White Paper: Family Office Capital for Healthcare Companies

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

Family office capital fits profitable healthcare companies that want patient equity, flexible structure and a partner without a fund's exit clock. The family's check size decides the structure. A large check buys control, a mid-size check needs a club of families, and a small check means a minority stake or a co-investment beside a PE sponsor. Pricing follows the same private-market multiples PE buyers use. The real value of an offer sits in the terms: preferences, puts, board seats and timing. This paper gives the benchmarks, the structures, two worked offer comparisons and a 120-day plan.

Data as of November 20, 2026. Every figure names its source, population and date. Calculations marked "our arithmetic" are hypothetical and state their assumptions.

Executive summary: 5 numbers that frame a family office raise

Number	What it measures	Source, population and date	What it means for a raise
1,029	PE-backed U.S. healthcare buyouts, add-ons and growth deals	PESP, 2025 in Review, calendar 2025	A count of PE deals. Family offices rarely announce theirs. It shows how many PE bidders a family office competes with in the same subsectors.
9.6x	Median EV/EBITDA	Buckhead FMV, 68 U.S. healthcare services control deals with positive EBITDA, January 2023 to October 2026	A cross-segment reference point. Your size band and segment matter more (Section 5).
4 to 8 turns	Premium that platforms command over add-on practices, by specialty	Sikich, Q3 2026 update, Sikich's indicative view	The value a family office is paying for when it backs a founder to build a platform

Number	What it measures	Source, population and date	What it means for a raise
82.0%	U.S. physicians employed by hospitals or corporate entities	PAI-Avalere data reported by Axia Growth, as of January 1, 2026	Independent practices are scarce. Part of what a family pays for is that scarcity.
$1,109.7B	U.S. physician and clinical services spending, up 8.1%	CMS National Health Expenditure fact sheet, calendar 2024	A large, growing revenue pool suits long-hold family capital

1. Where the demand and the deal volume sit

Demand backdrop. U.S. health spending grew 7.2% to $5.3 trillion in 2024, or 18.0% of GDP, per the CMS National Health Expenditure fact sheet. Physician and clinical services spending grew 8.1% to $1,109.7 billion. CMS projects that category to grow 5.5% a year on average from 2025 to 2034, and health spending to reach 20.6% of GDP in 2034. Payer mix drives risk. In 2024 Medicare paid $1,118.0 billion (21% of the total), private health insurance $1,644.6 billion (31%) and patients out of pocket $556.6 billion (11%), all per the same CMS release. A family office will ask where your revenue sits in that mix before it asks about growth.

Deal volume. The Private Equity Stakeholder Project counted 1,029 PE-backed U.S. healthcare deals in 2025: 151 leveraged buyouts, 664 add-on acquisitions and 214 growth investments, involving 420 platform companies and 708 investment firms. PESP built the count from PitchBook and LevinPro HC data and says it is likely an underestimate. Read every count below as a floor.

PE-backed U.S. healthcare deals by subsector, calendar 2025 (PESP)

Subsector	2025 PE deals (all types)	What it means for a family office raise
Health IT	151	The highest subsector count (a separate cut from the 151 buyouts above). Health IT companies with revenue and positive EBITDA fit direct family capital best.
Dental care	149	95% were add-ons by PE-owned platforms, and 10 of the 18 platforms with the most deals were dental. The exit buyer pool is deep.
Outpatient care	148	119 were add-ons. Dermatology (24), eye care (22) and oncology (9) led, per Becker's ASC Review on PESP data.
Medtech	117	Product risk and FDA timelines. Suits families with a device or operating background.
Behavioral health	56	Fewer deals and heavier compliance diligence. Fits patient families that put operators on the board.

What the dental number tells a founder. When 95% of a subsector's deals are add-ons, a single-practice owner is selling into a platform's roll-up math. A family office that backs that founder to become the platform moves the founder to the buying side.

Worked example (hypothetical, our arithmetic): the gross spread a platform investor pays for

Assumptions: a dental add-on with $2.0 million of EBITDA is bought at 6x, inside Sikich's 5 to 8x dental add-on range. The same EBITDA is valued at 10x inside a platform, inside Sikich's 9 to 11x DSO platform range. Both ranges are from the Sikich Q3 2026 update.

