White Paper: Raising Capital for Healthcare Companies Without a Bank

Reviewed by Richard C. Wilson, author of *Capital Raising* and founder of the Family Office Club. Reviewed November 20, 2026.

Yes, a healthcare company can raise capital without an investment bank, as long as the owner does the banker's five jobs: price the business, pick the capital layer, build the investor list, produce the materials and negotiate the terms. Three rules do most of the work. Price off private control deals, not public comps. Start with physicians and family offices that already know healthcare. On any sale of existing shares, plan for about a tenth of the price to sit in escrow. The median was 11.1% on 2025 deals without RWI, per SRS Acquiom.

This paper gives the 2026 data for each job, worked examples and a 13-week plan.

Data as of November 20, 2026. Observed data tables report a named source, its population and its period. Model tables are hypothetical. Their inputs are our assumptions and the arithmetic is ours. They are not market quotes. Every derived figure is listed with its inputs at the end of the paper.

Executive summary: 5 numbers that set the terms of a 2026 healthcare raise

- **1,029 PE healthcare deals in 2025, 664 of them add-ons.** Of the 1,029 PE-backed healthcare deals tracked in PESP's 2025 in Review (PitchBook and LevinPro HC data), 151 were buyouts, 664 add-ons and 214 growth investments. PESP says its count is likely an underestimate. Growth investments are the closest match to a minority raise. By our arithmetic they made up 20.8% of the total.
- **5.1x versus 12.9x EBITDA.** In Axia Growth's closed healthcare sales data (as of October 28, 2026), the median was 5.1x for the 13 sales with $2 million to $3 million of EBITDA and 12.9x for the 17 sales at $10 million and up. Both bands use the same EBITDA basis.
- **9.6x EBITDA.** Across Buckhead FMV's 187 U.S. healthcare services control transactions announced January 2023 through October 2026, the median was 9.6x EBITDA (68 deals with

positive EBITDA) and 0.88x revenue. Buckhead excludes minority stakes, so this is a control benchmark.

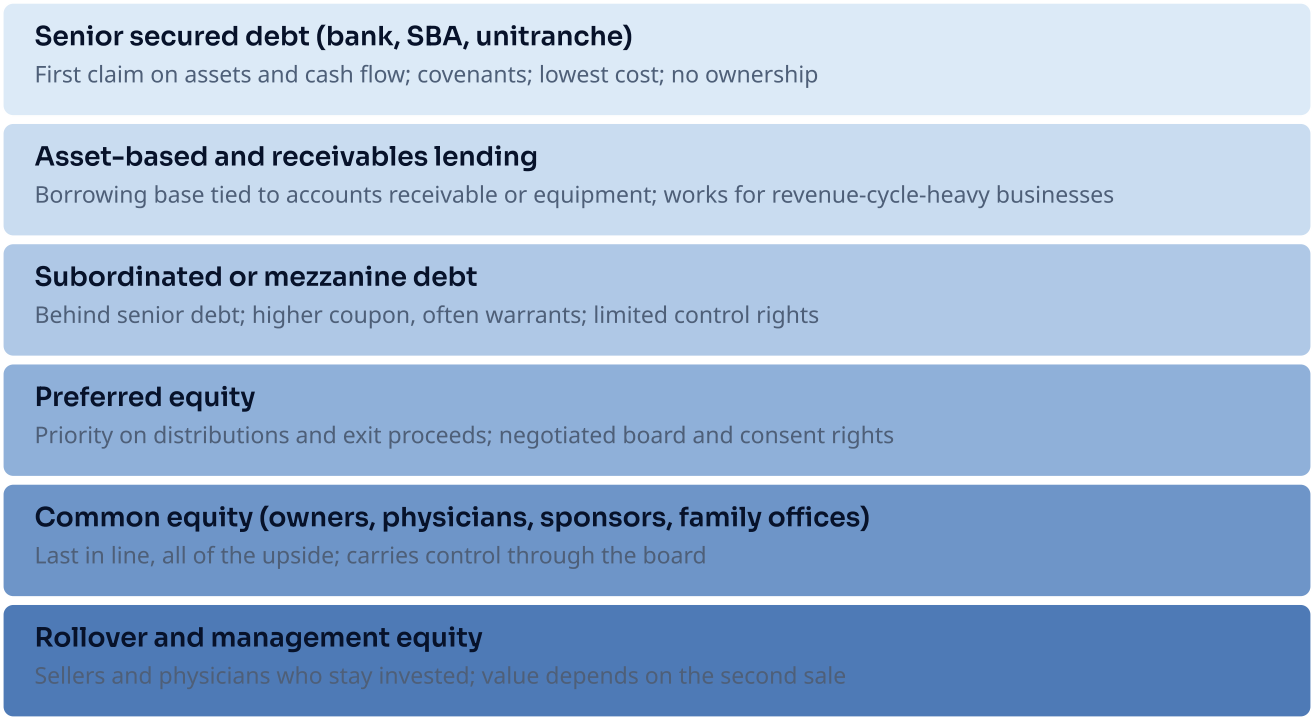
- **11.1% to 14.7% of value held back.** SRS Acquiom's 2026 Deal Terms for M&A Escrows reports that total escrow on 2025 deals without RWI had a median of 11.1% of transaction value and an average of 14.7%.
- **2.5% hospital operating margin.** Kaufman Hall's Q3 2026 release (October 13, 2026) puts the year-to-date hospital operating margin, including allocations, at 2.5% through August 2026, with nearly 43% of hospitals operating at a loss. Divestitures made up nearly one-third of the 16 hospital deals announced in Q3 2026. That makes systems more likely sellers of outpatient assets than funders of an outside group.

