices because they agree each is contributing roughly one third of the total value. They also decide not to hire an attorney to assist them with exploring the complex issues of co-ownership and putting an owners' agreement together. They figure they've been friends and colleagues for a long time and they'll work things out as issues come up. They plan to pool all the costs and revenues of the business and pay each a fixed salary, regardless of what they each individually "bring-in". Profits (what's left over after all the expenses, including their salaries, have been paid) will be split evenly three ways.

Five years go by, during which they hire a dermatologist who has no ownership in the practice. In year six, the surgeon's son develops a serious and chronic respiratory ailment that will require the family to relocate to the drier climes of Arizona. The son's care is expected to cost tens of thousands of dollars annually, on top of health insurance proceeds already in place. Accordingly, the surgeon assumes that she will sell her one third interest to the other partners and the associate dermatologist. As a first step, the practice hires a practice appraiser who evaluates the last five years' financials and determines the aggregate value of the specialty practice to be $6 million dollars.

**What amount should the surgeon be paid for her practice interest?**

1. Is the surgeon's share of the practice value $2 million (1/3 of $6 million) since they agreed to be three equal owners?
2. Or is it 100% of the surgery practice value and 1/3 of the dermatology practice? Under this formula the surgeon would not receive any value of the internist's or ophthalmologist's practices, but would receive 1/3 of the employee's department.
3. If you were the surgeon, would your answer be different if you knew that you generated half of the total practice revenue during the past five years? Should you, therefore, be entitled to half the value of the total practice, or $3 million, plus 1/3 of the value of the dermatology practice?
4. What if you knew that the ophthalmologist worked only part time for the last three years because she had other interests (and had agreed to cut her salary by 10% "to compensate" for her reduced work schedule) but still continued to receive 1/3 of the total practice's annual net profits?
5. What if the practice had incurred a $3 million loan to build and equip a world class surgical suite for the surgeon's primary use and $2.5 million of debt remained outstanding? And each owner personally guaranteed 100% of the loan?
6. What if the internist's gross revenue during the past five years grew twice as fast as the surgeon's?
7. Does it make a difference if the partners' salaries were based on their respective revenue production instead of being fixed? What's a fair salary? What's a fair benefit package?
8. What's a fair buy-out price? What's a fair loan that finances one specialty? Who should buy out the surgeon? The other partners personally or the company?
9. What happens if the partners don't want to buy out the surgeon and don't want the dermatologist to be a partner? What if there is no money to buy out the surgeon's share?

## Suppose the partners are all "good" people and are still on speaking terms after considering these questions.

They want to reach a result that's "fair to everyone." But what's fair? "Bah, you say, just apply the golden rule."[1] That's nice in theory, but very hard to apply after a potentially contentious situation has arisen. Additionally, individuals' personal, financial and career circumstances change all the time, and what they might have thought to be fair at one time, suddenly becomes unfair. Try explaining to a mother that the "golden rule" means that she will receive hundreds of thousand of dollars less for her practice, money she dearly needs for her son's medical care.

If you "feel lucky," and think that this kind of situation will never happen (to you), you can stop reading here. For the rest of us, the lesson is the same one you try to drill into your clients every day: "treat early" and "vaccinate." In our illustration, the failure to treat early means that important issues which should have been raised at the beginning of the business relationship—and addressed in a calm, professional manner—now need to be resolved in the heat of the moment, when the interests and priorities of at least one of the partners diverge widely from the others.