Step	Calculation	Value
Add-on EBITDA	Given	$2.0M
Price paid at the add-on multiple	6x × $2.0M	$12.0M
Same EBITDA at the platform multiple	10x × $2.0M	$20.0M
Gross spread per add-on	$20.0M - $12.0M	$8.0M

The $8.0 million is gross. It excludes acquisition debt and interest, integration and management cost, and dilution from equity raised to fund the buys. It also assumes the platform exits at 10x. Families with healthcare operating experience back the buy side because they can price those costs.

Hospitals are a separate market. Becker's Hospital Review on Kaufman Hall data counts 56 hospital transactions announced through Q3 2026 (22, 18 and 16 by quarter), against 46 in all of 2025, the lowest annual count since Kaufman Hall began tracking in 2011. Kaufman Hall's Q3 2026 report (October 13, 2026) puts Q3 transacted revenue at $8.2 billion and average seller revenue near $586 million. Two Q3 deals were megamergers, where the smaller party has more than $1 billion in annual revenue. Not-for-profit systems made up most acquirers, and divestitures were nearly one-third of announced deals.

The same report explains the divestitures. As of August 2026, year-to-date hospital operating margin was 2.5% including allocations, and nearly 43% of hospitals were operating at a loss. Non-labor expense per adjusted discharge rose 6% year to date versus 2025, with supply costs up 5% and drug costs up 6%.

Takeaway. Whole hospitals trade between systems. The family office opening is the divestiture pipeline: outpatient sites, imaging, ambulatory surgery and service lines that systems sell under margin pressure. In dental, dermatology, eye care, ASC, behavioral and healthtech, a family office bids against active PE platforms. Use that competition in your process.

2. Family office or PE fund: what changes for the owner

The money prices off the same comparables. The differences sit in who decides, how long they hold and how they exit.

Point of difference	Family office investing its own capital	PE fund
Source of capital	The family's balance sheet	Commitments from outside limited partners
Hold period	No fixed end date	Set by the fund's life, so a sale or recap comes on a schedule
Who decides	Principals, often in the first meeting	Deal team, then an investment committee
Acquisition debt	Varies widely. Many families use little or none.	Standard on buyouts. Sikich reports 5.2x entry leverage for PE-backed healthcare services buyouts in 2025.
Diligence	Often hired out to a QoE firm and outside regulatory advisers	Large in-house team plus outside advisers
What they ask for in place of control	Preferred return, put right, board seat	Control, or a minority stake with heavy consent rights
Owner's main risk	No natural exit date. Liquidity has to be written into the documents.	A sale timed to the fund, not to the company

Rule of thumb. If you need a defined exit, take PE money or write the exit into the family deal. If you want a partner who will hold through a reimbursement cycle, a family office is the better fit, provided the put, liquidity window and drag-along are in the term sheet.

3. Which family offices write direct checks

Many family offices invest mainly through funds. A smaller group runs direct teams and buys operating companies. Three questions sort them on the first call:

1. Does the office have its own deal team?
2. Has it led a healthcare deal, or only followed?
3. What check did it write last time, and for what share of the company?

Family office profile	How it invests in healthcare	What it wants from you	Structure it can support
Single family office with a direct team	Leads deals, takes board seats, holds long term	Reviewed or audited financials, a management team, a growth plan	Control when its check covers a majority of equity value, minority above that size
Family with healthcare wealth (former physician, operator or founder)	Direct or club deals in sectors it knows	Clinical credibility, a clean referral structure	Practices, ASCs, specialty platforms
Families in a club deal	Two to four families pool checks under one lead	One lead family, shared diligence, matching hold periods	Control deals too large for one family
Multi-family office	Pools client capital one deal at a time	Defined terms, a lead investor, a clear exit path	Minority growth or preferred equity
Family office without a direct team	Fund commitments, syndicates, co-investments	A sponsor or lead already in place	Co-investment slots in a PE-led deal
Family office co-investing beside a PE fund	Invests on the sponsor's terms	The sponsor's diligence package	Larger platforms and add-on programs

Check size decides control. Worked example (hypothetical, our arithmetic). A recapitalization at three enterprise values with no acquisition debt, so equity value equals enterprise value.

Enterprise value	60% control check	25% minority check	What it means
$20M	$12M	$5M	One family with a direct team can lead alone
$40M	$24M	$10M	Control often needs a club, for example a lead family at $12M plus two families at $6M each
$80M	$48M	$20M	Families join as minority holders or co-investors beside a sponsor

Debt lowers the equity check. Take the $40 million company with $4 million of EBITDA (10x). Senior debt of 2x EBITDA ($8 million) cuts equity value to $32 million, and a 60% equity stake falls to $19.2 million (our arithmetic). Ask each family whether it uses debt on direct deals. A family that never borrows can buy less.