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1. Choose the capital type first: the healthcare capital stack

An owner who starts by calling investors usually ends up with whatever structure the first investor proposes. Decide first what the money is for. Then pick the layer that funds that use and gives up the least control.

The healthcare capital stack, from cheapest and safest to costliest and riskiest



Order reflects typical priority in a default or sale; actual terms depend on the documents.

▶ Text version

1. **Senior secured debt (bank, SBA, unitranche)**: First claim on assets and cash flow; covenants; lowest cost; no ownership
2. **Asset-based and receivables lending**: Borrowing base tied to accounts receivable or equipment; works for revenue-cycle-heavy businesses
3. **Subordinated or mezzanine debt**: Behind senior debt; higher coupon, often warrants; limited control rights
4. **Preferred equity**: Priority on distributions and exit proceeds; negotiated board and consent rights
5. **Common equity (owners, physicians, sponsors, family offices)**: Last in line, all of the upside; carries control through the board
6. **Rollover and management equity**: Sellers and physicians who stay invested; value depends on the second sale

HealthcareInvestmentBanking.com

Layer	Funds	Control given up	What the investor gets	Fits
Senior debt (bank, SBA)	Equipment, real estate, working capital	None beyond covenants	Interest, collateral, personal guarantee	Stable EBITDA, hard assets
Private credit, unitranche	Acquisitions, dividend recaps	Covenants, sometimes a board observer	Higher coupon, fees, tight covenants	Larger, steady EBITDA
Seller note	Buying out a partner or a practice	None	Deferred, subordinated payment	Internal successions, tuck-ins
Physician syndication	De novo sites, ASC equity	Minority stake under the operating agreement	Distributions, local ownership	ASCs, imaging, multi-site groups (referral rules in Section 7)
Family office direct minority	Growth, partner buyouts, MSO build	Board seat, protective provisions	Patient equity, flexible hold period	Profitable groups that want to stay independent
PE growth equity	Platform expansion	Minority stake with heavy vetoes	Preferred return, liquidation preference	Fast-growing services and health IT
Control recap (PE platform)	Founder liquidity plus growth	Majority	Control. The founder gets a second exit through rollover	Owners ready to give up control

Three rules decide most choices.

1. **Debt is cheaper than equity only while cash flow covers it.** PitchBook data reported in Sikich's Q3 2026 update puts 2025 entry leverage on PE-backed healthcare services buyouts at 5.2x EBITDA. Those targets had a median implied EBITDA of roughly $33 million and a sponsor behind them. For a founder-owned group, 5.2x is an outer limit, not a target.
2. **Know the size limits on cheap debt.** The SBA's 7(a) program, its main small business loan program, caps a loan at $5 million, per the SBA's program page as of November 2026. A single 7(a) loan cannot fund a $6 million raise.
3. **Every step down the stack costs more governance for each dollar raised.**

Model, not a market quote: debt versus minority equity. A hypothetical three-site dermatology group has $3.2 million of adjusted EBITDA and $4.0 million of existing net debt. It needs $6.0 million. Our arithmetic. The debt row assumes the full $6.0M is borrowed and added to the existing $4.0M, and that all $10.0M carries an assumed 9% all-in rate. The equity row assumes $6.0M gross with no fees deducted.

Route	Amount raised	Leverage after the raise	What the owner gives	What the owner keeps
New senior debt	$6.0M borrowed	New debt alone 1.9x EBITDA. Total net debt $4.0M plus $6.0M equals $10.0M, or 3.1x	Covenants, guarantee, about $0.9M a year of interest	100% of the equity
Minority equity at $21.6M pre-money (Section 2)	$6.0M of new shares	Unchanged at $4.0M, or 1.3x	21.7% of the equity, a board seat, protective provisions	78.3% of the equity, no new debt service

Interest alone on $10.0M at 9% is $0.9M a year, or 28% of EBITDA, before any principal. The debt route keeps all the equity but more than doubles the fixed claim on cash flow. The equity route leaves cash flow alone and gives up a share of all future value. If you are confident in next year's EBITDA, borrow. If you are not, sell the equity.

Size the raise against each layer in the Capital Raise Sizing Calculator before any investor conversation.

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2. Price the round from private-deal data, not public comps

Public multiples set expectations that private buyers will not meet.

Observed data: U.S. public companies, January 2026. Source: Aswath Damodaran, NYU Stern, EV/EBITDA by sector and his separate Price and EV to Sales file. The two files aggregate differently, so do not divide one by the other to infer a margin.

Public sector (US, January 2026)	EV/EBITDA	EV/Sales
Healthcare Products (204 firms)	19.78x	4.76x
Healthcare Support Services (104 firms)	11.17x	0.46x
Hospitals/Healthcare Facilities (31 firms)	8.86x	1.69x