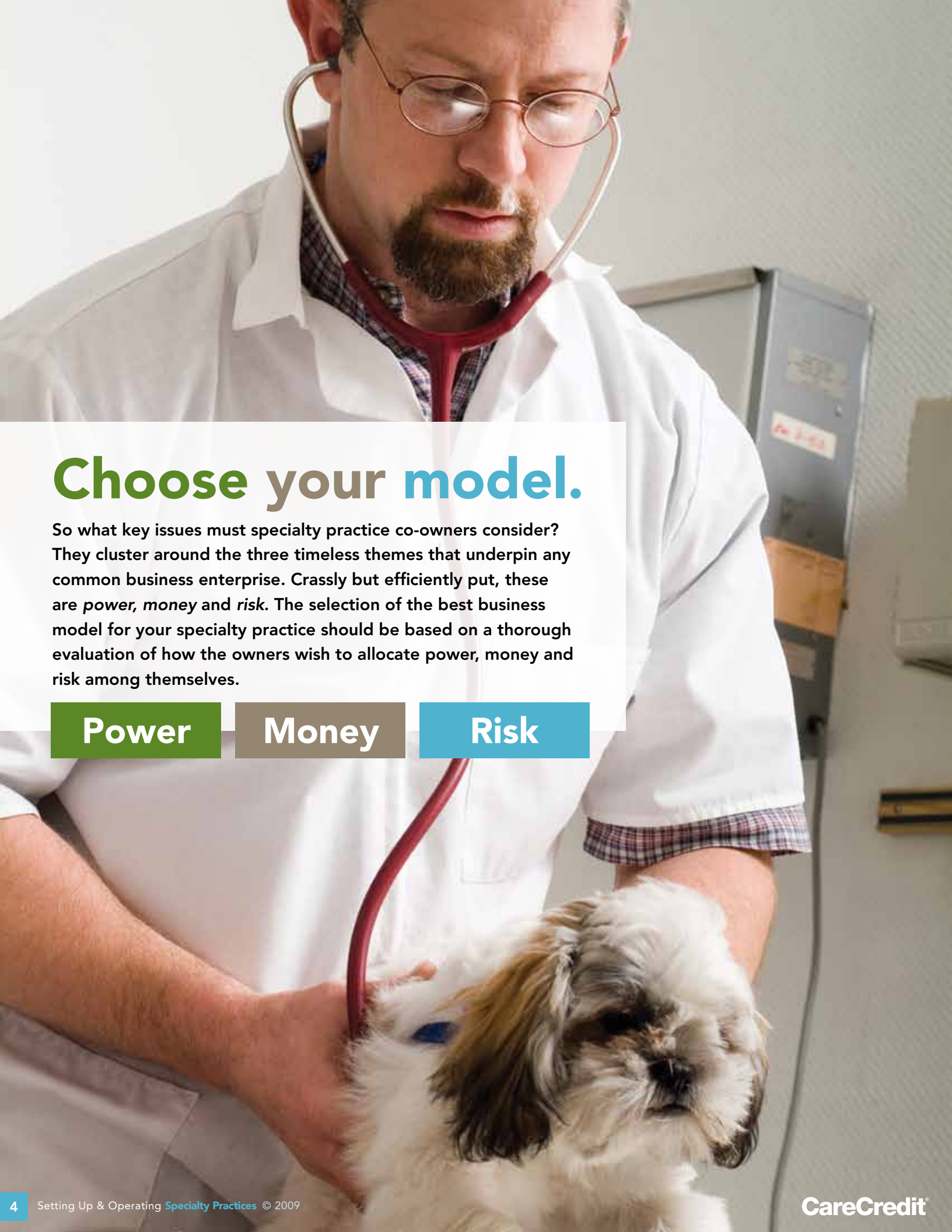
Hopefully, our partners will be able to work it out without resorting to litigators and the courts to resolve their dilemma. But the prognosis is poor—the stakes are too high.

Practice co-ownership always looks rosy at the beginning, and each owner believes that the practice will succeed, the money will flow in, and the other co-owners will make decisions with only the practice's best interest in mind. "Nice people" avoid raising ugly issues at the beginning of an otherwise harmonious relationship. Veterinarians as a group—unlike dastardly lawyers and dreary accountants—don't like conflict and generally don't even want to talk about it. Do you want to ask your new partner what would happen if she developed a dependency on narcotics, went bankrupt or if she got divorced from her greedy spouse? What if two of the three owners want to expand or remodel the facility but the third owner, who is close to retirement, objects?