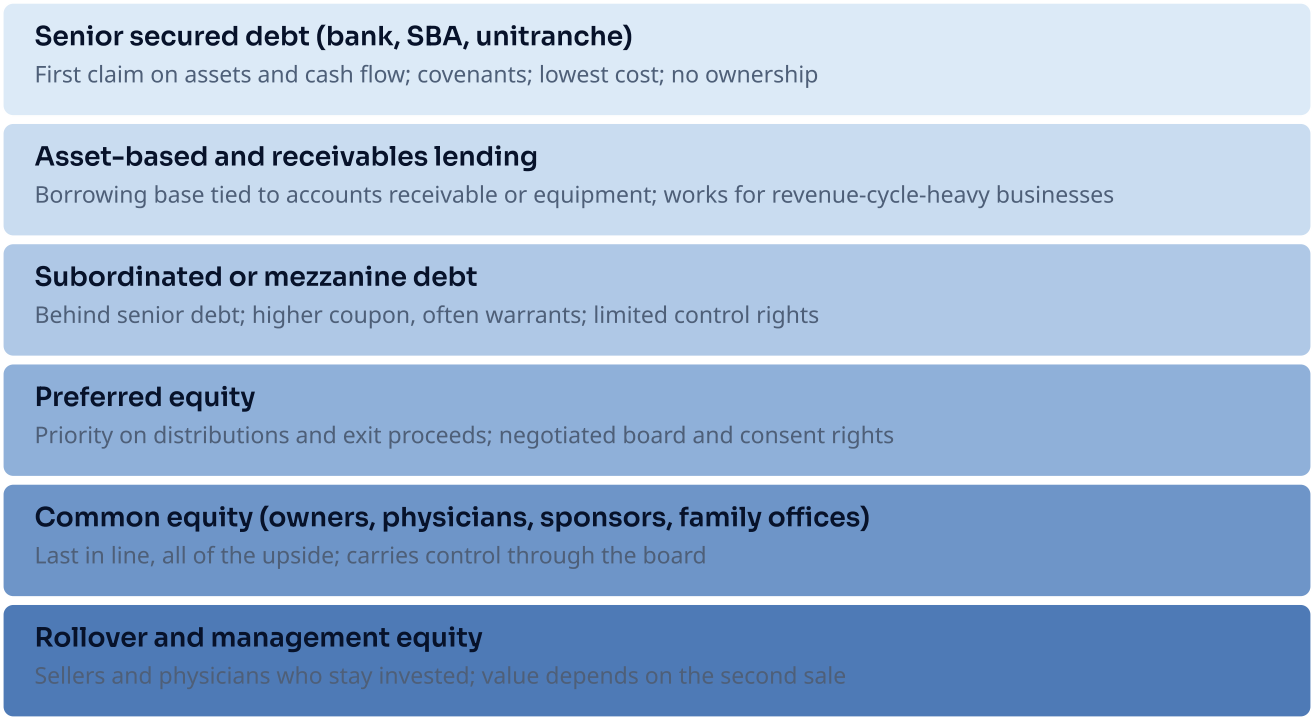
Each profile is covered in How Family Offices Invest in Healthcare.

4. Control or minority: six structures and when each fits

Start from the goal, then pick the structure

Your main goal	Start with	Second choice	Avoid
Cash now, keep running the company	Minority growth equity with a secondary component	Sale-leaseback if you own the real estate	Participating preferred
Cash now and a second payout later	Majority recapitalization with rollover	Co-investment beside a PE sponsor	Minority deals with no liquidity window
Growth capital, no loss of control	Minority growth equity	Mezzanine or private debt	Majority recaps
No dilution at all	Mezzanine or private debt	Sale-leaseback, or for smaller practices an SBA 7(a) loan	Any equity structure
Disagree with today's valuation	Preferred or structured equity	Minority stake with an earn-up	A full sale at today's multiple

