

Transaction Structure Insights

HEALTH CARE SYSTEM ACQUISITIONS OF MEDICAL PRACTICES

Charles A. Wilhoite

Acquisitions of medical practices by health care systems, particularly tax-exempt health care systems, appear to be on the rise currently. This is because health care systems throughout the country are continuing their strategic efforts to position themselves to be more competitive in the markets that they serve. Motivations for such acquisitive transactions vary from circumstance to circumstance. Generally, however, health care systems are driven by the need to develop diverse service delivery capacity at a reasonable and supportable level of economic investment. In addition to economic considerations, physicians often are equally motivated (1) by the desire to relieve administrative and capital investment burdens associated with private practice and (2) by the opportunity to affiliate with large health care systems. Such large systems provide potential for increased collegiality as well as access to advanced technology and related practice support. Regulatory guidelines currently in place mandate the use of generally accepted valuation approaches and methods in order to insure that medical practice transactions occur at a fair market price. Such guidelines, and related generally accepted valuation practices, affect key premises and/or assumptions that can impact the practice transaction pricing and structuring process. Such medical practice transaction pricing and structuring issues include: (1) whether the transaction will be structured as an acquisition of assets or equity, (2) reasonable provider compensation and the related impact on practice value, and (3) post-acquisition physician employment and noncompetition agreements.

INTRODUCTION

While the volume of medical practice acquisitions has slowed over the past decade, recent medical practice acquisition activity and related physician employment arrangements suggest that health care systems and physicians throughout the country continue to recognize the value inherent in certain strategic alliances.

During the early to mid-1990s, significant medical practice acquisition activity was driven by the anticipated need for health care systems to control primary care “gatekeepers,” widely viewed as regulating:

1. the entry of patients into the health care delivery system, and
2. the flow of patients through the health care system.

Such anticipation related to the expectation that most patient revenues (i.e., reimbursement) ultimately would be under the control of large, managed care insurance plans.

Currently, just under 60 percent of all Americans, or approximately 180 million people, are covered by private health insurance plans. Approximately 25 percent of all Americans, or 83 million people, are covered by Medicare, Medicaid, State Children’s Health Insurance Program (SCHIP), or other public programs. Finally, approximately 15 percent of all Americans, or 46 million people, are uninsured.

Although a significant number of individuals currently are covered by private health insurance plans, health care provider concerns of the early to mid-1990s relating to the thought that managed care—and, specifically, capitated care (i.e., fixed payments received to cover medical services provided to an insured population for a specified period of time)—would dictate patient flow have been mitigated to a large extent by patients’ demands for provider choice. Health care providers—hospitals, physicians, ambulatory care centers and others—remain challenged by contract reimbursement negotiations with private payers. Of almost equal importance, however, is the need to strategically

increase service delivery capacity in order to meet the growing demand for a wide range of medical services created by the aging U.S. population.

Historically, physician practices have been acquired by both physicians and health care systems. However, this discussion will focus on transaction issues frequently faced by health care systems—for example, hospitals and large medical groups affiliated with hospitals—and physicians when a physician practice becomes an acquisition target of a health care system.

While the list of such issues can become quite extensive during the course of a transaction negotiation, significant questions typically arise relating to:

1. whether the health care system will be buying assets or equity,
2. the impact that provider compensation exerts on the practice value, and
3. the significance of post-acquisition employment/noncompetition agreements