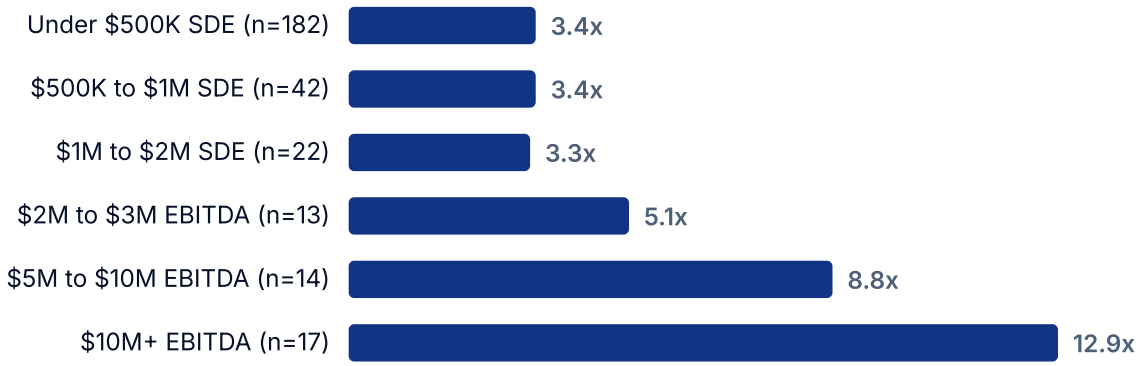
Public companies are liquid, diversified and large. A private practice is none of those, so it prices lower. The three private sources below each cover a different population and period. Compare figures within a table, not across tables.

Observed data: Axia Growth, closed healthcare small-business sales by size band, as of October 28, 2026. Source: Axia Growth, the healthcare subset of its 4,554 closed small-business sales over $500K. Figures are medians and the middle half (25th to 75th percentile) of sale price to earnings.

Bands below $2 million use seller's discretionary earnings (SDE), which adds back owner pay, so SDE multiples run lower than EBITDA multiples on the same business.

Size band	Sales (n)	Median multiple	Middle half	Basis
Under $500K SDE	182	3.4x	2.7x to 4.2x	SDE
$500K to $1M SDE	42	3.4x	2.5x to 4.4x	SDE
$1M to $2M SDE	22	3.3x	2.7x to 7.5x	SDE
$2M to $3M EBITDA	13	5.1x	3.1x to 10.9x	EBITDA
$3M to $5M EBITDA	Not published	Not published	Not published	
$5M to $10M EBITDA	14	8.8x	3.4x to 10.7x	EBITDA
$10M+ EBITDA	17	12.9x	9.4x to 18.5x	EBITDA

Median sale multiple by size band, closed healthcare small-business sales (Axia Growth, data as of Oct 28 2026) (x earnings)



Bands under $2M use seller discretionary earnings (SDE); larger bands use EBITDA.

▶ **Chart data**

Under $500K SDE (n=182)	3.4
$500K to $1M SDE (n=42)	3.4
$1M to $2M SDE (n=22)	3.3
$2M to $3M EBITDA (n=13)	5.1
$5M to $10M EBITDA (n=14)	8.8
$10M+ EBITDA (n=17)	12.9

Source: Axia Growth, Physician Practice Management sales dataset

Samples above $2 million are small and the ranges are wide. Read the medians as direction. Axia publishes no $3 million to $5 million band, so the worked example below uses Sikich's range for that size.

Observed data: Sikich indicative EV/EBITDA ranges, Q3 2026. Source: Sikich Q3 2026 US healthcare M&A update. These are ranges Sikich publishes as indicative pricing, not medians of a stated deal set. Use them as a starting band for negotiation.

Sub-sector	Size or type	Indicative EV/EBITDA, as published by Sikich
Physician practices	Under $1M EBITDA	5 to 7x
Physician practices	$1M to $3M EBITDA	7 to 9x

Sub-sector	Size or type	Indicative EV/EBITDA, as published by Sikich
Physician practices	$3M to $5M EBITDA	9 to 11x
Physician practices	Above $5M EBITDA	11 to 13x
Physician practices	Platform versus add-on, same specialty	Platforms 4 to 8 turns higher
ASCs	Single-specialty / multispecialty / regional operators	5 to 8x / 6 to 10x / 11 to 17x
ASCs	2025 median	7.9x, the highest in at least eight years
Dental (DSOs)	Platforms / add-ons / practices	9 to 11x / 5 to 8x / 5 to 9x
Home health and hospice	Enhabit take-private / small agencies	10.2x / mid-single digits
Urgent care	Under $10M revenue / $10M to $50M revenue	3 to 7x / 6 to 11x
Hospitals, public comps as of June 30, 2026	HCA / Community Health / Ardent	8.5x / 7.5x / 6.1x

Observed data: Buckhead FMV, U.S. healthcare services control transactions announced January 1, 2023 through October 31, 2026. Source: Buckhead FMV. The set is 187 deals with a disclosed or court-approved price and primary-source target financials. Minority and physician-syndication stakes are excluded. Buckhead shows EV/EBITDA only where EBITDA was positive. "Not published" means Buckhead gives no figure for that cell.

Cut	Median EV/EBITDA	Median EV/revenue
All 187 deals (EBITDA median on 68 deals with positive EBITDA)	9.6x	0.88x
Excluding bankruptcy and other distressed sales	10.1x	0.98x
By year: 2023 / 2024 / 2025 / 2026 through October 31	11.4x / 9.7x / 6.5x / 9.1x	Not published
Deals under $10M	2.8x	0.27x
Deals above $200M	11.2x	1.34x
Ambulatory surgery centers	12.4x	1.24x
Outsourced services	11.6x	2.8x
Hospitals	9.5x	0.41x

Cut	Median EV/EBITDA	Median EV/revenue
Primary care practices	Not published	0.11x
22 distressed sales with reported revenue	Not published	0.15x

Buckhead notes that large and public-company deals disclose EBITDA far more often than small private ones, which pulls its EBITDA medians toward bigger transactions. That explains much of the gap between its 12.4x ASC median and Sikich's 5 to 8x single-specialty range. The 0.11x primary care figure reflects hospital purchases of individual practices that Buckhead says price near equipment and records value.