As for the cost issue, veterinarians, like their clients, are reluctant to spend money on preventive medicine. Never mind that your professional and financial future are at stake, an issue which should be at least as important as the health of your clients' animals.

Up front planning gives you a road map to follow when new owners are admitted; when and how owners can (or should) leave ownership; how profits are split; what debt an owner can incur in the name of the practice, and so on. It also is much easier to deal with tough issues such as partner death, disability, divorce, bankruptcy, freeloading, etc., when each partner must consider that, down the road, he could be one who dies, is disabled, who becomes insolvent, is divorced, etc, or he could be one of the remaining partners "holding the bag." It is easier to apply the golden rule when it's only theoretical and you could end up on either side of the fence.

1 To paraphrase, treat others as you would like to be treated.



# Choose your model.

So what key issues must specialty practice co-owners consider? They cluster around the three timeless themes that underpin any common business enterprise. Crassly but efficiently put, these are *power, money* and *risk*. The selection of the best business model for your specialty practice should be based on a thorough evaluation of how the owners wish to allocate power, money and risk among themselves.

**Power** **Money** **Risk**

**Power issues revolve around the decision-making process within the specialty practice, both as to day-to-day operations and long-term strategic planning.**

# Power

## For example:

- Who decides the direction the practice will take?
- What specialties will be represented?
- Who hires and fires (if needed) the specialists?
- Who hires, trains, and supervises the staff?
- Who decides how many staff members are needed?
- Who decides what equipment to buy?
- What decisions can one owner make on behalf of the practice without the other owner(s)' consent?
- Who decides if the practice should borrow money?
- Who decides which vendors to use and what the arrangement should be? What about other contractual arrangements?
- Who controls the budget?

Specialty practices have addressed these questions in a multitude of ways of course, but two power models emerge based on whether power is *centralized* or *decentralized*. This gives rise to a centralized ownership power model at one end of the power spectrum, and a decentralized ownership power model at the other.

One must not forget, however, that in addition to the "structure" influencing the distribution of power, state laws and partnership agreements also impact the distribution of power among co-owners. This is especially the case with respect to minority owners, who own a lesser percentage of the company relative to one or more majority owners. Unless the minority owner is on the board of directors in a corporation (few understand that directors each have one vote, regardless of the number of shares they own), a managing member in an LLC or the general partner in a partnership, he/she will not have the final authority on decisions of the business. One way minority owners can protect their interest, is by ensuring that the co-ownership agreement has a list of "minority rights" that prevents certain business actions from being taken without their consent. Such a right, for example, may be that the majority stake holder(s) cannot sell 100% of the business to a third party without the minority owner's consent. This protects the minority owner's investment in the business.

## Centralized Ownership Power Model.

In this power model, one legal entity owns all the specialty departments and the control of the entity is concentrated in one or a few owners who make all the decisions about the business, including management over all the specialists and specialties. While the owners often have their own specialties over which they have wide (but not absolute) authority to run as they deem appropriate, they also make decisions about other specialty departments and the practice in general. They may allow key specialists to exercise medically-related decisions about their own specialty departments, but the owners typically retain the authority over financial and non-medical operational issues, such as the budget, debt associated with equipment purchases, whether bonuses will be paid to employees, and how much of the profit stream is distributed to the owners or reinvested in the department. Each of the specialists, including the department heads, is an employee of the practice, and there may be hundreds of employees. Ownership, however, stays with one or only a few individuals. A downside to the centralized ownership model, of course, is that the risks associated with owning and operating the business are concentrated among a few owners, so a problem in one practice department quickly becomes a problem for the whole specialty practice.