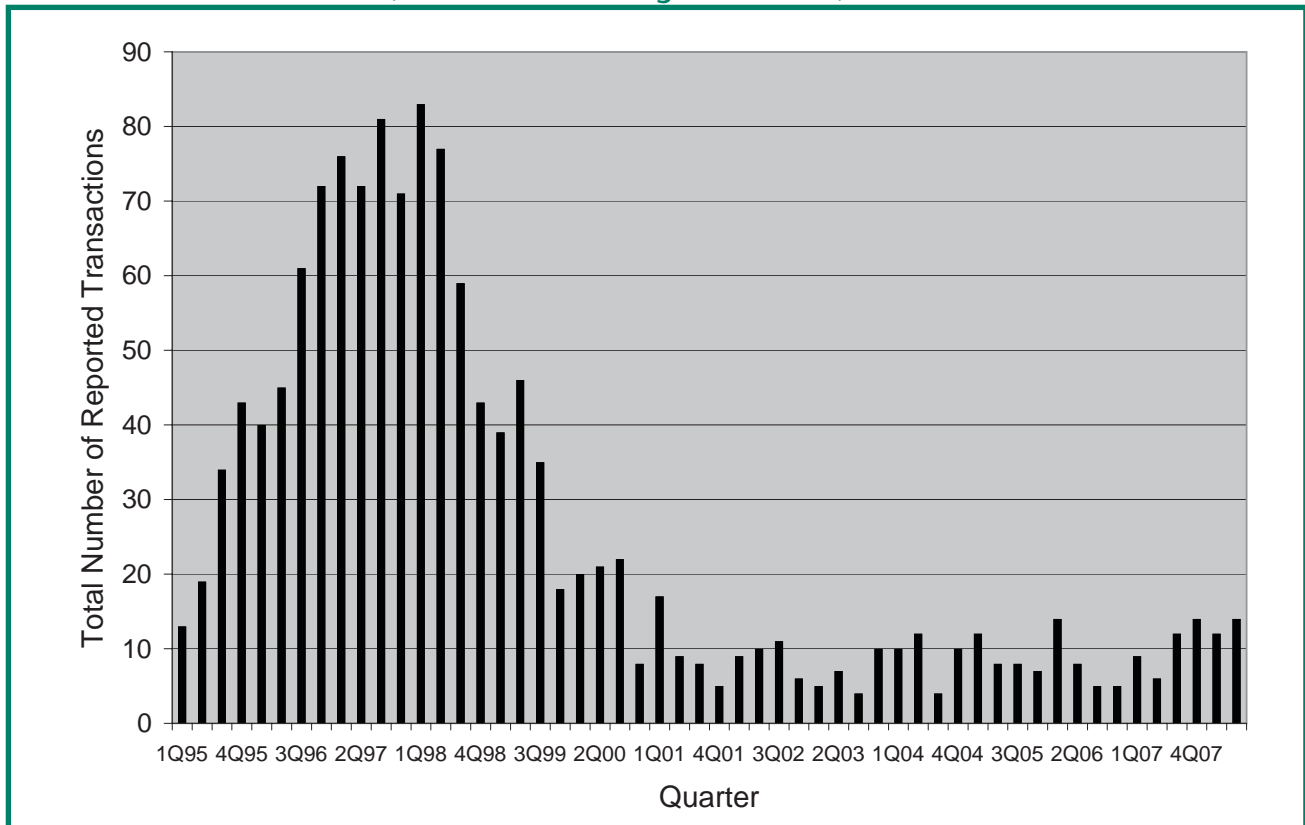
CURRENT LEVEL OF ACQUISITION ACTIVITY

The Health Care M&A Report (the “M&A Report”), published by Irving Levin Associates, Inc., provides market-based data regarding transactions involving the transfer of service-based, health care entities. A review of data published in the quarterly *M&A Report* issued since the first quarter of 1995 indicates that the number of reported transactions involving the transfer of medical practices has declined significantly over the past decade.

Table 1 demonstrates the historical trend noted with regard to medical practice transfers based on data published in the relevant *M&A Reports*. As indicated in Table 1, a strong growth trend in reported transactions occurred between first quarter of 1995, when 13 transactions were reported, and first quarter of 1998, when 83 transactions were reported.

However, the number of reported practice transfer transactions decreased significantly, and almost on a quarterly basis, between first quarter of 1998 and fourth quarter of 2000, declining to a low of eight reported transactions in fourth quarter of 2000.

Table 1
Medical Practice Transfers During the Period of
First Quarter 1995 through Second Quarter 2008



A general decline in transactional activity (such as the trend reflected in Table 1) with regard to medical practice transfers suggests a decrease in demand, and/or desirability, on the part of investors regarding the financial attractiveness of investments in the medical practice sector of the health care services industry. The observed period-to-period decrease may be attributable to an unusually high level of activity in prior periods.

However, due diligence procedures performed by valuation analysts should enable the analysts to ascertain whether such a decline is indicative of a true market trend.

