SUPPLEMENT TO

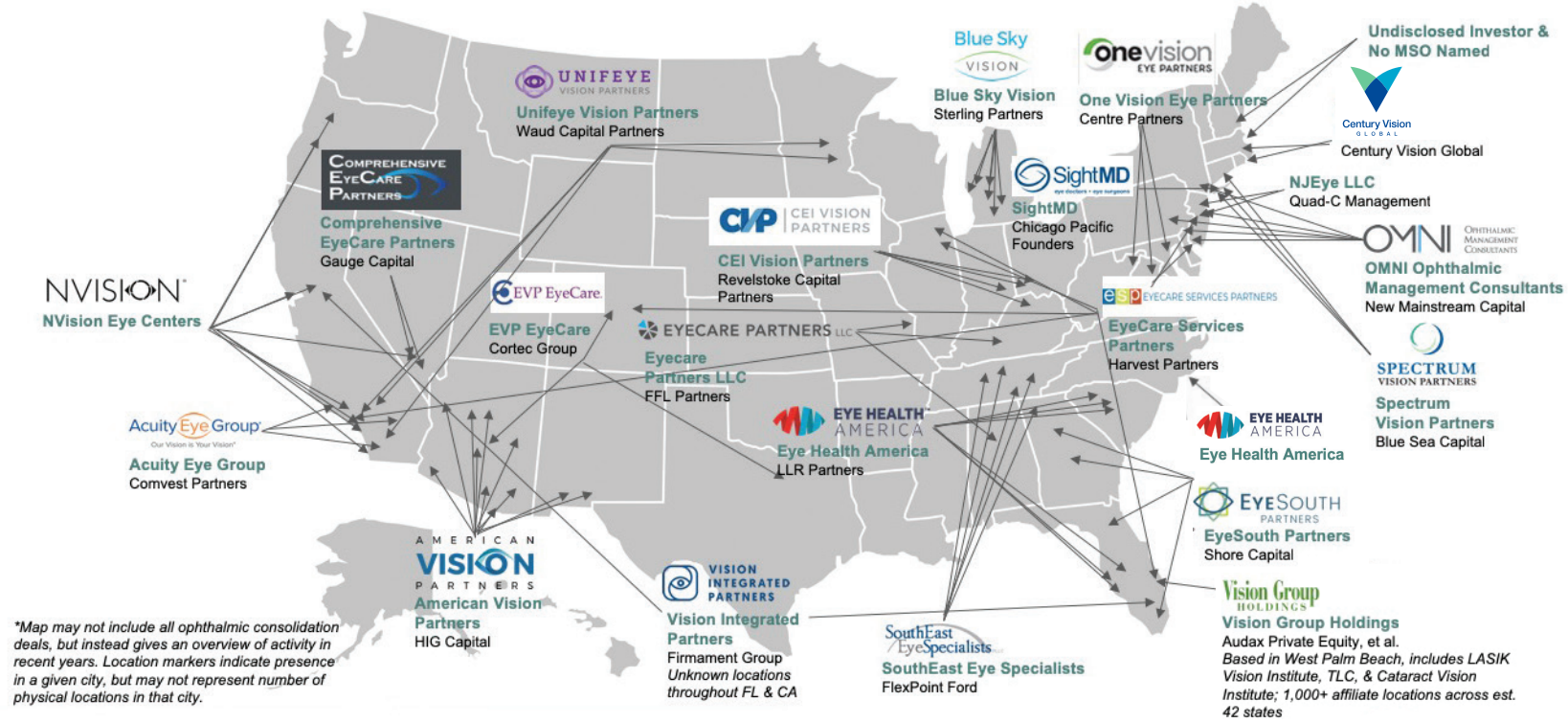
MARCH/APRIL 2019

CRST + COLLABORATIVE EYE

Cataract & Refractive Surgery Today

DISSECTING THE POTENTIAL ADVANTAGES AND PITFALLS OF

PRIVATE EQUITY



Leaders from all sides of a private equity deal provide valuable insights and factors to consider before signing a deal.

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TABLE OF CONTENTS

PRIVATE EQUITY STATE OF THE UNION

BY STEPHEN DAILY

After a 25-year hiatus, private equity (PE) investment has returned to the eye care market in a big way. During the past 3 years, PE has targeted ophthalmology as an attractive investment due largely to appealing secular growth, an aging US population, cash pay services, and diversification of offerings.

During the 1990s, ophthalmology was in the midst of the physician practice management company (PPMC) phenomenon. In comparison, today's PE companies are better equipped to manage the obstacles that might have been mismanaged by PPMCs in the past. PE capital is flowing into large, more established practices first, and seems destined to continue its outreach in the highly fragmented eye care space.

In an effort to connect physicians with the premier authorities in private equity, Bryn Mawr Communications hosted the inaugural Private Equity Live symposium in late October, prior to the annual American Academy of Ophthalmology meeting in Chicago.

With the influx of investment money flowing into the ophthalmic space, the goal of Private Equity Live was to address the many questions practitioners have about business principals not taught in residency, including how to: (1) evaluate your earnings before interest, taxes, depreciation, and amortization (EBITDA); (2) leverage your real estate; and (3) keep employees and partners engaged/motivated after a deal. The event also provided networking opportunities among physicians, private equity firms, and investors.

The inaugural Private Equity Live event began with a "State of the Union" address by health care consulting veteran Bruce Maller, the founder and CEO of BSM Consulting, a health care consulting firm that provides support for all facets of practice management. Founded in 1978, BSM Consulting currently has 17 shareholders and 60 employees with offices in Phoenix; Incline Village, Nevada; Orem, Utah; and Duncanville, Texas.

NOW AND THEN

Mr. Maller kicked off the symposium by providing the audience an overview of the current wave of market consolidation and compared it to the PPMC deals of the '90s.

"The wave—and it really is a wave—of consolidation is really not like anything that I have seen in my career," Mr. Maller said. "Some of us were here during the middle 1990s, when there was a fair amount of consolidation activity and, of course, everybody kind of knows if you were around, the outcome was not particularly positive."

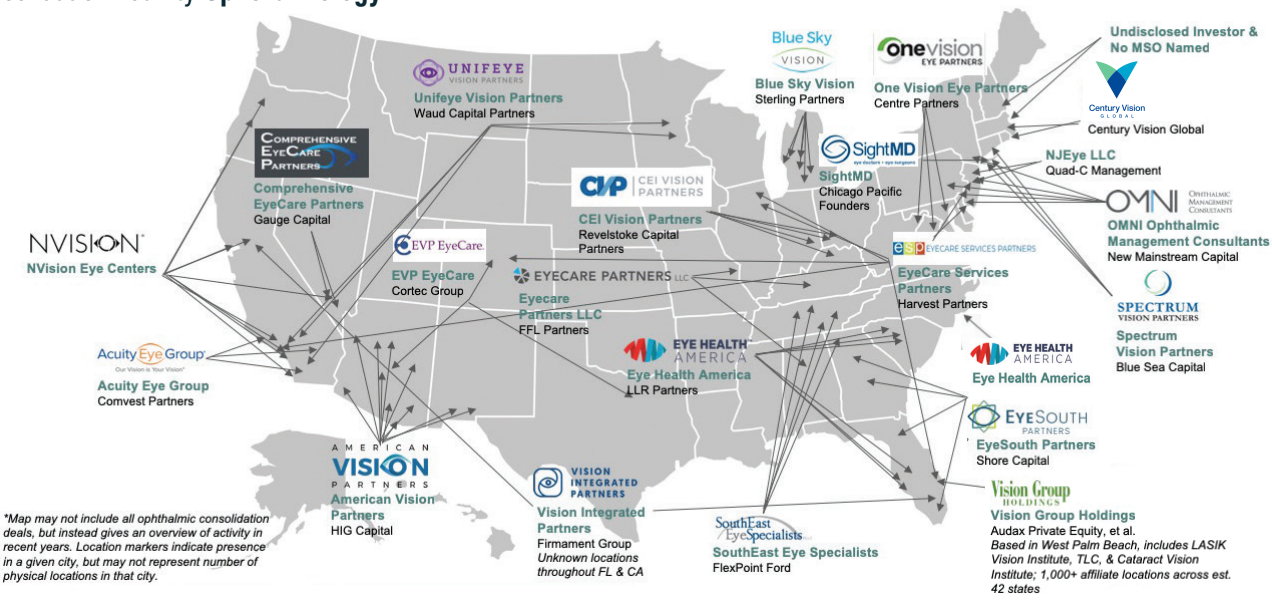
SO WHAT IS DIFFERENT TODAY?

"To put it simply, this time around there is actual cash," Mr. Maller explained. "In the 1990s, many of the deals were trading equity for equity or stock for stock. … We were all going

"TO PUT IT SIMPLY, THIS TIME AROUND THERE IS ACTUAL CASH. IN THE 1990S, MANY OF THE DEALS WERE TRADING EQUITY FOR EQUITY OR STOCK FOR STOCK. … WE WERE ALL GOING TO BET ON THE OUTCOME THAT WE WERE GOING TO BUILD THIS AMAZING BUSINESS, AND WE WERE ALL GOING TO MAKE A LOT OF MONEY WHEN WE TAKE THAT ENTITY PUBLIC OR WE TRADE IT OUT AND SELL IT OUT TO SOMEBODY ELSE. THAT IS NOT THE WAY IT WORKS TODAY. THERE IS ACTUALLY CASH."

-Bruce Maller, CEO, BSM Consulting

Figure 1
Consolidation Activity-**Ophthalmology**



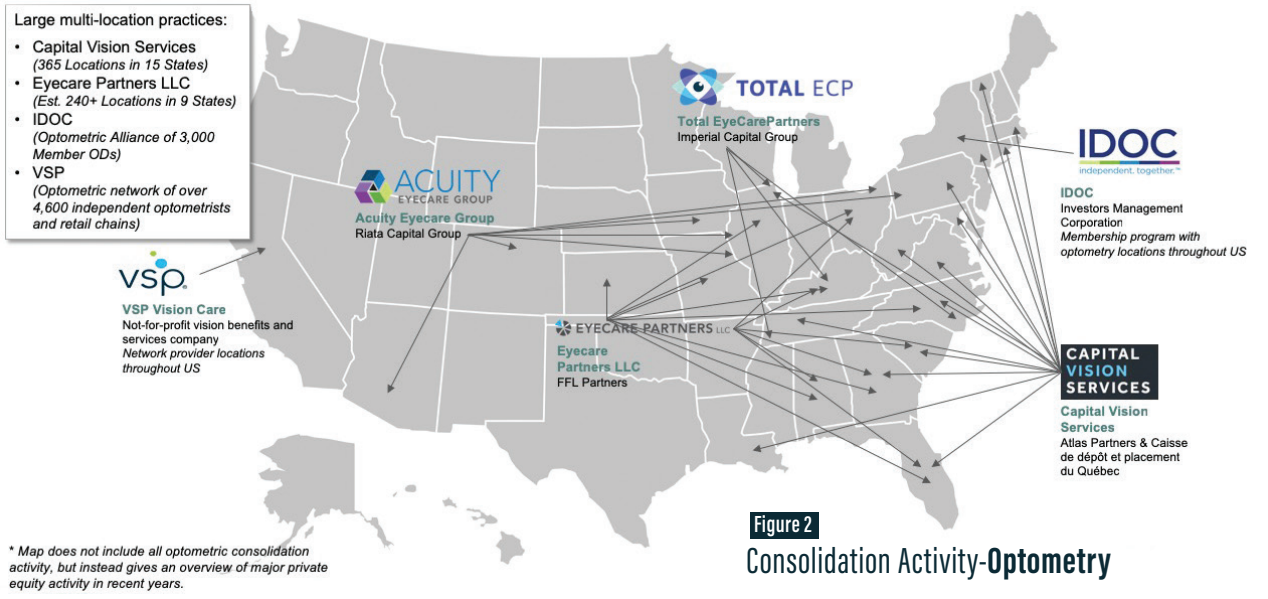


Figure 2
Consolidation Activity-**Optometry**

to bet on the outcome that we were going to build this amazing business, and we were all going to make a lot of money when we take that entity public or we trade it out and sell it out to somebody else. That is not the way it works today. There is actually cash."