Observed data: PitchBook market-level medians. Source: PitchBook data reported in Sikich's Q3 2026 update. The 2026 figure is year to date as of that Q3 2026 update.

Measure	2024	2025	2026 YTD
Median healthcare M&A EV/EBITDA	14.5x	13x	11.6x
Median EV/EBITDA, PE-backed healthcare services buyouts	13.5x	13.6x	Not published
Implied EBITDA of the median PE-backed target	Not published	Roughly $33M	Not published

These medians describe targets with roughly ten times the EBITDA of the $3.2 million group in our example. They show where a platform ends up, not what a $3 million practice should expect today.

Four pricing rules follow.

1. **Scale is the price.** Buckhead calls scale the largest single driver in its data, with medians running from 2.8x on deals under $10 million to 11.2x above $200 million. A raise that moves the company into the next size band adds more value than one that only funds operations.
2. **Platforms earn a premium.** Sikich puts it at four to eight turns over add-on practices in the same specialty. An investor who prices you as an add-on keeps that spread.
3. **Strip out distress before you compare.** Buckhead's median rises from 9.6x to 10.1x without distressed sales. Buckhead attributes its 6.5× 2025 median to a smaller, more mid-market deal mix, not a broad repricing.
4. **Every benchmark above is a control price.** A minority investor gets no control, no say over the exit date and no power to replace management. It pays a lower multiple or recovers the difference through liquidation preferences, preferred returns and vetoes. None of these datasets publishes a standard minority discount. Put the discount on the table as an explicit number.

Model, not a market quote: pricing a minority round. The same hypothetical group has $3.2 million of adjusted EBITDA and $4.0 million of net debt. It raises $6.0 million of new money. All figures are

gross, before transaction fees, option pools or any other dilution. Two inputs are our assumptions. The 9.5x control reference is a point we chose inside Sikich's 9 to 11x band for practices with $3 million to $5 million of EBITDA. The 8.0x minority multiple is 15.8% below that reference.

Step	Calculation	Result
Control reference value (assumed 9.5x)	$3.2M x 9.5	$30.4M enterprise value
Minority enterprise value (assumed 8.0x)	$3.2M x 8.0	$25.6M
Less net debt	$25.6M minus $4.0M	$21.6M pre-money equity
Add new capital	$21.6M plus $6.0M	$27.6M post-money equity
Investor ownership	$6.0M divided by $27.6M	21.7%
Same raise at the control reference	$6.0M divided by ($26.4M plus $6.0M)	18.5%

On these assumptions the minority discount costs the founder 3.2 points of ownership.

Model, not a market quote: what each turn of multiple costs the founder. Same group, same $6.0M gross raise, no fees. Pre-money equity equals $3.2M times the multiple, minus $4.0M of net debt. Investor ownership equals $6.0M divided by pre-money plus $6.0M.

Multiple (input)	Discount to 9.5x reference	Pre-money equity	Investor ownership
9.5x	0%	$26.4M	18.5%
9.0x	5.3%	$24.8M	19.5%
8.5x	10.5%	$23.2M	20.5%
8.0x	15.8%	$21.6M	21.7%
7.5x	21.1%	$20.0M	23.1%
7.0x	26.3%	$18.4M	24.6%
6.5x	31.6%	$16.8M	26.3%

Suppose an investor argues for 6.5x because two of the three sites are less than three years old. Going from 8.0x to 6.5x costs the founder another 4.6 points. Site-level P&Ls and a documented EBITDA bridge are what defend the higher number.

Test your range against the Healthcare Valuation Multiples guide before it goes into a deck.

3. Map who is writing checks: where 1,029 PE healthcare deals went in 2025

Capital keeps coming to the sector because spending keeps growing. Per the CMS National Health Expenditure fact sheet, US health spending grew 7.2% to $5.3 trillion in 2024, 18.0% of GDP. Physician and clinical services spending grew 8.1% to $1,109.7 billion. CMS projects physician and clinical services spending to grow 5.5% a year on average from 2025 to 2034.

Observed data: PE healthcare deals, 2025. Source: PESP's 2025 in Review, built from PitchBook and LevinPro HC data. PESP tracked 420 platform companies and 708 investment firms, and says its count is likely an underestimate. By our arithmetic, add-ons were 64.5% of the 1,029 deals, buyouts 14.7% and growth investments 20.8%.

Subsector (PESP, 2025)	PE deals	What it means for a raise
Health IT	151	The most active subsector. Growth equity and minority rounds are part of the mix
Dental care	149	95% were add-ons by PE-owned platforms. Independent practices mostly get bought, not funded
Outpatient care	148	119 add-ons. Dermatology 24, eye care 22, oncology 9
Medtech	117	Product risk. Investors underwrite regulatory milestones
Behavioral health	56	Fewer deals. Compliance diligence runs deeper

The outpatient breakdown comes from Becker's ASC Review's summary of PESP 2025 outpatient data. By our arithmetic, 119 of 148 outpatient deals, or 80.4%, were add-ons. PESP also reports that ten of the 18 platform companies with the most deals in 2025 were dental companies. For a dental owner, most active capital is acquisition capital. Use those platforms as price evidence and as a fallback buyer, not as minority money.

Ownership data points the same way. PAI-Avalere data reported by Axia Growth shows 82.0% of physicians employed by hospitals or corporate entities as of January 1, 2026: 59.7% by hospitals and 22.3% by corporate entities such as PE firms or insurers. Hospitals and corporate entities owned 157,200 practices, 63.9% of the total, with corporate ownership (33.2%) ahead of hospital ownership (30.6%). Groups that want to stay independent need capital that does not take control. Family offices and physician investors fill that gap.