A true market trend is one that should be expected to exert a general, detrimental impact on the value of industry participants currently being valued (as reflected in a general decrease in transaction-based valuation multiples).

However, simply to conclude that the current value of all physician practices is affected in a detrimental manner as a result of the trend reflected by the reported level of medical practice transfers ignores practice-specific characteristics, operating histories, and market positions that distinguish most practices.

Further, to value all physician practices at “book value” ignores the often significant level of “goodwill” (i.e., collective intangible asset value) that exists at many larger practices as a result of considerable time and effort expended to develop the related intangible assets.

It is an error to attribute no value to:

1. existing long-term patient and payer relationships,
2. a skillful and experienced trained and assembled workforce,
3. efficiency-promoting policies and procedures manuals, and
4. the organized assemblage and coordination of both tangible and intangible assets into an operating entity that historically has generated favorable economic returns.

Such an error completely ignores: (1) the economic utility associated with these intangible assets and (2) the time and cost that would be incurred to recreate the assets.

Therefore, a critical review of the facts and circumstances specific to each practice acquisition candidate is an important procedure. Such a review may reveal several dominant practices that are strategically located and strategically positioned in their respective market areas. These practices provide an investment opportunity for a hospital system with the potential for significant economic rewards attributable to the integrated delivery system benefits that could be realized.

While the level of reported medical practice transfers has slowed considerably since the fourth quarter of 2000—

averaging approximately nine transactions per quarter through the second quarter of 2008—it is worth noting that transactional activity for the most recent four quarters through the second quarter of 2008 has averaged 13 medical practice transfers per quarter. This period represented the first time since the four consecutive quarters ended September 30, 2000, that double-digit medical practice transfers were reported each quarter.

An increase in the level of reported medical practice transfers should not necessarily be interpreted as representing a general increase in the value of medical practices. However, an increase in the level of reported medical practice transfers does suggest that a general increase in the demand for medical practices is occurring. This trend supports the notion that an increasing number of strategic acquisition opportunities continues to be identified by health care system buyers.

CURRENT OBJECTIVES REGARDING MEDICAL PRACTICE ACQUISITIONS

As previously discussed, health care system acquisitions of medical practices during the mid-90s and late 90s were driven largely by the desire to control primary care gatekeepers. The motivation behind such transactions frequently resulted in competitive bidding for the targeted practices, often resulting in market-based transaction prices implying the existence of significant intangible asset value for the medical practices ultimately acquired.

The current acquisition of medical practices by health care systems continues to be motivated by the systems' need to maintain a strong, diversified network of qualified providers in order to maintain the level of service capacity and provider options demanded by patients and health plans. However, health care systems' current pursuit of medical practices and/or the employment of physicians is driven more by the need to maintain or achieve competitive advantages in their service regions.

“Market share” in a service region typically is measured by a health care system's proportionate interest in the total level of patient visits, admittances, discharges, procedures performed, or other measure of health care delivery activity for the service region. Typically, such activity is attracted, retained, and/or directed by physicians.

Further, a health care system's ability to provide a new service line, or expand an existing service line, is often dependent on maintaining or acquiring the appropriate medical expertise. And, such an objective is often achieved through the acquisition of medical practices with special expertise.

A strategic and well-planned physician integration program provides significant potential benefits for all involved.

Such a program enables a health care system to:

1. maintain market share and expand or develop new service lines,
2. align incentives with partner-physicians in order to promote cost-effective operations, and
3. obtain essential physician input regarding clinical matters and service-line management.

Physicians, in turn, have an opportunity to:

1. reduce administrative and operating burdens and related risks associated with private practice,
2. obtain a significant voice with regard to the clinical management of expanded service lines, and
3. significantly reduce their personal level of capital investment required and yet remain on the cutting edge of technological advancement with regard to medical care.

Finally, patients (and payers) benefit from:

1. an expansion of the scope and accessibility of the type of services offered by the health care system,
2. improved quality of the related medical services through increased hospital-physician coordination, and
3. potential reductions in the cost of the services achieved through greater efficiency obtained as the result of more coordinated hospital-physician service delivery.