Here's an example of how a centralized ownership structure might work. Two individuals, one a surgeon, Dr. S, and the other a critical care specialist, Dr. C, decide to start a specialty practice in their region. There are no other specialty hospitals within 100 miles, although there are a couple of small emergency practices near the location where they wish to set up their hospital. Neither Dr. S nor Dr. C views these emergency practices as serious competition to the multi-discipline specialty center they envision. Dr. S and Dr. C have discussed it thoroughly and have concluded that they do not want to delegate major decision making to other specialists, nor do they want to share the profits with other owners. Instead, they plan to limit future ownership to themselves, although they will encourage the senior doctor within each specialty/department to take control of day to day operations in that specialty. They will expect this person to operate within the overall budget guidelines set by the owners, although they want each department head to assist in developing the budget and may be willing to share a portion of the departmental profits with that person as an additional incentive. Dr. S. and Dr. C will jointly decide whether or not to add other specialties, and how to allocate facility costs and other shared expenses among the various departments.

## Group of Equals Power Model.

Contrast the foregoing with a decentralized structure in which each specialty is separately owned and operated by its own respective owner(s). We call this the group of equals model. Each practice is a distinct legal entity and may have been set up as a corporation, sole proprietorship, limited liability company or partnership, each typically owned by different individuals. Other than sharing certain common costs and resources, each specialty practice is financially and legally independent, meaning it has its own profit (or loss) center and is responsible for its own operations and the risks that come with it. What often ties these separate businesses together is an oversight system, which frequently consists of a committee with a representative from all or most of the specialties that meets periodically to decide matters relating to common issues for the good of the group, such as shared costs and developing common policies relating to referrals, marketing, etc. This oversight committee has control over the individual practices only to the extent that their actions or inactions impact the group overall. Most operating decisions happen at the individual specialty practice level, with little decision-making authority or responsibility resting with the oversight committee.

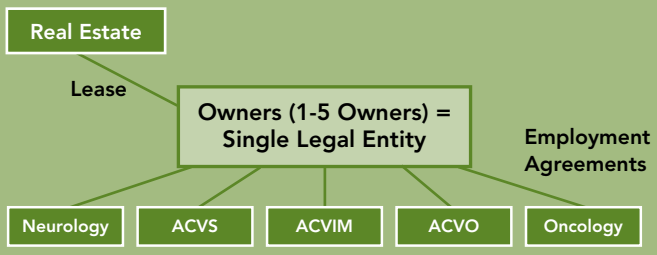
Here's an example of a group of equals practice. Dr. I, an internist, and Dr. D, a dermatologist, each have started their own practices and wish to find a facility together out of which they could both operate their practices and share some of their common overhead expenses. They also hope that by working together in the same facility, they will be able to attract other specialists and more referrals from local practitioners. Because they both wish to maintain their independence and run their own businesses without having to deal with the complexities of other specialties, their decisions have led to a different model compared to the centralized ownership group. Rather than merging their separate practices into one legal entity, they have kept their practices separate but decided it would be more economical to operate under one roof. They plan to be the initial members of a governance board which will deal with overall issues that impact them. As they have no interest in adding different specialists to their respective practices (i.e., Dr. I bringing in a surgeon), when they locate other specialists who wish to join them, they will require those specialists to operate independently as co-tenants.

Each tenant specialty practice will designate the person to join the governance board on its behalf. Profits from each practice will belong to that practice's owner(s), but each practice will pay its share of common expenses, including rent, shared salaries, shared equipment, etc., based on allocation ratios determined by the governance board. New specialties will be added if the board agrees, but each practice can add doctors or staff within its specialty at will. When the specialty center grows large enough to need administrative help, a practice manager or hospital administrator will be hired by the governance board, and the person's salary, benefits, recruiting costs, etc. will be shared among the co-tenant practices. Dr. I and Dr. D do not want the management responsibility of the entire specialty center, and they believe in sharing as much decision making as possible among the various practice owners within the center.