Learning from mistakes of the past, Mr. Maller said that today's investors are more nuanced in terms of running a business. In addition, purchase terms are different, as well as how the deals get structured.

"One of the big aspects that I see is that investors today are bringing greater structure, order, and discipline from a governing standpoint," Mr. Maller said. "They set up better governance, they oversee more effectively, and they bring more discipline.

"They are smart enough to know what they don't know and are the first ones to say, 'We are going to rely upon you.' Or 'together, we are going to hire talent into our organization to help in building and strengthening infrastructure.'"

CONSOLIDATION ACTIVITY – OPHTHALMOLOGY

Based on research provided by BSM, there have been PE transactions in 45 states in recent years, with approximately 22 management company platforms. Providers involved in acquisitions include more than 850 MDs/DOs and more than 400 optometrists in platform activity (Figures 1 and 2).

Mr. Maller noted that consolidation is not just limited to ophthalmology; there is similar activity taking place in optometry, albeit not to the same degree. The margins in optometry are typically not as good, making it tougher for the business model to work, he said.

He also pointed out that prior to the wave of PE investment in ophthalmology, there was an influx of PE dol-

lars in dermatology. The dermatology space can be used as a comparative benchmark, Mr. Maller said, because like ophthalmology, it is an insular specialty with strong demographic trends. Many of the same companies now investing in the eye care space were previously investing in the dermatology space, and the investment opportunities look strikingly similar in some ways to the ophthalmic space.

Mr. Maller said that the demographic trends of the ophthalmic space are very attractive, providing a "bull market" for investment opportunities. He added that a combination of increasing eye disease diagnoses, the emergence of new technology, and the allure of ambulatory surgery centers (ASCs) that provide cash pay services have provided a growing stream of cash flow.

"The most important reason why any practice should think about doing something (with PE) is because you want a partner that is going to help you execute a growth plan," he said. "That is at the very essence of why and how you need to think (when) doing these kinds of deals."

Mr. Maller said while all PE investors want control, with the ultimate goal of increasing cash flow, the deal structures and long-term strategy of PE firms vary substantially. Therefore, it's crucial for any practice to know the motivation of the PE partner.

"Deal structure varies; their motivation can be very, very different," Mr. Maller explained. "That investor who looks at your practice and surgery center and says, 'Hey, we want to be here for the duration,' meaning we want to buy an asset, build it, grow it, keep it, hold it. (That investor) thinks very differently than (an) investor who says, 'Hey, I want to buy this asset, I want to build up the cash flows, but I have got investors over here that I need to satisfy, and the only way I do that is to flip or turn or sell that asset in a period of time.'"

Therefore, sellers need to educate themselves on what makes PE films different and know their motivation, so they can align themselves with the best strategy for their business.

TYPES OF CONSOLIDATION AND FACTORS TO CONSIDER

During the opening session of the Private Equity Live event, Mr. Maller also outlined the different types of consolidation in the eye care space and the metrics in which the private equity market will value a business.

When determining valuation, investors look at whether a practice is a "platform" or a "tuck-in." A platform is based on the quality and integrity of the infrastructure, personnel, IT systems, and ability to scale-up the business.

"Can you bolt on additional practices and operate them efficiently and drive efficiencies to the bottom line?" Mr. Maller asked. "You may or may not be in that category. But the platform practices, because they are more mature and more sophisticated, are going to likely command a higher price point from a valuation standpoint versus that practice that is folded in or acquired by an existing platform."

Mr. Maller also discussed how the main metric in which the PE market will value your business is based on adjusted EBITDA.

"Once you get to a number, a buyer assigns a multiple to that, and the multiple has everything to do with the buyer's expected rate of return and how (it) views the asset that you have available to sell," he said. "And there are many factors that impact the multiple."

Mr. Maller outlined other factors that are important for investors and sellers to consider, providing the following commentary on them:

- **Due diligence.** "I want to buy you, (so) we sign some letter, which is nonbinding, and now I am going to go in and look at everything you do, and how you do everything you do, to determine if you really are who we hope you are."
- **Purchase terms.** "How much is cash? How much of the cash that we receive is potentially going to be rolled over into equity in the successor company? That rollover equity becomes an important part of every deal that practices contemplate. It's very important to know the value of the equity, and (if) that equity going to go up in value over time. It is variable."
- **Tax considerations.** "You want to optimize from an after-tax return perspective—the proceeds. These are complex issues and require intense work from legal, accounting, and regulatory (personnel) to make sure that you are managing that appropriately."
- **Allocation of money among partners**. "Do we have to divide the money equally? Is there any opportunity for disparate allocations of sales proceeds? Complex issues, again, that you need counsel for."
- **Terms of employment.** "I am going to go work for somebody—what is it going to look like post-closing? How am I going to get paid? What are my benefits? What about those associates who work for us, how are they going to be affected by this transaction?"
- **Real estate.** "We own the building. Do we sell it? Do we keep it? Do we lease it? Do we do a sale lease-back? All kinds of considerations one needs to think about."

Mr. Maller concluded his presentation by saying he believes consolidation in the eye care space will continue. This could cause disruptions to referral channels, and potential out-migration on the payer-contract side. Still, he believes many markets will be unaffected by PE consolidation, and that practices can still be successful even if not part of a PE-backed platform. He advised all practice owners to continue educating themselves, reassess their vision, values, and long-term goals, and evaluate capital needs to execute a plan.

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ANATOMY OF A DEAL

BY MATT OWENS, ESQ., AND NAOMI HARTMAN, ESQ.

During the Private Equity Live Symposium, we provided an overview of private equity (PE) transactions in the eye care space. Most notably, the discussion focused on how these transactions are structured, who the key players are, the stages of a transaction, and the key issues that are presented in these deals.

For various reasons, including prohibitions in some states regarding the corporate practice of medicine, PE firms (and similar financial investors, collectively, "financial partners") will often structure transactions with physician practices through a management services organization or "MSO" model. In this model, an MSO holds the nonclinical assets of the practice and enters into a management agreement with the practice to manage the day-to-day operations. Meanwhile, the practice retains authority over the clinical aspects of the business. In a transaction using the MSO model, if the financial partner does not already have an existing MSO in place, then the physician practice and the new financial partner will form an MSO into which the financial partner then invests. After the transaction, the practice—which at this point is generally referred to as a "captive practice"—remains owned by one or more physicians, while the MSO is generally majority owned by the financial partner, with the former practice owners owning a minority "rollover" interest in the MSO. In some instances, the financial partner's MSO may already have a captive practice that it manages, in which case, a physician practice looking to transact may have all of its clinical assets and operations moved into the existing captive practice.

In any practice management transaction with a financial partner, there are various parties that will be involved:

- **Physician Owners:** The owners of the practice who are looking to transact.
- **Financial Partner:** The PE firm or similar financial investor that is looking to invest in the business of the practice.
- **Investment Bankers:** Financial advisor that assists the physician owners in all stages of the transaction, from the marketing of the practice to finding the right financial partner (as well as maximizing the value of the transaction).
- **Lawyers:** Legal advisors that assist in all stages of the transaction, from ensuring the structure of the deal is tax efficient and compliant from a regulatory perspective, to ensuring that the physician owners protect the value created in the transaction.
- **Accountants/Tax Professionals/ Wealth Managers:** Additional financial advisors that help physician owners with tax structuring and asset protection in connection with these types of transactions.

It is critical that physicians who may be considering a transaction with a new financial partner consult with their advisors early in the process. Advisors will help to guide physicians through the transaction, ensure no key issues slip through the cracks, and minimize missed opportunities throughout the process. Often, these deals are transformational in nature and represent a once-in-a-lifetime opportunity. As with anything this important, selling physicians must have proper advisors in place to ensure value is maximized, assets are protected, and the transaction is structured and consummated in compliance with law.

Most practice management transactions follow similar paths, and include many of the same stages (though no two deals are the same and each can certainly take on a life, and path, of its own):

- **Internal Discussions:** It is absolutely essential before proceeding down this path that all owners of the practice reach consensus on whether they want a transaction and how they see the process unfolding.
- **Hiring of Advisors:** For significant transactions like these, it is always best to engage advisors early in the process.
- **Marketing and NDAs**: Once the practice has decided to pursue a transaction (and often after the practice has hired an investment bank), the practice will begin the process of marketing itself to potential financial partners. These partners will sign nondisclosure agreements and then receive access to financial information and other key items of information about the practice to decide if they wish to pursue a transaction.
- **Initial Due Diligence ("The Dating Stage"):** A subset of financial partners that received initial information will seek additional information about the practice and may want to meet with management and the physician owners to get a better feel for the business. This is not only a time for financial partners to do initial due diligence on the practice, but also an opportunity for the practice to do its own due diligence on the potential financial partners.

STAGES OF A DEAL

- Internal Discussions and Hiring Advisors
- Marketing and NDAs
- Initial Due Diligence/The Dating Stage
- Letter of Intent
- More Extensive Due Diligence and QofE
- Agreement Negotiations
- Closing/Transition

- **Letter of Intent:** Eventually, the practice will likely sign a letter of intent with its preferred financial partner, signaling its willingness to negotiate exclusively with that one financial partner for some period of time as the parties work to get a deal completed based on high level terms set out in the letter of intent.
- **Continued Due Diligence/ Quality of Earnings:** The preferred financial partner will then conduct more extensive legal and financial due diligence on the practice and will most likely want to perform its own "Quality of Earnings" review to ensure the valuation agreed to in the letter of intent is supportable.
- **Agreement Negotiations:** All parties, with the help of legal counsel, will negotiate the key transaction documents, which generally will include, at a minimum, a purchase agreement, employment agreements for the selling physicians, and agreements related to the terms and conditions of the rollover equity that will be received by the selling physicians.
- **Closing/Transition:** After all documents have been fully negotiated and all issues resolved, the parties will close the transaction, wire funds, and start working together on the new partnership.