VALUATION CHALLENGES REGARDING MEDICAL PRACTICE ACQUISITIONS

Typically, of primary consideration in a medical practice transfer is the acquisition price. From an economic perspective, the transaction price is a key consideration—from both the seller’s perspective and the buyer’s perspective—in all settings, but this is particularly true when the health care system operates as a tax-exempt entity.

In circumstances in which the buyer is a tax-exempt entity, a complex framework of legal and regulatory requirements—embodied largely in the Medicare anti-kickback laws, federal and state self-referral laws (commonly known as “Stark”), and the provisions of the Internal Revenue Code governing a not-for-profit hospital’s ability to qualify for federal tax-exempt status—must be considered when establishing the transaction price. Other important legal and regulatory compliance considerations include federal and state securities laws and antitrust laws.

Generally, an arm’s-length transaction resulting in the acquisition of a medical practice by a health care system results in a transaction price that reflects fair market value. Fair market value is defined in Section 2.02 of Revenue Ruling 59-60 as:

[t]he price at which the property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of relevant facts. Court decisions frequently state in addition that the hypothetical buyer and seller are assumed to be able, as well as willing, to trade and to be well informed about the property and concerning the market for such property.

While the definition of fair market value refers to “property,” it is generally accepted within the financial, regulatory, and health care sectors that the term “property” refers to assets, or investments in health care entities such as medical practices. As previously discussed, a number of regulatory guidelines must be considered in a transactional setting involving a medical practice transfer, particularly when one of the parties is a tax-exempt entity.

Based on consideration of the relevant regulatory guidelines, the value of a medical practice targeted for acquisition by a tax-exempt health care system must be estimated consistent with definitions provided under the federal Anti-Kickback Statutes and Stark.

Stark generally defines fair market value as:

[t]he value in arm’s-length transactions, consistent with the general market rule—the price that an asset would bring, as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party . . . on the date of acquisition of the asset . . . Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition. . . .

As indicated, the definition of fair market value as provided in the Internal Revenue Code and Stark are similar. However, an important and significant distinction regarding the definition of fair market value as provided in Stark is represented by the condition that bargaining occur between well-informed buyers and sellers “who are not otherwise in a position to generate business for the other party.”

In effect, the Stark definition of fair market value requires that the negotiated transaction price relied upon

to consummate the sale of a medical practice to a health care system is independent of the volume or value of any historical or anticipated referrals from the seller (i.e., the physician practice or any of its owners or providers) to the acquirer (the health care system or any of its affiliates).

The regulatory requirements imposed by Stark (and related legislation) are often inappropriately interpreted by medical practice sellers as a negotiation tactic on the part of health care system acquirers to artificially reduce transaction prices. For this reason, and others, it is important to note that fair market value—whether based on the Internal Revenue Code or Stark—should reflect the price that would result in a negotiated transfer of equivalent economic value.

While a particular medical practice may be credited historically with referring a number of patients to a health care system, the historical revenues and economic earnings realized by the medical practice and the physician-owners are attributable only to the professional and related medical services provided by the medical practice and its providers.

Therefore, should the related medical practice become an acquisition target, a well-informed buyer would be willing to pay a price representing no more than the estimated present value of the future economic returns that the practice is expected to generate.

Such future returns would not include any economic returns attributable to services provided by the health care system. And, therefore, no portion of the purchase price should be represented by health-care-system-related services.

MEDICAL PRACTICE VALUATION

Although it is not the intent of this discussion to provide a detailed focus on the process and methodology relied upon to develop a reasonable indication of the fair market value of a medical practice, a summarized discussion will provide some relevant context. Generally, the valuation of any operating entity can be estimated based on consideration of the three generally accepted approaches to value:

1. the income approach,
2. the market approach, and
3. the cost, or asset-based, approach.

As discussed in the *Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook* (1994 for fiscal year 1995), the discounted cash flow (DCF) method represents an income approach method that reasonably can be relied upon to estimate the business enterprise value of an a medical practice.