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

Structure	Owner gives up	Owner keeps	Family office protection	Best fit
Minority growth equity	Less than 50% and some veto rights	Control, the name, daily decisions	Board seat, information rights, protective provisions	Profitable company funding new sites or add-ons
Majority recapitalization	Control	Rolled equity and a second payout at exit	Board majority, employment and non-compete terms	Founder wants liquidity now and upside later
Preferred or structured equity	First claim on distributions and exit proceeds	Common ownership and control	Liquidation preference, fixed return, redemption right	Owner who will not sell control at today's multiple
Co-investment beside a PE sponsor	Whatever the sponsor deal requires	Rollover on the sponsor's terms	Sponsor's governance plus co-invest rights	Platforms too large for one family
Real estate sale-leaseback	Ownership of the building	The operating company, plus cash from the property	A lease, with the property as collateral	Practices and ASCs that own their facility
Mezzanine or private debt	Cash flow for interest, plus covenants	All of the equity	Covenants, security, sometimes warrants	Owners with steady EBITDA who refuse dilution

Three rules apply to every structure:

- **Practice ownership questions shape the entity.** Family capital often goes into a management services organization rather than the professional entity. See MSOs: How the Model Works, and take the ownership questions in healthcare compliance due diligence guide to your own attorney.
- **Rollover is a second investment.** Model it before you sign with the Rollover Equity Calculator.
- **Exit rights matter more with families.** A family can hold indefinitely. Put the liquidity window, put right or drag-along threshold in the term sheet. They are much harder to add after closing.

Terms to negotiate with a family office

Term	Owner-friendly version	Family-friendly version	The reason
Liquidation preference	1x, non-participating	Participating, or a multiple above 1x	Decides who is paid first in a flat or down exit (Section 5)
Preferred return	Simple, capped, or none	Compounding with no cap	Compounding adds up fast over a long hold

Term	Owner-friendly version	Family-friendly version	The reason
Put or redemption right	Not before year 7, priced at fair market value	Early put at a fixed formula	An early put can force a sale on the family's timeline
Drag-along	Triggered by holders of a majority of common	Triggered by the family alone	Controls who decides when to sell
Board	Owners hold the majority, family has one seat	Family seat plus an independent it chooses	Shapes every hiring and capital decision
Consent rights	Major events only (sale, new debt, new equity)	Broad list including budgets and hires	Broad rights give a minority holder control in practice
Information rights	Quarterly financials	Monthly reporting and site access	Sets your team's reporting workload

Worked example (hypothetical, our arithmetic): when a sale-leaseback adds value, and when it does not

Assumptions: - An ASC owns its building inside the operating company and pays no rent today. - A family office buys the building and leases it back at $500,000 a year, triple-net, so taxes, insurance and upkeep stay with the ASC. Buyers deduct the new rent when they compute EBITDA, so EBITDA falls by $500,000. - The operating company trades at 9x EBITDA in the base case. - Figures are before tax on the building gain. Closing costs are shown separately.

Step	Calculation	Value
Cash from the building sale at a 7.5% cap rate	$500K ÷ 7.5%	$6.67M
Lost operating company value	9x × $0.50M	$4.50M
Net value created before costs	$6.67M - $4.50M	$2.17M
Closing costs at 3% of the sale price (our assumption)	3% × $6.67M	$0.20M
Net value created after closing costs, before tax	$2.17M - $0.20M	$1.97M

The cap rate is the input that decides the answer, and it is an assumption, not a market quote. The only cap-rate evidence in our sources is for different property types: Sikich's Q3 2026 update cites a skilled nursing portfolio at about an 8.6% yield and senior living cap rates that compressed 25 to 50 basis points in 2026. Medical building pricing turns on tenant credit, lease term and location, so test a range.

Sensitivity: net value created before costs and tax (our arithmetic)

Cap rate	Building price	Net at 9x operating multiple (lost value $4.50M)	Net at 11x operating multiple (lost value $5.50M)
7.0%	$7.14M	$2.64M	$1.64M
7.5%	$6.67M	$2.17M	$1.17M
8.0%	$6.25M	$1.75M	$0.75M
9.0%	$5.56M	$1.06M	$0.06M
10.0%	$5.00M	$0.50M	-$0.50M
Break-even		11.1% (1 ÷ 9)	9.1% (1 ÷ 11)

The trade works only while the property market pays more per dollar of rent than the equity market pays per dollar of EBITDA. A higher operating multiple makes it worse, which is why platforms near exit often keep their buildings. Price the rent at fair market value. Above-market rent raises the building price but cuts EBITDA at the next sale and can look like a referral payment if a referring physician owns the building. This is one company's arithmetic, not a general rule.