Observed data: hospital and health system M&A, 2025 through Q3 2026. Sources: Kaufman Hall Q3 2026 release, October 13, 2026, and quarterly and annual counts from Becker's Hospital Review reporting Kaufman Hall data.

Measure (Kaufman Hall)	Figure
Transactions announced, Q1 / Q2 / Q3 2026	22 / 18 / 16
Total through Q3 2026, against all of 2025	56, against 46
2025 count in context	Lowest annual count since tracking began in 2011
Q3 2026 against Q3 2025	Matched the same period last year
Total transacted revenue, Q3 2026	$8.2 billion
Average seller size, Q3 2026	About $586 million in annual revenue
Megamergers in Q3 2026 (more than $1 billion in annual revenue)	2
Share of Q3 2026 deals that were divestitures	Nearly one-third
Most common acquirer type, Q3 2026	Not-for-profit organizations
Hospital operating margin with allocations, YTD through August 2026	2.5%
Hospitals operating at a loss, as of August 2026	Nearly 43%
Non-labor expense per adjusted discharge, YTD through August 2026 vs 2025	Up 6% (supply up 5%, drugs up 6%)

Kaufman Hall tracks hospital M&A, not minority investing, so this data does not measure how often systems fund outside groups. It does show where their attention is. Margins are thin, costs are rising and systems are selling assets. For an independent owner, the practical opening is to buy a divested outpatient site with committed capital, not to pitch a system for a minority check.

4. Build the investor list: 4 tiers ranked by sector knowledge

Tier	Who	Sector education needed	Typical ask	Decision process	Screen before pitching
1	Physicians and former operators in your specialty	Low	Minority stake, distributions, a board seat for a lead	Individual decision	Referral relationship with the company (Section 7)

Tier	Who	Sector education needed	Typical ask	Decision process	Screen before pitching
2	Single family offices with healthcare wealth	Low to moderate	Minority or structured equity, governance rights	The principal, often with a small staff	Accredited status, conflicts with portfolio companies
3	Multi-family offices, independent sponsors, growth funds	Moderate	Preferred return, vetoes, a defined exit window	Investment committee, bound by fund life	Fund life, fee structure, restrictions from prior deals
4	PE platforms and strategics	Low on the sector, high on your numbers	Control or a path to control	Investment committee and a set process	Restrictions from prior deals in your specialty

Start with Tiers 1 and 2. They already understand reimbursement, credentialing and payer mix, so their diligence goes to your numbers. Tier 1 also carries the most regulatory exposure, because the physicians who know your specialty best are often the ones who send you patients.

Model, not measured data: the investor funnel. A $6.0M raise with a $1.5M lead needs the lead plus three followers at $1.5M, or four at about $1.1M. That is four or five investors. We assume one in five first meetings produces an engaged investor, so five engaged investors takes 25 meetings. We assume 25% to 40% of names agree to a first meeting, so 25 meetings takes 63 to 100 names. A 60-name list at the same rates yields 15 to 24 meetings and three to five engaged investors, which leaves no margin if one drops. Build 80 to 100 names and replace these rates with your own once meetings start.

List-building checklist

- [ ] 80 to 100 names in Tiers 1 and 2 before any outreach
- [ ] Each name tagged by source of wealth, prior healthcare deals, typical check size and accredited status
- [ ] Each name flagged yes or no for referring patients to, or doing business with, the company
- [ ] Introduction path recorded for each name (lender, accountant, vendor, former partner)
- [ ] Each name tagged as a pre-existing relationship or a new contact, because securities rules treat outreach to strangers differently
- [ ] Form D notices searched on SEC EDGAR full-text search for healthcare companies in your specialty and region. The notices name the issuer and its officers, not the investors, but they show who raised private capital and when, which points you to the backers
- [ ] Ten Tier 3 names held in reserve as a price check
- [ ] Two or three Tier 4 buyers identified as the walk-away alternative
- [ ] Reverse diligence on every lead investor, following Reverse Due Diligence

How Family Offices Invest in Healthcare explains how Tier 2 makes decisions.

5. Write the materials: a one-liner with numbers, a 12-slide deck and a 10-folder data room

A healthcare one-liner states EBITDA, site count, growth and the use of funds in one sentence. Expect to rewrite it several times.

Hypothetical one-liner. "Three-site dermatology group, $3.2M EBITDA, 18% same-site growth, raising $6M to open four de novo sites in a payer market we already contract with."

Slide	Content	Number the investor looks for
1	One-liner and the raise	Amount, structure, use of funds
2	Business today	Sites, providers, revenue, adjusted EBITDA
3	Payer mix	Commercial, Medicare, Medicaid and self-pay shares
4	Provider base	Productivity per provider, retention, age profile
5	Growth record	Three-year revenue and EBITDA by site
6	Use of proceeds	Dollars by line, with payback per site
7	Market	Local share, referral sources, competing groups
8	Regulatory and structure	Entity chart, MSO structure, licenses
9	Management	Owners, administrators, compensation model
10	Projections	Base case and downside, three years
11	Terms	Valuation, security, governance, investor rights
12	Exit paths	Recap, platform sale, continued distributions

Data room folders. Have these ready before the first meeting:

1. Corporate and entity documents
2. Three years of financials plus trailing twelve months
3. EBITDA adjustment bridge
4. Payer contracts and rate schedules
5. Provider agreements and compensation plans
6. Licenses, enrollment and accreditation

7. Compliance program, audits and billing reviews
8. Real estate and leases
9. Litigation and claims
10. Cap table, existing investor rights and prior securities filings

Build the folders from the Healthcare Data Room Checklist. Investors treat every gap as a reason to cut price. The EBITDA bridge is where you defend the valuation, so every add-back needs a document behind it.