As stated in the *Technical Instruction Program Textbook*:

The business enterprise value (“BEV”) is defined as the total value of the assembled assets that comprise the entity as a going concern (the value of a company’s capital structure). BEV can be defined in other ways. Another definition of a more technical nature states it is the capital structure of the business, the components of which are common (or partners’) equity, preferred equity (stockholders), and long term debt. By removing long term debt from the business enterprise, you obtain shareholders’ (or partners’) equity, or the net worth of the firm. The BEV is the basis for most appraisals submitted to the Service.¹

Additionally, the *Technical Instruction Program Textbook* states:

CC:AP:AS (i.e., the National Office Appeals, Office of Appraisal Services) expects all three methods of estimating BEV to be included in an appraisal. CC:AP:AS cautions, however, that even in those cases where the DCF method is appropriate to value the business being sold, the valuation must be based on a discount rate supportable by market transactions. To ensure a correct valuation, the results of the income approach should be tested against other approaches such as market and cost.²

Finally, the *Technical Instruction Program Textbook* requires (1) that the income approach (e.g., the DCF method) be completed using after-tax cash flow, and (2) that the discount rate reflect the impact of state and federal income taxes.³

ACQUISITION OF ASSETS VERSUS ACQUISITION OF EQUITY (STOCK)

The valuation methodology summarized in the preceding section can be relied upon to estimate either:

1. the asset value of a target medical practice or
2. the equity value of a target medical practice.

From a health care system’s perspective, as the buyer, the most typical and appealing form of practice acquisition structure is an asset purchase.

Based on an asset purchase, a health care system buyer specifically identifies the assets of the subject medical

practice that will be acquired. Of almost equal importance is that, based on an asset purchase, a health care system buyer determines which, if any, of the target practice's liabilities that will be assumed.

Alternatively, an acquisition structured as the purchase of the equity (assumed to be 100 percent) of a medical practice results in a health care system acquiring substantially all of the assets, as well as assuming all of the liabilities—both known and unknown—of the target medical practice.

From the selling physicians' perspective, typically it is more advantageous to sell equity. In an equity sale, the selling physicians typically are exposed to only one level of taxation—relating to the gain represented by the excess purchase price above the physicians' basis in the practice (i.e., the net depreciated value of the total practice asset base).

Alternatively, if the transaction is structured as an asset sale, the selling physicians often are subject to two levels of taxation. First, if the target practice is incorporated, the entity will be taxed at the corporate level on the sale of the practice's assets. Second, the physician-owners will be taxed individually on the distributed gain from the sale.

While it is beyond the scope of this discussion to identify all of the potential differences in tax consequences between structuring a transaction as an asset transfer versus a stock transfer, it is important to note that long-term capital gains currently are taxed at a rate of 15 percent, while taxes on ordinary income currently are taxed at rates as high as 35 percent.

Medical practice acquisitions structured as equity transfers generally are less complex and easier to consummate relative to acquisitions structured as asset transfers. However, and in addition to the tax implications previously discussed, the following key issues with regard to the target medical practice should be analyzed prior to structuring a transaction as an equity transfer:

1. reported liabilities, related cost of debt rates and refinancing opportunities, and potential prepayment penalties
2. unreported liabilities, such as accrued expenses that may not be reflected (such as in cash-basis financial statements maintained by the target medical practice)
3. potential for contingent liabilities, as represented by the target practice's malpractice history and/or employment claims history

The potential ease with which a transaction can be consummated and the related benefits can quickly be offset and overwhelmed by significant cost contingencies relating to long-term obligations and related high, debt-service costs, prepayment penalties, and unknown liabilities.

THE IMPACT OF PROVIDER COMPENSATION ON MEDICAL PRACTICE VALUE

As is the case with most closely held professional practices, most closely held physician practices are operated for the primary benefit of the physician owners. In other words, the practice of medicine by the physicians generally adheres to the following two basic tenets:

1. satisfying the internal desire to provide the necessary and valuable service of quality health care delivery
2. satisfying personal financial objectives by generating economic returns commensurate with the value of the services provided

In responding to the second tenet noted above, most physicians in closely held practices realize little benefit from reporting significant practice earnings at the end of a given fiscal operating period. Rather, the maximum benefit realized by most practicing physicians in closely held medical practices results from the withdrawal of substantially all practice earnings in the form of compensation and related economic benefits (e.g., retirement, automobile, club memberships, etc.).