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5. Valuation: which benchmark fits your company

How to read the sources together. Each dataset has its own population, period and EBITDA definition. They are not one series.

Source	Population	Period	Measure
Buckhead FMV	187 U.S. healthcare services control deals with disclosed or court-approved prices, 68 with positive EBITDA. Includes distressed sales. Excludes minority and physician-syndication stakes. Some prices include real estate.	January 2023 to October 2026	Medians
Sikich	PitchBook healthcare M&A medians as reported by Sikich, plus Sikich's indicative ranges by sub-sector	2024 to Q3 2026	Medians and ranges
Axia Growth	Closed small-business healthcare sales	Data as of October 28, 2026	Medians by size band, on SDE or EBITDA
Damodaran, NYU Stern	U.S. public companies by sector	January 2026	Sector EV/EBITDA

No public dataset tracks family office healthcare deals. Families rarely disclose prices, and Buckhead's screens exclude the minority stakes where many family checks sit. Use the control-deal data for price, and build the family-specific evidence yourself (Section 7).

The sources disagree for the same year because the samples differ. Buckhead's 2025 median is 6.5x and PitchBook's 2025 median for all healthcare M&A is 13x. Use the dataset whose population looks most like your company.

Buckhead FMV: overall and size medians (January 2023 to October 2026). The 9.6x median EV/EBITDA comes from 68 deals that disclosed positive EBITDA, and the revenue median across the 187 deals is 0.88x. Buckhead notes that large and public-company deals disclose EBITDA far more often than small private ones, so its EBITDA medians lean toward larger transactions. Excluding distressed sales, the medians are 10.1x EBITDA and 0.98x revenue. Deals priced above $200 million traded at 11.2x EBITDA and 1.34x revenue. Deals priced below $10 million traded at 2.8x EBITDA and 0.27x revenue. Yearly medians were 11.4x (2023), 9.7x (2024), 6.5x (2025) and 9.1x (2026 through October). Buckhead attributes the 2025 dip to a smaller, more mid-market mix, not a repricing.

PitchBook medians as reported by Sikich (Q3 2026 update). Two separate PitchBook series. Do not compare across rows.

PitchBook series	2024	2025	2026 year to date (Q3 2026 update)
All healthcare M&A, median EV/EBITDA	14.5x	13x	11.6x
Buyouts of PE-backed healthcare services companies, median EV/EBITDA	13.5x	13.6x	Not reported

The same update puts the trailing-12-month median for all healthcare M&A at 12.7x and median EV/revenue at 2.4x. In the PE-backed services series, implied target EBITDA rose about 27% in 2025 to roughly $33 million. Those companies are far larger than most founder-owned practices.

Physician practices by EBITDA (Sikich, Q3 2026 indicative ranges)

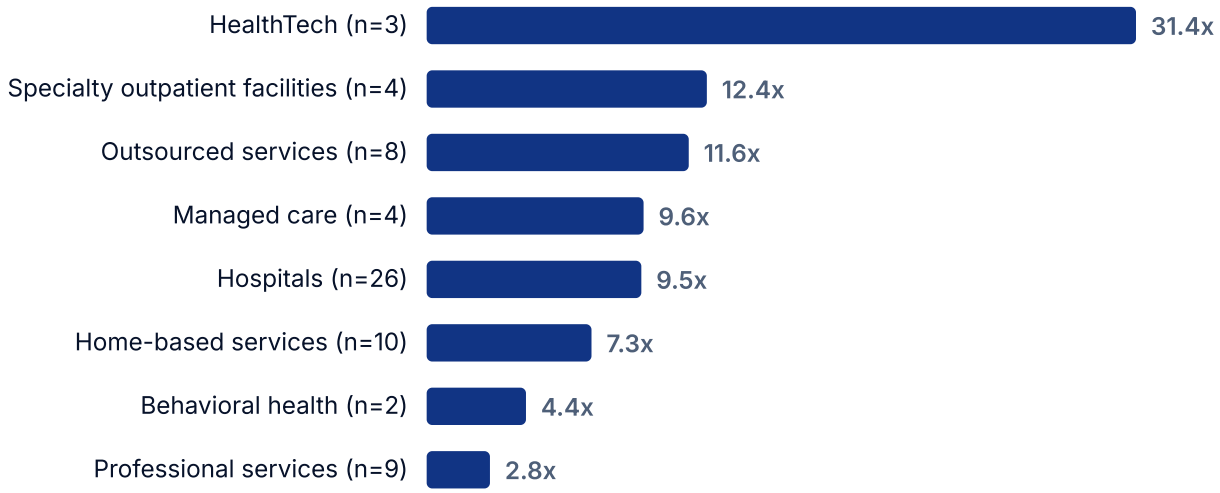
EBITDA band	Indicative EV/EBITDA
Below $1 million	5 to 7x
$1 to $3 million	7 to 9x
$3 to $5 million	9 to 11x
Above $5 million	11 to 13x