Under the group of equals model, the lease arrangements between the tenants and the landlord can be quite complex and create inequities if the interests of the respective tenants are not thoroughly examined. This model works because for the most part, all the tenants have common goals and there is synergy in sharing a facility. However, there are several areas, such as the allocation of expenses and overlap in services, that can create conflicting opinions as to what is "fair." While the entity under the centralized model also typically leases space, the lease terms are more traditional as there are no co-tenant issues which have to be addressed. The role of the landlord, under the group of equals model, is often more like a "management company", as the issues addressed in the lease deal with "operational" responsibilities, in addition to the leasing of space. In these situations, the landlord becomes the gatekeeper and is responsible for controlling the terms and conditions under which the various practices can occupy a portion of the facility. Included in these leases are provisions governing shared operating expenses, such as staff, pharmacy, employee benefits, etc., which means that these landlords have the power to control more than mere occupancy of the facility. For example, the lease would prohibit the internist from hiring a surgeon who would potentially compete with the surgery practice within the facility.

# Specialty Practice Comparison

## Centralized Ownership




**Owners share equally:**

- Expenses
- Profits
- Control
- Risk (liabilities)

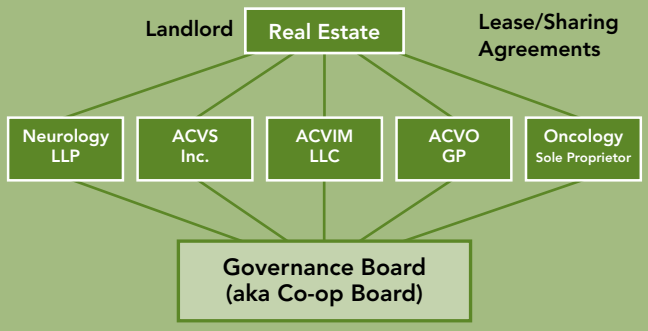
### Pros

- Faster decision making
- Profits shared among a limited number of owners; potentially higher profits per owner
- Owners can share or keep the profits from all departments as they choose
- Adding specialties doesn't require adding a new legal entity
- Simpler model
- Decisions aren't made by an increasing number of specialists who must reach agreement
- Permits the founding owners to add specialties without the consent of other specialists

### Cons

- May discourage entrepreneurial-minded specialists from joining
- Significant management burden upon a limited number of owners
- May discourage departments from watching costs, growing revenue, etc. because of limited upside potential for non-owner specialists
- Greater dependence on a small number of owners whose primary interest may lie in their own specialty
- May be more difficult to value as a conglomeration of different specialties
- The price to buy out an owner at retirement may be very high
- Future owners may not want to own part of many different specialties

## Group of Equals




**Each Tenant:** gets own revenue, gets own profits, pays own expenses, has own risk—BUT—share in decisions regarding shared resources.

### Pros

- Encourages specialists to be entrepreneurial
- Avoids conflict over different cost structures within different specialties
- Owner(s) of each specialty retain their own profits and can reinvest or pay out as each specialty chooses
- Permits each practice to borrow and finance its own business
- Keeps specialty-specific equipment leases or purchases at the specialty level
- Each specialist can transfer ownership within his specialty and realize his share of specialty practice appreciation

### Cons

- Decision making by committee can be slow and cumbersome
- Duplication of effort in terms of separate legal entities, separate tax returns for each entity, etc.
- Complex to set up and operate
- No exit strategy unless an associate wants to buy or the group will accept an outside purchaser
- Cannot sell the specialty center as an entity unless all the practice owners agree
- Difficult for vendors to deal with multiple practices under one roof
- Transferring cases between specialties can be cumbersome
- Can be confusing to clients

**Hybrid Power Models.**

Hybrid structures combine various features of these two business models. For example, the structure may start as a centralized ownership model and morph into the group of equals model. As the centralized ownership practice grows and adds more specialists as employees, the owners may find they have a tremendous amount of difficulty in attracting specialists without offering some kind of ownership interest. Therefore, as a compromise between not offering ownership and offering ownership in the centralized model, the owners might set up a specialty department as a separate legal entity, within which the original owners own 51% and the new specialist owns the other 49%. By doing so, the original owners have set up the new specialist as an owner of a separate practice but still retain financial and legal control over the new practice entity.