A large physician practice that reported virtually no bottom-line profits in the operating periods immediately preceding a contemplated sale as a result of the physician-owners' historical practice of withdrawing all practice earnings in the form of compensation and benefits would not appear to represent an investment option offering much potential for significant future economic returns to a health care system acquirer.

Herein lies one of the more significant trade-offs that typically should be addressed in the circumstance of the potential acquisition of a physician practice by a health care system—the trade-off between future compensation and current purchase price.

Physician compensation (often defined as salary and benefits) at most closely held physician practices typically ranges from 40 percent to 60 percent of gross practice collections.⁴ Absent the ability of the physician practice to significantly reduce operating costs in future periods while generating increasing revenues, physician compensation and benefits represent the most significant expense categories available for reduction in order to realize higher future profits.

Through a structured physician compensation plan—generally relating physician compensation and benefits directly to physician production—the expected profitability of a targeted acquisition can be projected. Such a procedure should be considered in most circumstances, particularly those circumstances in which the targeted practice has reported minimal earnings in the periods preceding the contemplated transaction.

Any contemplated transaction requires consideration of the impact that a potential future decrease (or increase) in average physician compensation may exert on both the operating performance and retention rate of the targeted practice's physician base. The selling physicians undoubtedly will reflect on past compensation levels, comparing them with projected, future compensation levels.

The trade-off to be recognized—and presented—relates to the fact that a dollar of reduced physician compensation in the future generally translates into more than a dollar of increased transaction value today.

For example, if the selling physicians of a \$50 million revenue practice agreed to an average reduction in total compensation of 2 percent of revenue, the resulting increase in pretax profits would be \$1.0 million, and approximately \$600,000 on an after-tax basis (assuming a 40 percent effective tax rate).

Assuming a transaction pricing multiple equivalent to 12 times after-tax earnings, the increase in practice equity value would approximate \$7.2 million dollars (i.e., $12 \times \$600,000 = \$7,200,000$).

While the expected remaining practice life of each physician would play a significant role in establishing whether such a trade-off represents an economic benefit, such a trade-off should be analyzed in each potential practice transaction involving a tax-exempt health care system in those circumstances where the target medical practice historically has reported minimal profits.

The previously referred to private benefit and inurement provisions and excess benefit provisions in the Internal Revenue Code, and Stark, restrict a tax-exempt hospital from paying more than fair market value to acquire a medical practice.

Such provisions risk being violated in those circumstances in which:

1. the historical earnings of the target medical practice are minimal,
2. the transaction does not contemplate the adjustment of physician compensation and benefits in future operating periods to levels that would increase the probability of higher future practice earnings, and
3. the acquiring health care system pays an acquisition price that implies the existence of significant intangible asset value.

It is important to note that the current state of the health care industry—reflecting continuing reimbursement pressure and pressure to reduce the delivery of high-fee, specialty services—is forcing many medical practices to consider investments to development ancillary service lines (e.g., imaging services, catheterization services, etc.).

While the cost to develop such ancillary service lines may be significant, the potential returns are equally significant, typically over a longer period of time.

When the potential for economic returns relating to the development of ancillary service lines at a medical practice exists at a high level, such potential reasonably can be included in the expected economic returns of the target medical practice, with appropriate adjustments relating to the required cost of the investment as well as the risks inherent in the related, expected economic returns.

The potential sale of a private medical practice provides physicians with what often can be viewed as an appealing and economically rewarding opportunity to escape from many administrative (e.g., payer-related pre-certification and case management requirements) and capital investment (e.g., investments in expensive medical technology, including electronic medical records capability) practice burdens. Further, many physicians simply want to escape the stress often associated with recurring human resource issues and on-call demands.

The potential positive aspects associated with this escape require a considerate analysis of the trade-off between potentially lower future physician compensation in exchange for a higher current practice sales price.

Further, the sale of a physician practice with continued “employee” status for the selling physicians—at a market-based level of fixed compensation—can provide a level of financial security previously unknown to many self-employed physicians over the last decade.

POST-ACQUISITION EMPLOYMENT/ NONCOMPETITION AGREEMENTS

The acquisition of a medical practice by a health care system typically includes the requirement that the selling physicians enter into post-acquisition employment agreements. Additionally, the selling physicians typically are required to enter into noncompetition agreements (or the employment agreements typically contain restrictive covenants).