Throughout these stages of a transaction, there are several key issues that selling physicians need to navigate:

- **Valuation:** Valuation is often the first—and most important—issue that physicians focus on. If there are multiple owners, as noted above, it is important they reach consensus at the outset on what the minimum valuation is that all physicians require before transacting. Part of the valuation analysis includes determining how much annual post-closing compensation each physician owner will want (because the more post-closing compensation an owner wants to retain, the lower the upfront valuation will be).
- **Tax Structure:** Physician owners must be sure not to look at valuation in a vacuum—it is just as important to determine how the physician's sale proceeds from the transaction will be taxed. The goal is to structure the transaction as tax efficiently as possible (eg, capital gains instead of ordinary income). The tax outcome will be impacted by the existing legal structure of the practice, how the transaction is structured, and how the rollover equity will be issued, among other issues. Tax needs to be front of mind from the outset, as it can have significant implications on the transaction.
- **Rollover Equity:** Closely related to valuation, because rollover equity frequently represents a large portion of the overall sale proceeds received by the selling physician, are the terms and conditions of the rollover equity (eg, the equity in the MSO that selling physicians will receive as part of the transaction). It is not just a question of what percent of the sale proceeds will be payable in equity, but also a question of what the terms will be of that equity. Two significant questions to get answered at the outset of a transaction are: (1) will the equity received by the selling physicians be the same class of equity held by the financial partner (in terms of economics, etc.), or will the financial partner have a senior, or

preferred, security; and (2) what governance rights will the selling physicians have in the MSO in which they own rollover equity.

- **Noncompetes:** The financial partner will require that all selling physicians enter into noncompetition and related restrictive covenants. This will likely include, at a minimum, a sale of business noncompete for a period of years following the closing, as well as a new employment noncompete that lasts for the period of employment plus some tail period (depending on state laws with respect to physician noncompetes). Selling physicians should determine how important this issue will be to them before getting too far down the road with a transaction.
- **Employment Agreements:** Generally, the selling physicians will be required to enter into new employment agreements with the captive practice. For some selling physicians, this may be the first time they have had to negotiate the terms of their employment. Employment agreements will raise several important issues, including whether a specific work schedule will be required, whether certain outside activities will be permitted (hospital call, expert witness work, etc.), how compensation will be measured and calculated, and the terms of restrictive covenants, among other issues.
- **Associate Physicians:** Frequently, practices that are pursuing a transaction with a new financial partner must address how to treat an associate physician who may be up for partnership (or already in the middle of the partnership buy-in process). This is a delicate issue, and one that requires careful thought and consideration as the practice balances doing what is right by the associate physician and the existing physician owners who may have been partners for many years.
- **Real Estate:** To the extent physician owners also own some of the real estate that is leased and used by the practice, the financial partner may require negotiation of a new lease (as they rarely look to acquire the actual real estate). Not only must the leases be on fair market terms, but physician owners will need to ensure that certain terms of the leases that are important to them as landlord (length of term, triple net, etc.) are not materially changed.

There continues to be significant interest in practice management transactions, and many practices in the eye care space are pursuing (or have pursued) transactions with financial partners. The summary above is just that—only a high-level summary of the some of the many issues and aspects of these transactions. These are complicated transactions, but when done right, they can lead to successful partnerships and exciting opportunities for physician owners.

WHAT IMPACTS YOUR VALUATION?

BY BRUCE MALLER

Within the context of private equity (PE) transactions, the determination of value is normally based on a multiple of EBITDA (earnings before interest, taxes, depreciation, and amortization). EBITDA is often used to describe the "free cash flow" of a business. Free cash flow is the amount of cash available for capital expenditures, debt service, and distribution to the owners of a business. It is calculated by subtracting from revenue the cost of goods sold and operating expenses of the business, including a market rate of compensation to the selling physicians.

When using a "multiple of EBITDA" valuation method, the buyer assumes they will be acquiring the business free and clear of any encumbrances. To the extent there is debt on the balance sheet at the time of closing, the seller is normally required to pay off the debt out of the sales proceeds.

The multiple applied to the adjusted EBITDA corresponds to the buyer's expected rate of return on capital invested in the transaction. Generally, there is good faith negotiation between the buyer and seller on the purchase multiple as well as other deal terms.

In arriving at EBITDA, it is common to eliminate one-time gains or losses, as well as nonrecurring revenue and expenses. As noted, the compensation of the selling physician(s) is "normalized" to a rate of pay likely to be paid to the physicians postclosing. This is normally a percentage of professional collections in the range of 30% to 35%. The following is a list of additional items that are typically adjusted in arriving at the EBITDA.

- Excess or below market rent paid to shareholders/related entities
- Excess or deficient owners' compensation
- Personal travel and entertainment
- Above market fees paid to a related entity

CONSIDERED IT, SERIOUSLY CONSIDERED IT … DECIDED AGAINST IT

As part of the PE Live symposium, Robert J. Weinstock, MD, provided a first-hand account of the process behind considering a partnership with a PE firm.

Dr. Weinstock is a partner and the Director of Cataract and Refractive Surgery at The Eye Institute of West Florida, a 45-year-old family owned and operated subspecialty ophthalmology practice in Tampa, Florida. The institute has six locations, a surgery center, aesthetic center, two optical centers, and a retail store. It employs about 300 people, including 35 providers and eight partner physicians.

When the PE activity in ophthalmology started to take off, Dr. Weinstock decided to explore all possibilities, committed to engage in a full vetting process to see if such a deal would benefit the practice and its partners.

Dr. Weinstock said the prospect of partnering with a PE firm that could provide management services was appealing to him as his practice is transitioning from a "mom-and-pop" organization to a more corporate type of culture.

"[The practice] has grown tremendously. We need more management, capital for growth, and quite frankly, we need help in operations," Dr. Weinstock said. "We believe there are economies of scale, and opportunities for cost savings by consolidating back-office processes, such as human resources and billing, across a group of practices."

Dr. Weinstock engaged in an 18-month endeavor to evaluate all prospects of partnering with a PE firm.

Based on what he learned during the process, Dr. Weinstock identified several potential pros and cons of doing a deal with a PE firm.

PROS

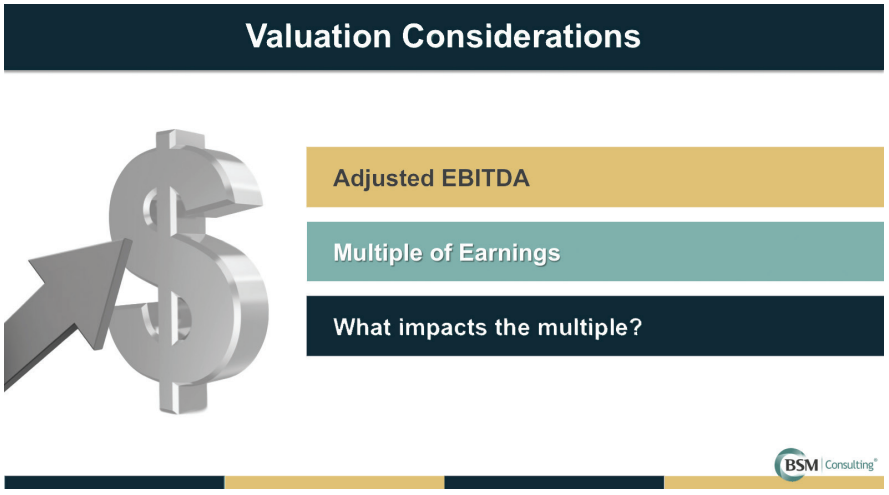
- **Access to new capital growth.** "We have growing debt because, as we all know, every time you expand your practice, buy a new piece of equipment, or open a new satellite, you go to the bank and borrow money. [Partnership with PE] would allow us to grow without continuously borrowing money."
- **Management and financial support.** "We are in a continual state of rapid growth and expansion, which requires a lot of capital and a lot of management time on my part and the other partners' time. Management becomes challenging and we are doctors, not necessarily business people."
- **Marketplace insulation.** "Become the big provider in the community and have all the patients flow to you and not be carved out of insurance plans."
- **Financial divestment for the partners.** "There is a good tax benefit for capital gains when you sell the entity, versus ordinary income on a going-forward basis as an owner-employee of your practice."
- **Sale proceeds, immediate and delayed.** "There is immediate cash upfront as you sell some of the EBITDA (earnings before interest, taxes, depreciation, and amortization), and then there is the option for the second bite."

CONS

- **Loss of control of practice.** "You need to ask yourself questions such as, 'What is the board going to look like? What is the leadership going to be? What if I want to buy a new femtosecond laser or I want to buy a VisuMax laser (Zeiss)? What if I want to grow the practice, take more time off, redecorate, hire additional help…how are these decisions made? Will you be able to make these decisions or are you going to have a team of people make these decisions?'"
- **Change in practice culture.**
- **Concern of next owner and the second bite.** "Concerns of whether this next bite will really happen and whether you are going to see that at any point in time."
- **Quality-of-life issues around becoming an employee.** "Many of us are self-employed. It is quite a change to be an employee. In some of the contracts, there are some sticking points about being an employee. How much vacation time do you get? What about other income through consulting and other work that you may do?"
- **Distribution of proceeds.** "If you sell a partnership and you have equal partners on paper, those proceeds will be distributed equally by law, but we all know in certain practices there are some partners who contribute more than others. There are different aspects of the practice like the optical, or the surgery center, or other arenas in cosmetics where some of the partners can gain access to the EBITDA and the profits unequally, but when you sell it, it has to be distributed equally. So that creates potential challenges in large partnerships."
- **Risk of the second bite.** "When/if there is another sale, how will the proceeds be distributed? What happens if you are not happy after a year or two with the next owner? Do you have to pick up and move your whole family to another state to practice?"

Dr. Weinstock concluded by advising practices that are considering partnering with PE to have a good legal firm, and to set up noncompete clauses as an added protection.

"Ultimately we passed on the deal. We decided to continue to grow our practice, which we have been doing," Dr. Weinstock said. "We have good EBITDA, like most of you, so we have value. We decided to do what PE wanted to do: acquire smaller practices and acquire optometric practices and grow our practice organically. We also want to look at other partnership models where some of the PE risks are mitigated."



- Litigation expenses, payments, or recoveries
- Extraordinary one-time casualty expenses, ie, hurricane
- Any one-time expenses incurred in conjunction with the sale transaction. This would include legal, accounting, or consulting fees

Although there are several other methods of valuing a business, the multiple of EBITDA approach is the most common within the context of the sale of physician practices and surgery centers to PE buyers.