**It should be clear from the preceding discussion that the choice of the power model will have an influence on how money is generated, spent, and how the profits are shared among various owners, but the power choice is far from dispositive of the money issues.**

# Money

A primary goal of all specialist practices is to maximize profits of course, but that doesn't necessarily mean that the owners who have contributed the most money, or that the practices who generate the most profits, should call all the shots. From a purely economic perspective, the owner of a higher revenue generating specialty (i.e., surgery) would have no reason to join with a lower generating revenue specialty (i.e., dermatology), unless she believed that the combination would be more profitable than practicing alone. And of course, a low revenue generating specialty would not join up with a higher revenue generating one unless it had some say in the budget and management of the joint enterprise. Accordingly, specialty partners need to determine to what extent money should translate into practice management power, and conversely, to what extent practice management power should dictate how money is used and shared.

## Concretely, this means answering a lot of tough questions:

- Where is the money going to come from to start the practice?
- Is each owner bringing equal money to the practice? If not, are certain owners contributing by bringing equipment, inventory, superior knowledge, experience, contacts or work? How much is each of these worth?
- If the original owner contributions are different, is that reflected in the ownership percentage for each owner? Should it be?
- What if one owner needs to borrow money to get the practice started but the others don't? Does that owner borrow outside the practice or does the practice borrow in the specialty hospital name, with all owners liable for the debt?
- How will the practice produce enough revenue to cover its costs, including owner compensation?
- What if more money is needed to get the practice started than is initially projected? Will each owner contribute an equal amount? Or an amount based on ownership percentages, if not equal? What if one or more can't come up with additional funds?
- How will each owner be compensated for veterinary services?
- How much will be spent to pay for benefits (e.g., health insurance, income disability insurance, retirement plan)?
- Will owners receive compensation for management duties?
- How will the owners divide up the profits?
- How much of the profits, if any, will need to be shared with specialists in order to entice them to join the practice?
- What if there aren't any profits? Who will fund the initial losses?
- Who would take over—and pay for—a deceased or disabled owner's ownership interest?
- If an owner wants to work less in the future, should he continue to make the same salary? Take home the same share of profits? What if two owners want to do that at the same time?
- How much money will each owner be entitled to if he or she decides to leave ownership?
- If an owner retires, does his or her retirement income come out of the practice operations in the future, from a retirement plan that the practice establishes on behalf of the owners and employees, or from the retiring owner's individual assets outside the practice?
- What if two owners want to retire at the same time? Who will buy them out?
- If an owner retires and is bought out, how is the value of that ownership interest determined? Will it be a lump sum payment or a series of payments over time?
- If the practice owners also own the practice facility, are the real estate ownership percentages the same as the practice ownership? Are all the practice owners (including future owners) entitled to own part of the real estate? If so, how will the cost for them to buy in be determined?
- How will the owners decide whether or not to buy equipment, which equipment to buy, and at what price?

**To deal with all these issues, specialty practices have followed two basic "money models" that we call the Capitalist Model and the All-For-One-One-For-All Model[2]. Of course, there are hybrids of these models as well.**

[2] With no political implications ascribed to either, of course.

## The Capitalist Money Model.

**This model is based on the belief that each specialty is entitled to generate its own revenue, must pay its own expenses (including its portion of shared expenses), and can keep most if not all of the profits it generates. For specialty hospitals that choose this money model, they may have chosen either the centralized ownership or group of equals business structure (or some hybrid of them). How the money flows can be different from how the power is allocated.**

Here's an example of how the capitalist model works. Let's go back and revisit our surgeon and criticalist, who have a centralized ownership model and have limited ownership of the business to themselves. So while they agree to share the power, they also believe that the individual specialty departments (and the individual specialists within that department) will be more motivated to produce revenue and monitor expenses if they are entitled to share in their own departmental profits. Their share of the profits in that department will be paid out as compensation, but each department head can decide how the pool is divided among the doctors and staff in that specialty. For example, 60% of the departmental profits could be allocated to that department's doctors and staff, while 40% would be equally allocated between Drs S and C, as 50/50 co-owners.