Where investors cut price, and the document that stops it

Investor's argument	Price effect	Document that answers it
"New sites are unproven"	Lower multiple on blended EBITDA	Site-level P&L with ramp curves by opening year
"Owner pay is below market"	Lower adjusted EBITDA	Market compensation survey, cross-checked against current wage data on the BLS Health Care and Social Assistance page, and a signed post-close pay plan
"Payer concentration"	Lower multiple	Payer contracts with renewal dates and rate history
"Provider departure risk"	Holdback or earnout	Employment agreements, tenure and productivity by provider
"Billing exposure"	Larger escrow	Third-party coding audit and remediation log

6. Negotiate the terms a banker would: escrow, survival and rollover

Escrow and survival terms apply when an investor buys existing shares, as in a majority recap or partial sale. A primary minority round, where new money goes into the company, usually carries no escrow.

Observed data: SRS Acquiom, 2025 deals. Source: SRS Acquiom, 2026 Deal Terms for M&A Escrows. Population: 2025 deals in SRS Acquiom's dataset. Escrow is stated as a share of transaction value. "Not published" means the source gives no figure for that cell.

Term	Without RWI	With RWI
Deals with an indemnification escrow or holdback	84%	92%

Term	Without RWI	With RWI
Sellers' general reps survive closing	11%	43%
Total escrow, average / median	14.7% / 11.1%	Not published
General indemnification escrow, average / median	11.3% / 10.0%	Not published

RWI does not end seller exposure. In the same data, 92% of RWI deals still carried an indemnification escrow or holdback. The insurance changes who pays first and for how long.

Model, not a market quote: cash at close on a $20.0M majority recap without RWI. Our arithmetic. We assume 30% rollover and apply SRS Acquiom's total escrow median (11.1%) and average (14.7%). The base case sizes escrow on the full $20.0M headline price, which favors the buyer because part of that price is rollover the founder never receives in cash. The last rows size escrow on the cash portion only. All figures are before debt payoff, taxes and transaction fees. Escrow is deferred, not lost. It is released on schedule, less any claims.

Line	Calculation	Amount
Headline price		$20.0M
Rollover equity at 30%	$20.0M x 30%	$6.0M stays invested
Cash consideration	$20.0M minus $6.0M	$14.0M
Escrow at the 11.1% median, on $20.0M	$20.0M x 11.1%	$2.22M
Cash at close, median case	$14.0M minus $2.22M	$11.78M (58.9% of headline price)
Escrow at the 14.7% average, on $20.0M	$20.0M x 14.7%	$2.94M
Cash at close, average case	$14.0M minus $2.94M	$11.06M (55.3% of headline price)
Escrow on cash only, median / average	$14.0M x 11.1% / $14.0M x 14.7%	$1.55M / $2.06M
Cash at close, escrow on cash only, median / average	$14.0M minus $1.55M / minus $2.06M	$12.45M / $11.94M (62.2% / 59.7% of headline price)

On these inputs the founder receives 55% to 59% of the headline price in cash at close when escrow is sized on the full price, and 60% to 62% when it is sized on cash only. Negotiating the escrow base is worth $0.67M to $0.88M at close. Model your own deal in the Deal Proceeds Calculator.

Term checklist for the owner

- [ ] Escrow percentage, the base it is sized on and release dates in writing at LOI

- [ ] Indemnity cap, basket and survival period set separately for general and fundamental reps
- [ ] RWI quote requested and premium split agreed
- [ ] Rollover equity valued at the same price per unit as the investor's cash
- [ ] Earnout tied to metrics the owner controls, with acceleration on a resale
- [ ] Minority protections: information rights, preemptive rights, tag-along, and a seat or observer right
- [ ] Liquidation preference and preferred return stated as numbers, so the effective minority discount is visible
- [ ] Non-compete scope and length agreed at LOI, not in the final documents
- [ ] Exit window, drag-along trigger and valuation method for any put or call

For a full recap, the Physician Practice Recapitalization white paper covers rollover terms and second-bite mechanics.

> **Talk to your own attorney.**
> We are not lawyers, we are not your attorney, and we are not in charge of your compliance. The legal points on this page are issues that may exist and may apply to your situation. Check with your own attorney before acting on anything you read here or on any website.

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7. Deal breakers: what to settle before investors see a term sheet

Raises that stall after an LOI usually stall on an issue the owner could have raised in week three. The table lists the issues that most often reprice or delay a healthcare raise, the evidence that settles each early and where it sits in the 13-week plan.

Issue	How it surfaces late	What to have ready	Plan week
Physician investors who also refer patients	Investor asks to restructure or remove their stakes	Referral-source flags from Section 4 and each physician's proposed stake	3
Where outside equity sits	Investor asks which entity it is actually buying into	Entity chart showing the practice, any MSO and the flow of management fees	3
How intermediaries are paid	A finder asks for a percentage of capital raised	Every intermediary, its role, whom it represents and how it is paid	4
Transaction review timing	The closing date moves	Every state where the company holds a license, plus expected deal size	3

Issue	How it surfaces late	What to have ready	Plan week
Investor restrictions from earlier deals	An institutional investor cannot close in your specialty	Written answer from each institutional investor on restrictions in your specialty	9 to 11
Change of ownership in payer contracts and enrollment	Payer or enrollment steps delay cash after close	Payer contracts with change-of-control clauses flagged, current enrollment records	5
Tax structure of rollover and proceeds	After-tax value of competing offers shifts	Structure memo from the company's tax advisor before the LOI	3 to 4
Billing exposure	Investor asks for a larger escrow	Third-party coding audit and remediation log	5

Model: what a late surprise costs. On the $20.0M recap in Section 6, a diligence finding that moves escrow from the 11.1% median to the 14.7% average cuts cash at close by $0.72M ($2.94M minus $2.22M). On the minority round in Section 2, a move from 8.0x to 6.5x hands the investor 4.6 more points of the company. Both costs shrink when the owner raises the issue first with the document already in the data room.