Such agreements generally are viewed as a means of ensuring the continuation of the productive capacity inherent in the “human capital” component of the acquired medical practice. As a service-based entity, the economic earning capacity of a target medical practice, and often the most significant portion of the value of the practice, is deemed to be inherent in the providers and their underlying support systems.

The terms of employment agreements vary widely, and typically are driven primarily by market conditions. While employment terms of two to three years are common, employment terms for significantly longer periods are often negotiated to address market shortages of certain medical specialties and related recruitment challenges.

Typically, compensation established in an employment agreement incorporates:

1. an element of fixed salary and
2. an incentive component based on production.

Once again, market conditions typically exert a significant effect on the level of compensation incorporated into an employment agreement. This is because medical specialties in short supply, and the significant demand for certain medical specialties, tend to drive up negotiated compensation levels.

However, national and regional compensation medians for the relevant medical specialty(ies), as published by the Medical Group Management Association or the American Medical Association, can and should be consulted to verify the reasonableness of compensation incorporated in an employment agreement.

Further, and based on the regulatory guidelines previously discussed, employment agreements of longer duration should incorporate terms establishing the need for the periodic review of compensation in order to maintain market-based reasonableness.

Noncompetition agreements, or restrictive covenants, associated with a medical practice transfer generally must comply with reasonable, legal limits regarding geographical range and period of time. Several states and courts have determined that noncompetition agreements and restrictive covenants are prohibited or unenforceable, concluding that they unreasonably restrict a medical professional from earning a living.

The reasonableness of the geographical scope covered by a legal noncompetition agreement varies, but is largely affected by whether the market is defined as metropolitan, urban or rural. Additionally, the geographical scope of a restrictive covenant also must consider issues relating to multi-site operations, and whether the restrictions reasonably should apply to all sites within a health care system, specific sites, or a single site.

The reasonableness of the restrictive term incorporated in a noncompetition agreement also varies. However, and based on a review of court decisions regarding noncompetition agreements and restrictive covenants, it is not unusual to see a restrictive covenant of 12 months to 18 months in duration.

Such a restrictive term typically is interpreted as preventing a departing physician from competing in any way with the contracting health care system—in the designated restricted area—for the specified period of time.

Of particular significance in an employment agreement are termination provisions. Most physician employment contracts allow for either (1) termination for cause (e.g.,

loss of a medical license, felonious acts, contract violation, etc.) or (2) termination without cause (e.g., a simple notice, with a 60 to 90 day period).

The integration of an acquired medical practice into a large health care system typically imposes significant change on all parties involved. Therefore, considerable risk exists regarding the possibility that the “fit” will not be perfect. As a result, a well-crafted physician employment agreement, with clear terms (including a potential dispute resolution clause) is a requisite component of the practice transaction negotiation.

SUMMARY AND CONCLUSION

A recent uptick in reported medical practice acquisitions suggests that the potential for strategic integration activities continues to exist in the health care industry as relating to the purchase of medical practices by health care systems. As health care systems and medical practices negotiate potential transactions, it is critically important to consider:

1. the legal structure of the practice transfers,
2. the impact that post-employment compensation arrangements can exert on the ultimate transaction price, and
3. post-acquisition employment agreements and noncompetition agreements.

Existing regulatory guidelines effectively require that health care systems mitigate the risks relating to integration activity. Health care systems can mitigate that risk by relying on the advice and guidance of both qualified legal counsel and valuation experts. Health care systems should seek such advice when engaging in medical practice acquisitions and related transactional activity.

Notes:

1. *Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook* (1994 for fiscal year 1995), L., *Integrated Delivery Systems and Joint Venture Dissolutions Update*, p. 163.
2. *Ibid.*, p. 166.
3. *Ibid.*, pp 167–169.
4. See, generally, *Physician Compensation and Production Survey: 2008 Report Based on 2007 Data* (Englewood, CO: Medical Group Management Association), pp. 102–103.

Charles Wilhoite is the national director of health care services at Willamette Management Associates, based in the firm's Portland, Oregon, practice office. Charles can be reached at (503) 243-7500, or at carwilhoite@willamette.com.