For selling physicians, it is important to engage experienced professionals to assist in performing these calculations. Most often, physicians only get one opportunity to put their best foot forward and to project the best possible picture of practice performance, within the context of a sale. Suffice it to say, buyers will perform a significant amount of due diligence to "prove" that the assumptions provided by the seller are reasonable. This is a normal part of the deal process. Selling physicians should not be offended if a buyer disagrees with certain assumptions included in the EBITDA analysis. Normally, selling physicians are provided ample opportunity to support their argument.

WHY I DID IT, HOW I DID IT, AND HINDSIGHT

During the Private Equity Live Symposium, several physicians who have completed deals with private equity (PE) firms participated in a panel discussion with audience engagement to discuss why they decided to enter into a PE deal, and what they learned from the experience.

Topics included the role of investment bankers and law firms, what makes ophthalmology compelling to PE, how to calculate EBITDA, the impact of PE on partners' control and lifestyle, and what factors should be considered before signing a contract.

What follows is a partial, edited transcript of that discussion.

Steven J. Dell, MD, moderator: We have a panel comprised of physicians, all of whom have completed deals with PE firms. Each member will tell us a little bit about their practice and share some details of their deal.

Paul Koch, MD: I'm from Rhode Island, and we were the first practice in America to go with PE. We are now out of PE and into entrepreneurial strategic partnerships, and I will explain why later in this discussion. When we entered into our deal, no one had done one before. We kind of explored new grounds. At the time of our deal, we had around 20 providers, who were probably doing about $20 million.

V. Nicolas Batra, MD: I practice in Berkeley, California. We completed a deal in April (2018), so we are fairly new to this. Our practice has five providers and about $8 million in revenue. We did a deal with the Firmament Group where we are a 50:50 partnership with PE, so 50% physician-owned and 50% PE owned, which is a little bit different.

Eugene Gabianelli, MD: I practice in Atlanta, and our practice is called Georgia Eye Partners. We partnered in February of 2017 with Shore Capital from Chicago and we are building an eye care affiliate network throughout the Southeast.

Cathleen M. McCabe, MD: I am at The Eye Associates in Bradenton and Sarasota, Florida, and we are relatively new to PE as well, in the fact that we partnered with LLR under the MSO (Management Services Organization) of Eye Health America in March (2018). We have 17 providers in all service types and have a vertically integrated practice.

Richard Lindstrom, MD: I practice in Minneapolis, Minnesota. I am a partner in a 30-year-old practice, Minnesota Eye Consultants. We had 10 partners, one partner-track surgeon, three medical ophthalmologists, and 10 optometrists who were part of the group when we partnered with

Waud Capital from Chicago to create Unifeye Vision Partners.

Dr. Dell: How many of you used an investment banker? And Dr. Koch, would you want to address why you did, and how was that helpful?

Dr. Koch: Yes, very simply we had reached sort of a maturation in our practice. My brother was 60 years old, I was 58, and my sister was 56. We said, 'What do we do now?' And we knew our younger doctors could not afford our practice, nor could the other practices near us. And so my brother, who ran the practice, came up with a very simple question, he asked 'What would we do if we were a widget company? If we were a widget company, we would enhance our performing assets. We would fix up our depreciating assets and put ourselves on the market.' The people who do that are investment bankers, so we hired one. That was one of the first things we did.

Dr. Dell: Dr. Lindstrom, why did you hire an investment banker?

Dr. Lindstrom: We were pretty early into the process. We looked in general for about 18 months without a banker, but then we felt we needed the guidance of a banker and we also engaged a national legal team, Arnold & Porter, as well as BSM Consultants to work with us. I think the quality of advisors is critical. Our banker was Provident.

Dr. Dell: Dr. Batra, you have a background in finance. Could you tell us why you elected not to use that?

Dr. Batra: I think there are great reasons to use investment bankers. We had a panel of four different investment banks come and present their ideas and explain what it would be like to work with them and discuss the pros and cons. We actually took a day out of our practice—all the partners. It was also great information gathering for us, and there is a lot of valuable information.

At the end of that process, the partners all discussed the pros and cons of the different bankers. In the end—I did this 20 years ago—we all realized it was probably better for me just to handle it and not charge a fee. And so that ended up being pretty good. The other big thing that is different is that right now the market is more mature and there are many PE companies looking for deals. We had multiple companies already soliciting us without the use of a banker, and that was a part of why we did it. But I do think it is very helpful for the right practice.

Dr. McCabe: I would agree with Dr. Batra that you do gain a lot of information just by speaking to a broker or an investment banker. That was a really important part for us, too. But as you mentioned, we were also being approached directly by PE firms and we were introduced to PE from some of our nearby neighbors.

Dr. Gabianelli: Our story is a little different as well. We met with the banker maybe a year before we met Shore Capital and decided that route was not for us at the time. Then we had a personal introduction to Shore, and essentially got to know them over a period of about a year. As our relationship grew, we became convinced it was the right partner for us. We used a local health care law firm and our accounting firm that also has a consulting branch and valuation specialists. We used a law firm and accounting firm to help us do the transaction, but I think using an investment banker is also a great idea.

Dr. Dell: Dr. Koch mentioned the junior associates in his practice didn't have the financial wherewithal to acquire the practice, and that was one of the motivating factors for looking elsewhere for capturing the value of his practice. Panel members, please describe your reasoning behind wanting to do one of these deals in the first place?

Dr. Lindstrom: Our experience was almost identical to the experience of the Barnet Dulaney Perkins Eye Center and Mark Rosenberg. We were growing meaningfully from me, a solo ophthalmologist for more than 30 years, to 24 doctors, five offices, and four ambulatory surgery centers, and it was demanding as well as expensive. We were capitalizing our growth with bank debt. I had young partners, 35 years old, who were guaranteeing more debt than their net worth—which made them and their financial advisors a little nervous.

They would try to buy a car or a home and their bank would take a look and say, 'You are already $1 million in debt and now you want to borrow another $500,000 to buy a home?' So it was not just the senior partners, it was the junior partners who were looking for an alternative to capitalize growth. We thought we had a lot of growth opportunity and wanted to grow, so that was No. 1. We wanted to continue to grow and we were hoping to find a partner who would help to capitalize it. Clearly, one of the things we are sometimes reticent to talk about, but is real, is that it was also an opportunity to monetize some of the value we had built during the previous 30 years. We were all are looking at what is happening in medicine, and thinking 'We are today worth a lot as an ophthalmology practice? Will we be worth a lot more in 10 years or a lot less?' Actually, the truth is, and I am a pretty good futurist, that I do not know.

There are a lot of things that could come along to make the value of our practices worth a lot less in 10 years, and so our group thought this was a good time to take some money off the table. It turns out PE right now is fairly cash-rich and is interested in select ophthalmology practices. These windows of opportunity usually open

and close unpredictably—it might be 3 years from now, at any price, that no PE company would want to buy our practice. Right now, the window for ophthalmology is open, and the monetization opportunity and some fear of the future certainly played a role in our choice as well. We mostly wanted to grow, and we needed capital to grow. It also turned out that bringing some really smart business people in on top of people we already had enhanced our business plan and brought value to us as well.

Dr. McCabe: Our motivation was a similar desire for growth. In our practice, we had just purchased the shares of a retiring founding physician. We had just purchased our primary location real estate as well. Everything we were buying, all the capital outlay, was guaranteed by personal guarantees. And we had ideas on how we wanted to build a new clinic and also a new surgery center—more personal guarantees required from each of the partners—and so we wanted a business partner to help with that. We also could see what was happening in the market. We realized that we were a full-service provider that had a good infrastructure and we wanted to be considered as a platform practice in our area. We did not want to miss the boat on that either.

Dr. Gabianelli: I would agree with all that. We had grown from four to 13 physicians, and had a surgery center, but I think the reality is a confluence of factors: we are in a great field, we help people every day, and there is a huge demand for our services. We came to the realization that if you are doing a good job, you almost have to grow. Then the question is: 'If we are going to grow, are we better off doing it ourselves and having doctors sign personal guarantees? Or are we better off really concentrating on the medicine and finding a business partner who can help us capitalize, grow, execute, and have best business practices under the hood of their company?' So that was our calculus.

Dr. Dell: One of the reasons our industry is so attractive to PE or other investment firms is that the outlook for ophthalmology is spectacular. Recalling what Dr. Gabianelli said, I want to throw out the contrary point, just for balance. I think as a successful practice that is reaping the benefits of technology and the demographics, I want to make the argument that I think you could, in fact, stay your same size and have a very successful outcome over the next 20 years. Panel members, do you believe you absolutely have to grow?

Dr. Koch: I think that is a very legitimate point. I am a senior ophthalmologist and let's say I was in solo practice. You can just ride it down to 0 if you want to, and then step away whenever you decide to step away. I would say that you have to want to grow to make doing something with PE work. But you do not have to want to grow. I think people can be quite successful in one- or two-person practices; they don't need to do anything. Many of us who have founded practices would prefer to see the practice that we founded transition to the next generation and not go away, so that can be a motivation for the senior partner.

Dr. Dell: Echoing Dr. Koch's statement, I believe if you are going to partner with PE or similar firms, you have to want to grow. And if you want to stay the same size, that might not be the right option for you.

Dr. Gabianelli: That's an excellent point. This is not for everybody. It is definitely a team game, so the consolidation strategy is a team endeavor. However, there are arguments that we have so much technology available to us right now, so we want to use the best equipment and we want to operate in the best surgery centers that we own. It's harder to have those things if you choose to stay a two- or three-doctor practice. That may be a choice that works for some folks, but it is also, I would argue, more difficult to have the best technology, the best equipment, etc., in a smaller setting.

Dr. Batra: I agree with all these points. One other thing is to look at your local marketplace. In Northern California where I practice, one of the big issues is that nearly 70% of the patients are either in Kaiser, Sutter Health, Stanford, or UCSF. Therefore, we felt that being independent was going to become much more challenging during the next 5, 10, or 15 years. And while we were doing really well—we had a record year after record year and continued to grow—when I looked at 5 years in the future, my concern was, 'Can we survive as a smaller independent practice?' And so putting together a much larger growth entity with financial backing and the resources to continue to have the right technology and right skill set was important. The other big thing for us is that attracting physicians in Northern California is quite challenging because of the cost of living when you are a small practice. By having the PE backing and a much larger platform, attracting millennial physicians is easier because you can give them a salary package very commensurate with what a Kaiser or Sutter Health hospital system would offer. That was very attractive as well.

Dr. Dell: How have acquisitions of optometric practices played out for your individual practices and where you see that filling a role in this process?

Dr. McCabe For us, we really feel that vertical integration is part of our practice model. We feel that rolling in optometric practices is an important growth strategy. That is definitely something we are pursuing as well.

Dr. Dell: Does that mean trying to acquire individual optometric prac-

tices or groups, or partnering with PE firms that already have a head start on this? Or all of the above? What will be your strategy moving forward as you think about this?

Dr. McCabe: We have not yet explored partnering with PE groups that are already consolidating optometry, but are contacting individuals and groups that are successful and growth-minded and partnering with us already. I think that is where we are focusing at the moment. We are also speaking with referring individuals and groups about enrolling them into the bigger entity.