Regulatory areas that shape a healthcare raise

Area	Why it can matter to this raise	Read more
Securities offering rules	Selling equity or notes is a securities offering. Most private raises rely on an exemption from SEC registration, commonly under Regulation D, and leave a Form D notice on EDGAR. The exemption chosen governs how you may approach investors	SEC, exempt offerings
Broker-dealer registration and finder pay	Paying anyone a share of capital raised is the activity broker-dealer rules target. An M&A broker that represents both buyer and seller in a control sale needs clear written disclosure and written consent from both	FINRA BrokerCheck
Stark and Anti-Kickback	Investment returns paid to physicians who refer patients to the company can be treated as payment for referrals. This decides which Tier 1 investors you can take and how their returns are structured	HHS OIG, fraud and abuse laws
Corporate practice of medicine and MSO structure	Many states bar lay ownership of a medical practice, so outside equity often goes into an MSO that contracts with the practice. The rules differ by state and some states have tightened them	Management Services Organizations
State healthcare transaction notice laws	A growing number of states require notice or review before a healthcare deal closes, which can move the closing date	Healthcare M&A Process

Area	Why it can matter to this raise	Read more
Federal antitrust premerger notice and roll-up scrutiny	Larger deals can require a federal premerger filing, and serial acquisitions in one specialty draw FTC attention. The FTC's 2025 order in the Welsh Carson and U.S. Anesthesia Partners matter bars Welsh Carson from acquiring any interest in a U.S. anesthesia business without prior FTC approval	FTC, premerger notification
Medicare enrollment and change of ownership	A change in ownership can trigger enrollment steps that affect when the company is paid after close	Healthcare Compliance Due Diligence
Tax treatment	Rollover structure and entity type change the after-tax value of competing offers	Company tax advisor

Have your attorney review each area that applies before the first investor outreach. The site's high-risk area guides on physician investors who refer, securities rules for raising capital and paying intermediaries set out the questions in more depth.

Week 3 advisor packet: eight items to hand over in one meeting

Advisors work faster and bill less when they get every input at once. Assemble this packet by the end of week 2, so the week 3 to 4 review produces one written memo, not a running email thread.

Packet item	Where it comes from on this page	What it unblocks
Entity chart: the practice, any MSO, management fee flows	Section 7 table, slide 8	Which entity the $6.0M goes into, and the terms slide
Cap table and existing investor rights	Data room folder 10	The $21.6M pre-money at 8.0x and the 21.7% dilution math
Physician investor list with referral flags and proposed stakes	Section 4 checklist	Which Tier 1 names can be approached and on what terms
Full investor list tagged as pre-existing relationship or new contact	Section 4 checklist	How outreach in weeks 6 to 9 is run
Every intermediary: role, whom it represents, proposed pay, BrokerCheck record	Section 8 table	Engagement letters signed before any introductions
States where the company holds licenses, plus expected deal size	Section 7 table	A realistic closing date on the calendar
Payer contracts with change-of-control clauses flagged, enrollment records	Data room folders 4 and 6	Cash flow timing after close

Packet item	Where it comes from on this page	What it unblocks
Draft deal figures: $6.0M minority raise at 8.0x, or $20.0M recap with 30% rollover	Sections 2 and 6	Tax structure memo comparing after-tax proceeds

A packet that is complete by week 3 also gives the owner the documents investors will ask for in weeks 9 to 11, so the work is done once.

8. Decide who represents you: advisors, finders and dual representation

Raising without a bank does not mean raising without advisors. It means knowing what each one is paid to do and whom each one works for.

Role	Represents	Usual pay	Fits	Question to ask
Deal and healthcare regulatory counsel	The company	Hourly or fixed fee	Every raise	Which areas in Section 7 apply to us, and who prepares the filings?
QoE accountant	The company	Fixed fee	Raises large enough that investors commission their own QoE	Will the report hold up against the investor's QoE?
M&A broker	Seller or buyer	Success fee	Sale of control of a private company	Whom do you represent, in writing?
Placement agent	The issuer	Success fee plus expenses	Minority raises from passive investors	What registrations do you hold? Confirm on BrokerCheck
Finder	Unclear	Often asks for a percentage	Introductions	Whom do you represent, and exactly how are you paid?

On a control sale, watch for dual representation. If an intermediary brings you a buyer it also advises, get written disclosure of whom it represents and give or withhold written consent before going further. Look up every placement agent, broker and individual banker on FINRA BrokerCheck for registration and disclosure history before signing an engagement letter. How to Choose a Healthcare Investment Banker covers engagement terms in more detail.