Additionally, these owners believe that each department is best able to determine what costs, including equipment and staff costs, are appropriate for that specialty. So, for example, if the surgeon wants to buy more surgical equipment, the surgeon, with input from the staff, should decide whether the department can afford the expense, not the criticalist, who may be less able to judge the intangible value of the expense. The caveat, of course, is that such expense is solely borne by the surgical department and does not come out of the criticalist's revenue stream. This does not mean the two owners can't have a "cap" on departmental expenses, and require, for example, that any one departmental expense exceeding $20,000 per year must be approved by the owners.

Owners who choose the group of equals model likely will gravitate toward this method of dealing with expenses. Because each department maintains its autonomy and may in fact be a separate legal entity, each specialty will deal with its own income and expenses, whether directly related to that specialty or shared by some or all of the other specialties. Decisions about equipment purchases would be made by the individual entities, and not require approval as in the centralized model, unless its use would be shared by more than one specialty (such as digital radiography equipment). Then the governing board would be involved in the decision making process. The board would then have to decide how to split the cost to purchase and to maintain the equipment among the specialties using it.

## The All-For-One-One-For-All Money Model.

**This model is chosen by those practices that place less importance on each department's financial autonomy. They are more likely to have chosen the centralized ownership model and there likely are no more than 5-7 owners. These owners have a great deal of trust in each other and are willing to put the specialty center's overall interest ahead of any one specialty or department.**

Here's an example. Dr. O, an ophthalmologist, Dr. S, a surgeon, and Dr. I, an internist, decide to combine their practices, build a new facility, and start a specialty hospital. They have known each other and been professional colleagues for several years. They also believe that they have similar goals for the specialty hospital and are currently operating their practices in a similar manner. They view the new combined practice as a giant pool of resources, consisting of their own specialties as well as others they want to add in the near future. They are comfortable they will be able to allocate power pretty evenly and end up making much more money working together as opposed to working individually. Each plans to cut back his or her scheduled time seeing patients and spend approximately a third of the time managing the specialty hospital by dividing the various oversight functions among the three of them. Each department/specialty will have a lead doctor who will be in charge of medical decisions and operations, but the profits will not be divided up by department. In other words, all the revenue will be pooled and all the expenses will be paid by the specialty hospital overall, not by the individual departments. If one department needs to buy equipment, that cost will be shared by the entire practice and the three owners will make the final decision about whether or not to purchase the equipment.

**In discussing our "power" and "money" models, we have touched on how the choice of a model can affect risk. From an individual owner's perspective, joining a specialty practice offers the opportunity of sharing financial and other risks of the practice with other owners.**

# Risk

The downside of this, of course, is that—depending upon the model—an owner may also be assuming all or part of the risks of another owner's practice. So in addition to asking how much power will I have and how much money will I make, a specialty partner must also ask how much risk am I taking, and particularly to what extent am I taking on the risks of the other partners without having any say in controlling those risks. "How much risk am I taking" is a question that an owner must ask early and often. While you need to think of risk when choosing a business model, there are some risk areas that you will need to address, whatever model you choose.

### Here are a few specific risk questions that need to be considered:

- Who guarantees the practice's loans and leases, if that's the only way to get a loan or a lease?
- Who ensures that the veterinarians are not committing malpractice?
- Who makes sure that the facility is safe?
- Who has personal liability for business operations, i.e., employment law, environmental, or tax liabilities?
- Could the practice survive if one of the owners became disabled or died?
- What insurance policies, if any, would allow the owners to transfer or reduce their risk?
- When does a minority owner become equal, majority or 100% owner?
- Who will get sued if another partner or supervisory employee sexually harasses an employee?
- Who will be responsible if sales tax or other company taxes remain unpaid?

**Choosing the right business model is like treating a disease. The diagnostics should drive the treatment. Specialist owners often think that practices fail because they picked (or more often evolved into) the wrong business model. In fact, it's not that the models themselves are bad, but, rather, it's that the model did not fit the particular group of partners. So choose your model wisely. To do this, talk early, talk often, and hire your financial and strategic legal advisors early to assist you in spotting and allocating power, money and risk.**

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