Dr. Lindstrom: We at Unifeye Vision Partners are currently not targeting optometry. I think as our organization matures that we may begin to do that. So far, we are targeting only ophthalmology but the practices we are targeting are generally integrated eye care delivery systems that have both ophthalmologists and optometrists and work collegially with optometry. We have not been trying to acquire any of those optometric practices yet. I would simply say that we have not seen any disruption in our referral patterns, meaning that the fact that we have joined with a PE firm has not in any way been a negative. We definitely have some optometric practices that are interested in perhaps joining us, but we are not there yet.

Dr. Dell: Let's say you have 100 optometrists that refer to you and you try to maintain a relationship with all of them. Then you decide to buy 15 of them; what happens to the other 85? They may think you are now in direct competition with them. Has this come up in any of your individual transactions?

Dr. Gabianelli: For us, it hasn't. Like Unifeye, at Eye South we're definitely keeping an open mind about it. We have not acquired any pure optometry practices. Most of the practices in our network do have optometrists within them, but I think it best to say as we have an open mind on that.

Dr. Audience Member Question: If you are interested in PE, what would be the ideal time in advance that you should consider consulting an investment banker?

Dr. Koch: For us, it was the first call.

Dr. McCabe: I think there are some things you need to do internally first, including making sure you and your partners are all on the same page, that you really know some of your housekeeping is in place. I think part of the process after that is getting all the information.

Dr. Lindstrom: We met as a group every month, and we still do that. We talked about the universe of consolidation models that are out there—and realized there were several. In our market, hospitals are buying up practices. Super practices are forming. We have a group called Twin City Orthopedics that has 130 orthopedic surgeons in one group, versus this more-or-less mutual fund of practices, which is the PE model. And which one looked good and the why? And then, we even went so far as to say, 'If we are going to decide to do it, how will we decide?' We concluded that with 10 partners, seven out of 10 could carry the day. If someone didn't want to be a part of it and we voted to do it, would we let them out of their noncompete? We had a noncompete with every partner, but we agreed we would let any individual doctor leave the practice without enforcing the noncompete if they wanted out before we did the deal. We did a lot of thinking and discussing on our own as to how we were going to govern ourselves and make the decision before we brought in a banker, and we brought in a banker because there were too many interested PE companies to evaluate on our own. We needed someone that knew who they all were, so we started with a list of 100, went down to 50, went down to 20, went down to 10, went down to three, and we needed the help of a banker to find the highest quality potential PE companies that were out there.

Dr. Batra: I think you should start thinking about it in a partnership sense with the other doctors in your practice first. I think having consultants to start off with is very good, or your attorney, because you want to have a sense ahead of time of what your numbers are, what things you are interested in, and then discuss it with the partners. There are some services now that are available to help you decide: 'Is this a good idea or is this is not a good idea?' And from there, I think you can have a sense of whether this might make sense for you. If it makes sense, I think then you can decide whether a banker makes sense or not.

Dr. Gabianelli: I believe if there is partner consensus in your group to explore this, there is a lot of sophisticated investment banking advice available and those meetings do not cost you anything. If nothing else, it is an educational process to bring in one or two investment bankers. Your group would learn a lot about it.

Dr. Batra: We brought all the bankers in together. This is what you do when you run a business, have them sit in the room with each other, and have them pitch to you with each of them present. We're selling businesses here, and while we are all ophthalmologists, I think that's the right way to do it. Make them compete for your business if you are going to choose a bank.

I had them line up, each of them present—we spent an entire day doing this—then afterwards we solicited 10 letters-of-intent from PE companies, and did the same thing. We had four bankers come in. all of us took a Friday off, booked a conference room in a hotel conference center, and gave them 2 hours each and then question-and-answer discussions from the partners to decide if it made sense. At the end of that, we met and decided which of these banks might work the best for us.

Dr. Dell: Let's say you got down to your five favorite PE firms. What came next? Did you meet with them individually?

Dr. Batra: We met with them individually, and in many cases we met multiple times. I would say the last four or five firms, probably at least two to four of the partners met with them each probably three to five times minimum. We used Arnold & Porter and Matt Owens in the disclosure, and we tried to find a cultural fit. I think as you go through it, one of things to decide upon as a group is what you are really looking for. Are you looking for a partner? Are you looking for somebody to provide cash? What's the control situation? What's your involvement going to be as a physician going forward?

At the end of the day, the offers were arranged in a spread, but the reality is the spread is not that great. For us, we didn't take the highest dollar value offer. We had an offer that was a higher dollar value than what we accepted. The partners in our group felt it was very important to have control, so that's why we did this 50:50 partnership.

Dr. Dell: How many of you used Arnold & Porter or a similar firm that has previous experience in ophthalmology with these types of deals? Did anybody use a local law firm that had M&A experience but not specifically with ophthalmology?

Dr. Gabianelli: The firm we used is a large Atlanta firm, so they have lot of M&A experience, including in ophthalmology.

Dr. Lindstrom: We relied heavily also on BSM Consulting. Bruce Maller had been an advisor for the practice from day one and so he and his team were engaged. He helped us find our banker and attorneys. We had a high-quality local attorney, but we thought this transaction was a bit over the head of the local attorney, so we went with the national firm Arnold & Porter.

Audience Member Question: Is there is minimum size revenue that PE firms will look at it in a practice? When you are talking about revenues, are you talking about gross collections or billing? How do you define that?

Dr. Gabianelli: I would say, like anything else, there are differences. All PE firms are not the same, so some of them probably would be more comfortable in the smaller and some would be more comfortable in the bigger. Ultimately, when they look at your business they will boil it down to, 'What's your EBITDA?' That's sort of the language they will be speaking at the end of the day. But I think it is fair to say there are PE firms that would talk to a practice of any size. I am pretty confident of that.

Dr. Dell: One thing to keep in mind, for example, is if your practice has a 70% overhead, and there is no EBITDA. If you are being compensated at what you could hire a replacement physician for, which would be 30% of collections, there is really nothing left over. You might have $30 million in revenue but if your overhead is 70%, your practice is essentially worthless to a PE firm. Is that a fair statement?

Dr. Lindstrom: Yes, that has happened several times. As a group, you are going to sit around the table with your partners and decide on your posttransaction compensation. We did it in the same manner as the cardinals who elect a new pope. We said, 'Write down on a piece of paper what you can afford to live on for the next 20 years. What you would be comfortable with as an income?' And then we came to a consensus on a number. Then you calculate if everyone is paid this amount, will there be anything left over. If the number that you come to as a group that you are comfortable with regarding posttransaction compensation is so large that there is nothing left, then you have nothing to sell. And that eliminates the whole process. In our case, there was meaningful residual EBITDA, so a transaction was possible.

Dr. Dell: That's a very important point. You need to understand your true overhead structure and imagine replacing yourself Dr. Lindstrom with Dr. Windstrom that you just hire for 30% of collections, 'What's the delta between that?' And that's what your EBITDA is going to end up being on a collective basis.

Dr. Koch: I'd like to address the question. The question is, 'Can a small practice be involved with this as well?' And the answer is 'yes.' In every geographic location, a partner will acquire something they call the 'platform practice' or 'franchise practice.' That's the big one, and then they will acquire what they call 'fill-in practices.' So we may have six locations, but we don't have one in South County so we are going to want to buy a practice in South County, and you are the only guy in South County. Or, we are using our surgery center 4 days a week. We need two more surgeons to come in and fill it the last day. We are going to find two more fill-in people that we can acquire to fill the surgery center. Most of the symposium discussions are about the platform practices, but every platform practice is going to grow by acquiring the fill-in practices.

Dr. Dell: By the way, a platform practice is often a large practice but it doesn't necessarily have to be a large practice. It might be a practice, for example, that exemplifies the best practices that we are all trying to emulate in terms of practice culture, conversion to presbyopia-correcting IOLs, ie, their revenue mix. There may be a practice that is doing something really well or doing multiple things really well, that a PE firm might view as a model for franchising essentially to other locations in the geography. So, don't rule yourselves out as a platform practice because you don't have 20 doctors. You might have four doc-

tors who are exceling and that is very attractive to PE.

Dr. Lindstrom: Based on the practice location maps shown in an earlier presentation, it is clear that most of the PE firms are focusing on one, two or¾at most three¾geographies. We may still may be in the second inning, but the process is maturing a little bit. If there is already a strong PE player in a given market, it is unlikely that another player will chose to come into that market because there are so many other opportunities; it is foolish to go head to head and compete. If there is no one as yet interested in your market currently, then you are going to have to wait a little while until someone enters your market.

Audience Member Question: Is there anything you regret or would have done differently in your selling process?

Dr. McCabe: Once you sign that LOI and you are in due diligence, it takes away your administrative staff from the process of running your business and growing your business. And in the process of getting through that, you are still trying to improve your valuation. If you have taken your eye off the ball, and things are falling apart a little bit, that's not a great thing. Therefore, you want to make sure that you have all your processes in place and can run somewhat on autopilot. I would say be sure that all of the partners have a similar strategic goal. You want to make sure that's in place and that you are doing what it takes to get there because, if you take your eye off the ball for 6 months, 8 months, or a year, you are letting things fall apart and then the deal does not even go through, and you are in a worse situation at the end of that. I would recommend that you get everything in place before you start the process.

Dr. Koch: We were the first in PE and we got out. I wish I could share more information about our experience. I liken it to a television show on the HGTV network called Flip Or Flop. The concept is to purchase a property and as quick as they can, they put lipstick on it and they flip it. That's what PE is in my opinion. They are flippers. Every practice on this panel, everyone in the audience who has partnered with PE, they are for sale right now. If somebody else will give them enough money, the PE person will sell it and put money in their pocket. We are professional physicians, we are not money people. They are playing on their field, not on our field. They talk about the next bite, the next event. Our people had us for 6 years. We know we had the same equity agreement as everybody else because all of our signatures were on the same page. After 6 years they sold us and they called me and they said, 'Paul, we sold the practice for many times what we paid for it, and your equity value is zero, you're getting nothing for your equity.'

So, what happens behind the scenes? Behind the scenes, the investors that gave the money to the private firm that brought us, that was a loan. And the loan would be paid back at 17% a year. Now by the rule of 72, for 17% a year, the money doubles in 4 years and doubles again by the 8th year. So if they collectively put in, let's say $10 million, then in 4 years they were owed $20 million, and in 8 years they were owed $40 million. We were in 6 years, that is about $30 million by this example. When this practice was sold, and I am ready to get my second check, they said, 'Unfortunately, debt took it away.' And I said, 'What debt?' And they said, 'The debt that we paid the people who gave us the money in the first place. We had to pay them their 17% a year, give them twice what they put or three times what they put before we could pay back equity. There is no equity.'

Dr. Dell: I understand, Dr. Koch, that you had a bad experience with one particular outfit, but I have to imagine that not all PE firms function in that capacity.