13-week action plan: 12 steps from model to signed term sheet

Week	Step	Output	Owner
1	Define the use of funds and the amount	One-page use-of-proceeds table	CEO, CFO
1 to 2	Pick the capital layer	Debt, minority or control decision	CEO, board
2 to 3	Build the EBITDA bridge	Adjusted EBITDA with documentation	CFO, QoE firm
3	Price the business	Control reference, minority range and sensitivity table from Section 2	CFO
3 to 4	Legal, regulatory and tax review	One written memo covering the Section 7 areas and the advisor packet, securities approach settled, physician investors reviewed	Deal counsel, tax advisor
4	Write and rewrite the one-liner	Final one-liner with numbers	CEO
4 to 5	Build the 12-slide deck	Deck and three-year model	CEO, CFO
5	Stand up the data room	Ten folders, index and access log	Administrator
5 to 6	Build the investor list	80 to 100 Tier 1 and 2 names, ranked and flagged	CEO
6 to 9	Outreach and first meetings	Planning target of 25 meetings, notes logged	CEO
9 to 11	Second meetings, reverse diligence	Engaged investors vetted, restrictions from prior deals confirmed in writing	CEO, CFO
11 to 13	Negotiate terms and sign	Term sheet with valuation, governance and exit terms set, filings calendared	CEO, deal counsel

How we calculated the derived figures

Figure on this page	Inputs and source	Our assumption
Growth investments 20.8%, add-ons 64.5%, buyouts 14.7%	214, 664 and 151 of 1,029 PE healthcare deals (PESP, 2025)	None
Outpatient add-ons 80.4%	119 of 148 outpatient deals (Becker's ASC Review, PESP data, 2025)	None
Debt example: 1.9x new debt, 3.1x total, 1.3x unchanged, $0.9M interest, 28% of EBITDA	$3.2M EBITDA, $4.0M existing net debt, $6.0M raise	Hypothetical group, full $6.0M borrowed and added to existing debt, 9% all-in rate on all $10.0M
Minority pricing: 21.7% at 8.0x, 18.5% at 9.5x	$3.2M EBITDA, $4.0M net debt, $6.0M raise	9.5x control point inside Sikich's 9 to 11x band, 8.0x minority multiple, gross of fees, no other dilution
Sensitivity table, 6.5x to 9.5x	Same group	Each multiple is an input, not a benchmark
Funnel: 25 meetings, 63 to 100 names	Four or five investors needed	25% to 40% meeting rate, one in five meetings converts
Cash at close, 55% to 62% of headline price	SRS Acquiom 2025 total escrow without RWI, 11.1% median and 14.7% average	$20.0M price, 30% rollover, before debt payoff, taxes and fees
Escrow base worth $0.67M to $0.88M	$2.22M minus $1.55M, $2.94M minus $2.06M	Same recap
Late-surprise escrow cost, $0.72M	$2.94M minus $2.22M	Same recap, escrow on the full price

Questions owners ask

Can a healthcare company raise capital without hiring an investment bank?

Yes. The owner does the five jobs a banker does: price the business from private-deal data, choose the capital layer, build a ranked investor list, produce the materials and negotiate the terms. The company avoids an investment bank's success fee and deals with its investors directly. If it later hires a placement agent or broker, that intermediary is usually paid on success, so the saving depends on how the raise is staffed.

What multiple should I expect when selling equity in a physician practice?

Size sets most of the price. Sikich's Q3 2026 update gives indicative physician-practice ranges of 5 to 7x EBITDA below $1 million of EBITDA and 11 to 13x above $5 million. Axia Growth's closed healthcare sales data (as of October 28, 2026) shows a 5.1x median at $2 million to $3 million of EBITDA (13 sales) and 12.9x at $10 million and up (17 sales). These are control prices. A minority investor pays a lower multiple for the same EBITDA or makes up the difference through preferences and governance rights. None of these datasets publishes a standard minority discount, so negotiate it as a stated number.

Which investors should a healthcare owner approach first?

Start with investors who already understand healthcare: physicians, former operators and family offices whose wealth came from the sector. Their diligence goes to your numbers, not to basic education on reimbursement. Flag every physician investor who refers patients to the company. Stark and the Anti-Kickback Statute can restrict how referring physicians invest and how their returns are paid, so structure those stakes before offering them. Raising Capital from Physician Investors covers the questions. PE platforms generally want control. Hospital finances are thin. Kaufman Hall reports a 2.5% year-to-date hospital operating margin, including allocations, through August 2026, with nearly 43% of hospitals operating at a loss.

How much of my sale price will sit in escrow?

In SRS Acquiom's 2025 deal data, total escrow on deals without representation and warranty insurance (RWI) averaged 14.7% of transaction value, with a median of 11.1%. The general indemnification escrow alone averaged 11.3% (median 10.0%). On a hypothetical $20 million recap with escrow sized on the full price, our arithmetic puts total escrow at $2.22 million at the median and $2.94 million at the average. Insurance does not remove escrow. In the same data, 92% of deals with RWI still carried an indemnification escrow or holdback.

Do I have to file anything with the SEC for a private healthcare raise?

Usually, yes. Selling equity or notes to investors is a securities offering. Most private raises rely on an exemption from SEC registration, commonly under Regulation D, and the company files a short Form D notice that anyone can search on SEC EDGAR. The exemption you choose also governs how you may approach investors, so settle it before the first outreach. Capital Raising for Healthcare Companies covers the questions.

Can I pay someone a percentage for introducing investors?

Not without checking first. Paying a percentage of capital raised is transaction-based pay, which is the activity broker-dealer registration rules are built around. Confirm the person's registration on

FINRA BrokerCheck, put the role and the pay in a written engagement letter and sign it before any introduction is made. How to Choose a Healthcare Investment Banker covers the issues.

▶ **Sources**

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