Dr. Batra: Dr. Koch's experience impacted why we did what we did in our practice, where our company is a 50:50 partnership, so half of our board are physicians, half of our board is PE. That was by design and on purpose to avoid a lot of these issues. The other issues, which are the cap tables and the equity, that's really where you need counsel—either a legal counsel or financial counsel—so you don't enter into that kind of an agreement without knowing about it. If you voluntarily do it, so be it, but you want to have those things known upfront and I think there are definitely horror stories out there and that was the control issue. That's why we did a 50:50 partnership and didn't take the highest dollar offer because we wanted to be able to vote as physicians. It has come up already several times concerning what you are discussing about marketing, and essentially we present our spreadsheet saying this is our return on investment over 2 years or 3 years, not over 30 days or 90 days, and we have a discussion because when the votes are 50:50, it usually goes pretty well with what the physicians want. But there are times where we are not the experts and from a financial standpoint, that's where the value add comes in.

Dr. Dell: As a general concept, Dr. Batra, do you think that your decision-making process has remained relatively unchanged?

Dr. Batra: Yes, we are physician-led and physician-driven for that reason and to make those decisions.

Dr. Gabianelli: There are lessons to be learned there. If you do this, make sure you know your capital partner extremely well. Spend time getting to know them—whether through your own diligence with your banker or

with whomever, and make sure you know their exact record of their exits. Here is a partner that didn't have a good exit with the person that he partnered with, but there is a track record. There is a finite track record of any firm you talk to, so the first thing you should know is that story. We also have seven physicians on the board, so I think there are a lot of layers to that onion, but I think the lesson is: Make sure you know who you are partnering with, get to know them super well and their track record.

Dr. McCabe: I want to echo that, because we really wanted to make sure our partner had experience in health care—maybe not even exactly our particular area of it. We looked at that very carefully. We wanted to know they had experienced people as part of the MSO as well. We wanted to feel confident that we were moving forward with the right mindset.

Audience Member Question: My question goes back to the control issue. I think most of us sitting here have a real problem with letting go of control and what our life will look like after we enter a merger with a PE group, and how it will affect our schedule, our lifestyle, etc. If each of you could please address how you maintain control and how you regret or still think your lifestyle is great?

Dr. Lindstrom: I think we have to keep in mind that you are selling your practice, and you are definitely going to be giving up control at some level. If you're not comfortable with that, then probably you are in solo practice with no partners because I remember a little window in my life when I was in solo practice and I was in control. But with nine other partners and governance with a Greek democracy of one doctor, one vote, I did not feel any one of us was alone in control even before we did the PE deal. So, if you are one of those fiercely independent doctors that is in solo practice and does not ever want a partner and does not want to ever share governance at all, this is not for you. But if you pick the right PE partner, you will still practice the way you want.

Audience Member Question: We are a multispecialty group, and we have a lot of different thoughts around the table, so I completely get that. We are not talking about control at that level. The question is: On the really important things as far as patient care, your lifestyle, your schedule, etc., are you in control of that?

Dr. Lindstrom: I think we all have some fear that the PE partner will severely interfere with our lifestyle or practice culture. So far there is no evidence to support that fear, and it almost certainly is not going to be with your first PE partner. You will pick a first PE partner and that will not be an issue. The concern is that the first PE partner will sell to someone like Atilla the Hun, and that maybe your next PE partner won't be as benevolent and good to work with as your first PE partner. I think it comes down to how do you set up things. We set up a new corporation, UVP, with leadership that will go forward with us. We know who our leaders will be with our current and future PE partners. We believe this structure will buffer us from any negative consequences when UVP is recapitalized. We will have a different entity providing the capital. But this is a legitimate concern and one that everyone contemplating a transaction with PE really should think about carefully.

Dr. Dell: Were you able to build protections into your agreements in which you say, for example, 'I don't want to work on Thursdays' and 'Don't tell me what to do.'

Dr. Lindstrom: Everyone here is aware that I do a lot of things other than practice ophthalmology. Because most of my partners are very active with teaching and consulting, this was important to us. We were able to negotiate that we would be allowed to spend the same amount of time post-transaction on outside activities, and we did write this into the contract. We have since hired, I believe, seven doctors in the 2 years we have been with PE and as the new doctors come in, the contract can be slightly different. We have been able to recruit the best and the brightest so far, but they may not get the same deal that my partners and I received as far as the ability to spend time away from the practice.

Dr. McCabe: I wanted to add to that PE firms are really buying the current financial status of your practice. If the current financial status of your practice is that you are gone 50% of the time, you are doing missions, you are teaching, fly fishing, whatever it is, then they are expecting to maintain the status quo and then grow with growth initiatives. You want to make sure that you know what you have negotiated in the contract. We negotiated these kinds of things with the help of our legal partners. I am still going to be able to do the teaching I do, the missions, the other things that I do currently and at the level that I do them currently. What I guess you have to understand is they don't want you to get a big lump of money for your interest and then say, 'I now am not going to fly fish 50% of the time, I am going to fly fish 75% of the time.' You can't have the idea that you are going to do a lot less. Having protections to maintain your lifestyle is reasonable and I think a lot of time you can build that into your agreements.

Audience Member Question: In a practice in which the physicians are owners, at the end of the year the money is put between the partners, so effectively your EBITDA is zero. My first question is do you back off some of the money from physicians' salaries, and that becomes the profit and that becomes EBITDA. Is that correct? The second question is about equity

markets. In the equity markets, companies are valued not just for their current earnings are also their potential earnings. Rumors are out that Uber is going to be worth $130 billion and basically lost money. So how does this equation come in to the picture?

Dr. Dell: On the first question, I think that we established pretty well that your EBIDTA is, I think, a function of how you are compensated versus what a replacement physician would be compensated, or how you be compensated if you were a fair market value employee. In terms of the valuation of Uber or other enterprises that don't really have earnings, they are valued on revenue growth. I think it is a completely different metric. I think these practices are basically being valued as businesses have been valued for generations, which is on the basis of clean earnings, high-quality earnings, and I think that's a metric that's familiar to everyone in the financial community. Your growth potential certainly is important and that is part of what these firms want to buy into. But I think you are only as good as the last earnings you put up on the scoreboard. If you say, 'Listen, I think I am going to be really great player next year,' that's great, but I think you're valued based upon what you did this year.

Audience Member Question: How is debt on capital equipment handled in your transactions? Was that written down off of the multiple, or how was that handled?

Dr. Gabianelli: For most of these transactions, they are going to want that debt retired with the capital that you get as part of the deal, so once they walk you through that door in the new partnership, it's on the owner or the seller to retire that debt.

Audience Member Question: If you bought the LASIK laser, they would expect you to retire that debt with the proceeds?

Dr. Dell: That's is going to be backed out of EBITDA. With that I will thank our panel and thanks very much to everyone for your participation.

REGULATORY DUE DILIGENCE: TOP REGULATORY ISSUES THAT YOU DON'T REALIZE YOU HAVE

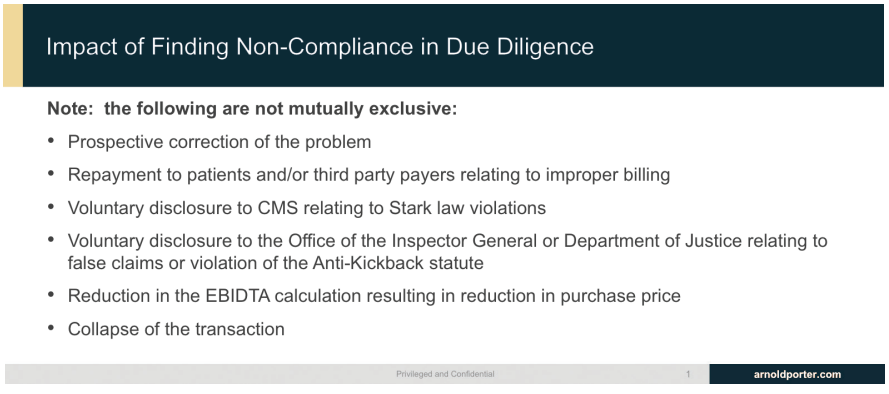
BY STEPHEN DAILY

In a session dealing with the important, yet sometimes overlooked, issue of regulatory due diligence, Alan Reider, Esq., Senior Counsel, Arnold & Porter, in Washington DC, shared his advice on the top regulatory issues that many practices may have—even if they didn't realize it.

Mr. Reider explained the main differences between corporate due diligence and regulatory due diligence as it relates to the health care field. Traditionally, when you had a transaction, due diligence focused on corporate issues, such as making sure that the corporation was appropriately registered with the state, making sure tax returns are filed, etc. But in the health care field, there are completely different types of due diligence to address.

"We are dealing with the question as to whether you are structured correctly from a regulatory perspective and whether your ownership is appropriate from a regulatory perspective," Mr. Reider said. "You are going to have to lay yourself bare before your private equity (PE) partner or potential partner to make sure that they are comfortable that you are doing everything right. And depending upon what they find, that could have a significant impact on the transaction."

Regulatory due diligence requires that a practice provide documentation about its structure, ownership, operations, and relationships with referral sources and vendors. After all, PE partners like a clean slate, Mr. Reider said, and this could lead to several actions



that a practice may not anticipate prior to a deal.

For example, during the due diligence process, the PE partner may find problems with the way a practice is doing business or improper billing procedures, which could lead to a repayment to patients and/or third-party payers. It could also lead to a practice making a voluntary disclosure of a Stark law violation to CMS.

"That is going to cost you more than just the overpayment," Mr. Reider warned.

Even worse, a practice may be obligated to make a voluntary disclosure to the Office of the Inspector General or Department of Justice relating to false claims or a violation of the Anti-Kickback statute.

"These are the kinds of problems that arise in the context of this due diligence and you want to make sure you take care of them before that happens so you are not confronted with that problem," Mr. Reider said.

There are important financial implications that could result from the regulatory due diligence process as well. Concerns from the buyers could affect the calculation of a practice's EBITDA, which ultimately could lead to a reduction in the purchase price.

"We have seen deals collapse because of regulatory problems. Either the practice is not willing to make the change or not willing to make the disclosure, disagrees with the conclusion of the PE folks, or the PE folks said, 'We did not know what we were getting into. We are out of here,'" Mr. Reider said.

To address the potential pitfalls of the due diligence process, Mr. Reider highlighted some of the more common issues that arise. He also provided advice for practices about things to know before they even begin the process of partnering with a PR firm or signing a letter-of-intent.

"When you have the folks from the PE firm coming to your practice, you want to minimize, if not eliminate, the possibility that they are going to find a problem that is going to either require you to change your practice or require you to repay money," he said.

STARK LAW

The Stark Law, which Mr. Reider described as "one of the most complex technical rules in the health care industry," has been the single biggest issue Arnold & Porter has seen when dealing with PE deals.

The Stark Law has a provision relating to productivity-based compensation for physicians. When it comes to eye care practices, risks arise in connection with the provision of certain diagnostic testing, such as OCT and A-Scans, in which the physicians personally perform the professional component (the interpretation), but not the technical component (which is generally performed by the technician). If the physician's compensation is based on the global revenue rather than the professional component only, the Stark law has been violated.

"This is the single most common problem we have seen on the regulatory front, so you need to be sensitive to that," Mr. Reider said. "Obviously, it is an easy fix. You just carve out the technical component and put it in a separate pool and you don't pay individual physicians based on that productivity, but you've got to fix it ahead of time."

Another significant issue that arises in many medical specialties is the administration of outpatient drugs. However, because most ophthalmologists personally administer outpatient drugs (such as anti-VEGF injections), it is usually not a problem with the Stark Law.

"YOU ARE GOING TO HAVE TO LAY YOURSELF BARE BEFORE YOUR PRIVATE EQUITY PARTNER OR POTENTIAL PARTNER TO MAKE SURE THAT THEY ARE COMFORTABLE THAT YOU ARE DOING EVERYTHING RIGHT. AND DEPENDING UPON WHAT THEY FIND, THAT COULD HAVE A SIGNIFICANT IMPACT ON THE TRANSACTION."

-Alan Reider, Esq.

PAYMENT TO PHYSICIAN PARTNERS

Another issue that arises during the due diligence process is payment to physician partners. Mr. Reider pointed out that most physician practices are structured so that all partners have an identical interest in the equity of the practice. And most physicians in a practice are compensated based on some form of productivity formula, which often results in significant variation in compensation among partners.

This structure works and is typically not a problem. However, when a PE transaction is under consideration, distribution of cash can become an issue.

Mr. Reider said, upon closing of a deal with a PE company, the initial payment to the physician is based on each physician's pro rata share of the equity in the practice, not productivity. As a result, the significant upfront cash payment will be shared equally by all partners regardless of their respective contribution to the value of the practice.

"We have seen some practices where the major producers are saying, 'Wait a minute. Let me get this straight. I am responsible for 50% of this very large dollar amount we are about to get, and I am going to get 10% of it? Something is wrong there,'" Mr. Reider said.

INDEPENDENT CONTRACTOR AGREEMENTS

Another common issue practices would be wise to be aware of is independent contractor agreements with physicians, or leases with referral sources, that don't meet safe harbors.

Many practices enter into contracts with other physicians who perform services with the practice on a part-time or full-time basis. Some practices also lease space, equipment, or staff to or from other practitioners who are referral sources. Because these practices reflect both a financial and a referral relationship, the Anti-Kickback Statute is implicated.

"The good news is that the government understands there are many perfectly legitimate deals out there that should not violate the law, so they developed safe harbors," Mr. Reider said.

The US Office of Inspector General has published guidance, in the form of safe harbor regulations, that provide protection from prosecution in such cases as long as all of the criteria are followed.

Mr. Reider said that even if an agreement does not follow all of the criteria of a safe harbor, the agreement may still be legal. But it is helpful for practices to adhere to the safe harbor criteria, if possible.

"When you are having a PE firm come in and write a check for many millions of dollars, they are going to

want to minimize any potential risk," he said. "You should be in a safe harbor. This is an easy fix. You shouldn't have to worry about this potential problem. But again, we have seen a couple of deals stumble, not collapse, but it has caused some anxiety, and they have had to reform these agreements."

PHYSICIAN CONSULTING AGREEMENTS WITH INDUSTRY

Physician consulting agreements with industry, including advisory board participation, performing clinical trials, and providing consulting services, are generally viewed as a positive and welcome by PE groups as they enhance the reputation of the physician. However, Mr. Reider said the consulting has to be done properly and can sometimes trigger anti-kickback concerns.

However, similar to independent contract agreements, there are safe harbor criteria that protect these arrangements as long as guidelines are followed. As with most elements of PE deals, documentation is crucially important. The major problem is the lack of documentation of the work performed and the scope of the service provided, generally in the form of time spent.

"If a PE firm comes in and you say, 'Hey, I am a KOL for this manufacturer.' That's terrific. They may say, 'Let's see what your contract says. Let's see how much you got paid and what did you do for that?' And if you can't show that last part, that's going to be a potential problem," Mr. Reider said. "We have worked with a number of practices where we have literally created a grid so the physician could document the hours that he or she has spent, and the work that he or she did."

Failure to validate with documentation the scope and amount of work performed raises questions about the fair market value of the payment made to the physician, Mr. Reider said.

EDUCATIONAL PROGRAMS

Many practices provide education programs to local optometric groups. While ostensibly these programs are to promote high quality patient care, Mr. Reider pointed out that they may be viewed as providing something of value in order to induce referrals, thus triggering an anti-kickback concern.

Mr. Reider advised the audience to ask themselves several questions when dealing with these types of education programs:

- Is the program open to all ODs or limited to referral sources?
- Does a program provide collateral benefits like a meal, and if it is a meal, what kind of a meal is it (eg, pizza or surf and turf)?
- Is it a program held locally or is it at a resort with golf and a variety of other activities?
- Does a program offer continuing education and if it does, do you charge for it?

"My belief is that a reasonable program with no significant collateral benefit should be fine, and there are number of PE folks with whom we have talked to who agree with me," Mr. Reider said. "There are others who don't want to have anything at all. So again, it's something to be sensitive to. Make sure that if you have these programs, you make them rational and reasonable."

Mr. Reider also advised audience members to be mindful of gifts and other benefits if they are intended specifically for referral sources. Even small gifts, such as a holiday wreath, to an optometric referral source could present unneeded scrutiny.

"The way to deal with it is to make no distinctions (for your gifts) and make it not limited to referral sources," he said. "PE will almost certainly cut down on any of the programs that are not reasonable and some will not let you do it all."

BILLING AND CODING ISSUES

Mr. Reider said billing and coding can be the single biggest issue a practice will need to confront when considering a deal with a PE firm. Any due diligence will include a comprehensive billing and coding audit by an independent billing and coding consultant. If the consultant takes issue with how the practice has billed for services, or the extent to which the documentation supports the medical necessity of the services billed, it will issue a report identifying a potential overpayment.

So what could happen as a result? Mr. Reider outlined several possible outcomes.

- The practice is able to convince the PE firm that no action is required (an unlikely scenario)
- The practice and PE firm agree that despite the finding, the practice need only make a change prospectively, although the practice likely will be required to indemnify the PE firm relating to the historical conduct
- The practice must make a refund of the overpayment and may have to perform a more extensive retroactive audit over a longer period of time to determine the full extent of the overpayment
- The overpayment results in a reduction in the valuation of the practice
- The billing and coding issues are so severe that the PE firm withdraws

"The overpayment reduction, if it is significant, could affect your EBITDA and it could affect the price of the deal. If it's a real problem, it could tank the deal," Mr. Reider warned.

Mr. Reider closed his presentation by giving one final piece of advice to practices considering partnering with PE.

"My advice is very simple: Do your due diligence before the PE firm does it for you. You are going to make that process go more smoothly. You are going to be able to decide how you want to deal with the problems that arise. You will present to PE firm as a practice that is sensitive to compliance issues and you will hopefully avoid being surprised."

SHOULD I HOLD OR SELL THE REAL ESTATE?

BY JACK CHAPMAN, MD, AND COLLIN HART, MBA

Real estate has been a great investment vehicle, but as I considered a transition in my ophthalmology practice, I contemplated whether I should I hold or sell the real estate.

I ASKED MYSELF A FEW QUALIFYING QUESTIONS:

Question #1: Are our associates able/willing to shoulder the debt/payment of buying into the real estate?

For our practice, the answer was "no." Our younger physicians were interested in the employed model, one with more predictability, less commitment, and thus without the risk/reward of owning a building.

Question #2: Is it an investment you want to continue holding as you transition?

I was developing my succession plan for the practice; the same held true for our flagship practice/ASC location that we built 10 years before. The continuous cashflow would be attractive, but could I receive a lump sum today without the worry of being a landlord or facing a future recession?

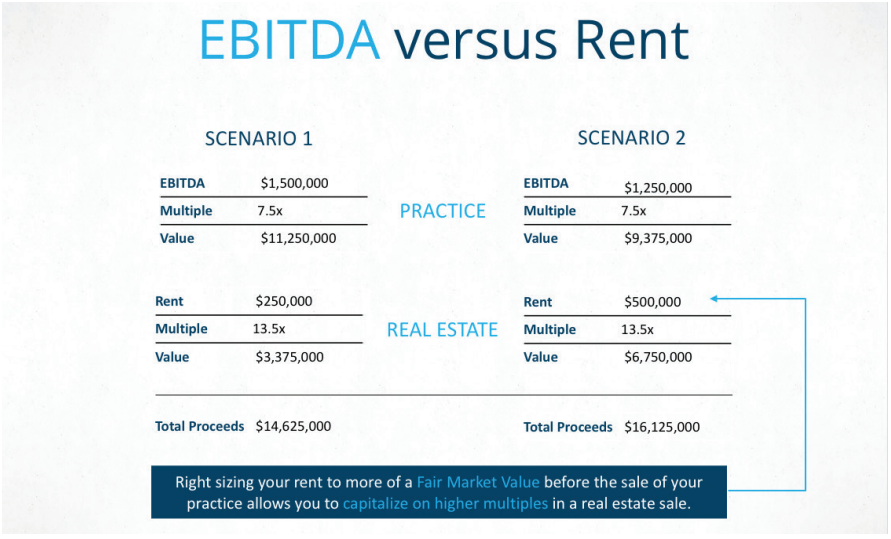
Question #3: Is the value significant?

The appraised value of our property wasn't quite as attractive as we hoped, but as we further explored our options, we were turned on to the idea of a sale and leaseback. This allowed us to sell our real estate at the highest possible price, while continuing to operate long-term in our facility without interruption.

We worked with a specialist in the field to help us advantageously structure and execute the real estate transaction, seamlessly interfacing with our new private equity partner.

Enter, Collin Hart of ERE Healthcare Real Estate Advisors.

Physicians always ask us about the keys to success in a sale and leaseback transaction, so we've highlighted three that were instrumental in our success with Dr. Chapman's transaction.



THREE KEYS TO SUCCESS

#1: Partnership conversations

It's critical that members of your partnership are on the same page in terms of objectives. Are they also a partner in your building, how long will each of you continue to practice, do you have similar financial objectives?

#2: Proper determination of rent

While most of our clients have historically paid themselves rent, that rent may have been set arbitrarily, depending on their financial and tax planning goals. When selling and leasing back your facility, it's important to right-size your rent to more of a fair market value. While this might decrease your EBITDA slightly, you'll more than make up for it in a real estate sale (Figure).

If your practice is being valued at 7.5x EBITDA, your real estate will be valued closer to 13.5x annual rent, so shifting some of your earnings to a slightly higher rental rate could serve you well.

#3: A controlled transaction process

Just as you might use an investment banker to find a practice partner, a specialized real estate advisor can help maximize the value of your real estate. Proper underwriting and marketing will help attract the most buyer interest, increasing demand and competition, resulting in the highest likelihood of your real estate sale actually going through.

Whichever path you choose, being armed with the right considerations will help you avoid missteps. ■

As part of a Q&A panel with private equity and platform executives, Chris Moore, President of Century Vision Global (CVG), spoke about the state of private equity (PE) as it pertains to eye care and shared the unique business model of CVG.

"Like PE companies, we are actively acquiring eye care practices. But life after the transaction is where we are really different (Table)," Mr. Moore said. "We are not motivated by short-term value creation, which allows us to partner responsibly with practices for the future."

CVG has acquired and partnered with more than 150 doctors nationwide and has never sold a practice. This gives physician-entrepreneurs the flexibility to partner with a capital partner without compromising the culture of the business, Mr. Moore said. CVG provides eye care practices with the capital, resources, partnerships and relationships they need to help doctors reach their goals—whether the goal is a new satellite location, updated technology, expanded services, or a pathway toward retirement.

"CVG invests in growth-hungry entrepreneurial doctors who are looking to build upon the legacies they have already created," he said.

Another distinguishing characteristic of CVG is that it only partners with eye care practices, Mr. Moore said, while many traditional PE firms are just entering the ophthalmology space.

"It's dangerous to lump all equity groups together. There are some good PE groups out there and those groups can create structures that work for all parties," Mr. Moore said. "However, I think it is important to realize that there are dozens of PE deals that have been done in eye care, but only a handful have included the 'second bite' when physicians realize the value of any remaining equity they have left in the deal."

Mr. Moore said the take-home message for doctors who are considering a partner is to fully understand the different options available to them.

"It's very early in the game for our industry. Take your time, keep learning, and let things develop and mature," Mr. Moore said. "Stay on the sidelines as long as you need to and develop your own plan for the future. You'll find the right partner that can help secure your legacy when the time is right."

For more information, contact **Chris.Moore@cvgloballlc.com**

Century Vision Global vs. Private Equity

KEY FACTORS	TRADITIONAL PRIVATE EQUITY	CENTURY VISION GLOBAL
Expected sale in 3-5 years	Yes	No
Depends on outside investors	Yes	No
Future exit multiple guarantee	No	Yes
Owner's exclusive focus on eye care	No	Yes
Dilutive to doctors as growth occurs	Yes	No
Model conducive to younger doctors	No	Yes
Geographic control	Sometimes	Always
Future commitment known	No	Yes

Sponsored Content

CROSS KEYS CAPITAL

Cross Keys Capital (CKC) has advised on more than $3 billion in transactions with more than 60 of them being physician practices. They have completed deals all across the country, and they have have ophthalmology clients in most areas of the United States.

CKC is a leading health care middle-market investment bank focused on providing merger and acquisition advisory services to privately-held companies with an emphasis in physician practice management. Headquartered in Ft. Lauderdale, Florida, they were founded by investment bankers with extensive experience gained at top tier Wall Street institutions including Goldman Sachs and Morgan Stanley. With a team of more than 20 professionals and heavily weighted to senior bankers, they provide exceptional, high-touch service.

The company's health care team is highly experienced in eye care, having completed more ophthalmology transactions than any other banker, including eight in 2018. This includes a well-known transaction in the space: SightMD, which was sold to Chicago Pacific Founders and is a leader in comprehensive eye care throughout Long Island. CKC works with clients of varying sizes and eye care subspecialties.

Because CKC is a middle-market firm, they are able to enhance the traditional approach by being extremely hands on at the senior banker level. A transaction is more complicated than most physicians are prepared for, and CKC understands that and supports their clients on more than just deal terms.

CKC has standard processes in place but also knows that every client is different, so the company takes a personal approach to this challenging process. Most of their clients come from referrals by prior clients because of this approach to the process.

For more information, contact Cofounder and Managing Director Bill Britton (bbritton@ckcap.com; 954-779-3195), or Managing Director Jeanne Proia (jproia@ckcap.com; 954-321-8287).

ERE HEALTHCARE REAL ESTATE ADVISORS

The ERE Healthcare Real Estate Advisors team (ERE) is led by real estate veterans with more than 70 years of combined experience. They have collectively advised on 184 real estate transactions nationwide, totaling more than $1.3 billion in asset value.

With a focus on structuring sale and leaseback transactions between health care operators and the most aggressive institutional real estate buyers in the market, the ERE team identifies solutions that meet the objectives of their clients. ERE provides expert guidance in transaction framework, marketing, and execution to ensure an exceptional sale price and outcome for their clients.

The unique background in the acquisition, development, and high-level advisory of health care real estate owners and operators positions ERE to deliver unrivaled results to their clients.

For more information, contact Managing Director Collin Hart (collin.hart@ereadv.com; 702.839.8737).

EYE HEALTH AMERICA

Eye Health America (EHA) is focused on eyecare partnerships in the Southeast United States. In 2018-2019, EHA completed eight strategic partnerships including Clemson Eye (Upstate South Carolina), Montgomery & Riddle Eye Care (Upstate and Midlands South Carolina), Piedmont Surgery Center (Greenville, South Carolina), Donelson Eye Associates (Greenville, South Carolina), The Surgery and Laser Center at Professional Park (Midlands South Carolina), Dr. Sara Bopp Optometry Practice (Simpsonville, South Carolina), The Eye Associates (West Florida), and Updegraff Laser Vision (Tampa/St. Petersburg, Florida).

Led by an experienced team of eye care industry leaders with more than 100 years of combined practice management experience, EHA partners with best-in-class eye care practices and ambulatory surgery centers in the Southeast to provide superior clinical care to the region. Its member practices offer full-service, integrated eye care from routine eye exams, contact lenses, and glasses to medical ophthalmology and surgery including cataract, cornea, LASIK, retina, glaucoma, pediatrics, and oculoplastics.

EHA was established in 2018 by private equity firm LLR Partners to support the expansion of leading eye care practices through both organic growth and acquisition initiatives. With a focus on the Southeast, EHA provides strategic and operational support to practice groups and ASCs, enabling them to focus on delivering the highest quality outcomes and meeting a rapidly growing need for eye care. Through the team's experience in the industry, EHA is familiar with processes from a practice level and is equipped to enable better efficiency, growth, and profitability in the future.

EHA is led by recognized eye care industry leaders who understand the challenges that practices face today and helps them discover new levels of success through capital, proven process, shared expertise, and collective strength. Eye Health America is strictly focused on partnering with eye care practices, ambulatory surgery centers, and optical dispensaries in the Southeast. Member practices are partners and the company's full service, integrated platform (1-stop shop eyecare) encourages an OD/MD delivery model that is both patient-centered and growth driven. EHA's high performance management services organization has the competency to navigate an increasingly complex health care business environment and the infrastructure to centralize and manage administrative functions, improve processes, and increase efficiencies.

For more information, contact EHA Chief Development Officer Philip Isham, COE, OCS, (pisham@eyehealthamerica.com; (M) 727-433-9899).

EYESOUTH PARTNERS

EyeSouth (ES) has completed eight affiliations as of early 2019, including the initial formation of EyeSouth Partners through Shore Capital Partner's (Shore) investment in Georgia Eye Partners in early 2017.

ES focuses on the Southeast region, including Georgia, Florida, Alabama, Tennessee, South Carolina, North Carolina, Mississippi, Louisiana, and may consider other surrounding states on a case-by-case basis.

ES supports its affiliated practices and physician partners with capital, administrative resources, operating expertise, and strategic guidance with an absolute focus on clinical quality and a patient-first culture. They have a robust corporate infrastructure, including a vast number of employees and numerous third-party advisors that provide administrative support to affiliated practices in areas such as revenue cycle management, finance/accounting, systems, legal/compliance, human resources, marketing and business development. Their goal is to supplement existing practice operations in these areas. The company targets a balanced governance structure between the local practice and ES, ensuring local autonomy is retained in key functional areas.

While not experts on the business models of other PE-backed management services organizations, there are a few important considerations to highlight related to the ES business model. There is a strong cultural fit and alignment of interests between ES and the physicians, administrators, and employees at each affiliated practice. This starts with the many long-standing relationships between the various ES physicians and creates a unique, collaborative culture as we continue to expand our offering of care.

The company's mission is to be a physician-led organization, and there is a tremendous value on existing ES physicians' relationships and provide ample opportunities for physician leadership and participation at the ES level. Two primary examples include the 12-member Board of Directors, which consists of six ophthalmologists and one gastroenterologist, and a physician advisory board to advise on ES level operational and strategic initiatives.

For more information, contact Vice-President of Business Development & Strategy Charlie Shreve (Charlie.shreve@eyesouthpartners.com).

UNIFEYE VISION PARTNERS

Unifeye Vision Partners (UVP) provides management and support services to ophthalmology and optometry practices, as well as single-specialty eye surgery centers. UVP operates through a network of 51 providers, 11 clinical locations, and five ambulatory surgery centers.

UVP's mission is to support its partners in their quest to improve the quality of their patients' lives. Through these partnerships, and UVP's commitment to upholding its mission and core values, the company is building a leading, nationally recognized integrated eye care community in the United States.

UVP is dedicated to helping a practice realize its highest potential. Its experienced team has a proven track record of transforming practices into industry leaders and market influencers. Backed by the capital, expertise, and foresight to grow, a practice partnered with UVP has boundless possibilities. The result is a differentiated, physician-owned, integrated eye care leader comprised of like-minded practices renowned for their clinical excellence and innovation.

UVP values all of its team members, and strives to help them realize their highest potential. In addition, the company values its partnerships, and vows to be great stewards to its partners, and refuses to be satisfied with the status quo. UVP believes that with respect, open and honest communication, and collaboration with its partners, the sky's the limit. Every one of its partners is entitled to feel fulfilled by their work, and to return home with a sense that they contributed to something larger.

UVP believes in transparency, so it communicates with its partners frequently, and collaborates with them every step of the way, from the initial meeting to the closing.

For more information, visit uvpeye.com.

VISION INTEGRATED PARTNERS

Vision Integrated Partners (VIP) has completed six deals in Northern California and Florida. The company is a physician-centric national eye care platform formed to accelerate regional growth strategies by providing access to capital, professional management expertise, and analytical tools to maximize operational performance. The firm operates as an integrated management services organization, supporting more than 30 ophthalmologists and optometrists. Four of its partner physicians sit on the board of directors giving them a strong voice in the strategic direction of the platform.

VIP is dedicated to alleviating the burdens of solo ownership and allowing eye care providers more time to focus on providing quality medical care to their patients. VIP's network of partner practices benefits from resources such as financial reporting support, regulatory expertise (MACRA & MIPS), advanced clinical research capabilities, comprehensive employee benefit packages, and much more. VIP's primary differentiator is that it is physician-led. VIP has four practicing MDs on its board who have a voice in the strategic direction.

For more information, contact Cofounder and Chief of Strategy Randall J. Shaw (rshaw@vip-us.net; 917-957-7893).