Segment ranges (Sikich, Q3 2026 indicative ranges)

Segment	Indicative EV/EBITDA	Direction vs 2025
ASC, single-specialty	5 to 8x	Up
ASC, multispecialty	6 to 10x	Up
ASC, regional operators	11 to 17x	Up
Dental DSO platforms	9 to 11x	Flat
Dental add-ons	5 to 8x	Flat
Dental practices	5 to 9x	Flat
Home health and hospice	Enhabit take-private at 10.2x, small agencies mid-single digits	Down

Sikich reports that the median ASC multiple reached 7.9x in 2025, the highest in at least eight years.

Median EV/EBITDA by healthcare services segment, deals announced Jan 2023 to Oct 2026 (x EBITDA)



n = deals with positive disclosed EBITDA. Small samples; read as indicative.

▶ **Chart data**

HealthTech (n=3)	31.4
Specialty outpatient facilities (n=4)	12.4
Outsourced services (n=8)	11.6
Managed care (n=4)	9.6
Hospitals (n=26)	9.5
Home-based services (n=10)	7.3
Behavioral health (n=2)	4.4
Professional services (n=9)	2.8

Source: Buckhead FMV, Healthcare Services M&A Valuation Multiples 2023-2026 (187 control transactions, Jan 2023 to Oct 2026)

Buckhead's text reports segment medians of 12.4x EBITDA and 1.24x revenue for ambulatory surgery centers, 11.6x EBITDA and 2.8x revenue for outsourced services, and 9.5x EBITDA and 0.41x revenue for hospitals. Both 2.8x figures are in Buckhead's text: one is an EBITDA multiple for small deals, the other a revenue multiple for outsourced services. Buckhead flags any cell with fewer than three observations. Read any bar in the chart built on one or two deals, behavioral health included, as individual transactions, not a segment price. Buckhead's disclosed-deal ASC median measures

larger, mostly public-buyer deals. Sikich's 5 to 8x single-specialty range describes a typical single center.

See the healthcare multiples by segment and size chart.

Small healthcare businesses (Axia Growth closed-sale data, as of October 28, 2026)

Size band	Deals (n)	Median multiple	Middle half (p25 to p75)	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
$5M to $10M EBITDA	14	8.8x	3.4x to 10.7x	EBITDA
$10M+ EBITDA	17	12.9x	9.4x to 18.5x	EBITDA

The upper bands rest on 13 to 17 deals each, with wide middle-half ranges. SDE (seller's discretionary earnings) adds back the owner's pay, so SDE multiples run lower than EBITDA multiples for the same business.

Public reference points (Damodaran, NYU Stern, U.S. public companies, January 2026: EV/EBITDA, EV/Sales, margins)

Public sector	Firms	EV/EBITDA	EV/Sales	EBITDA margin
Healthcare Information and Technology	115	21.27x	5.31x	17.12%
Healthcare Products	204	19.78x	4.76x	17.40%
Healthcare Support Services	104	11.17x	0.46x	3.21%
Hospitals/Healthcare Facilities	31	8.86x	1.69x	14.05%

Public multiples carry a premium for scale and liquidity a private company does not have. Use them to see which sectors the market rewards. Price a private company off the private tables.

Worked example (hypothetical, our arithmetic): two family office offers for a dermatology group with $4 million of EBITDA

Assumptions: - Entry multiples are 9x and 10x, both inside Sikich's 9 to 11x band for $3 to $5 million of EBITDA. - Both offers are recapitalizations. The family office buys shares from the owners, so all cash at close goes to the owners. No acquisition debt, fees or taxes. Both close on the same date

and exit on the same date five years later. - Offer A: the family office buys 40% as **non-participating preferred** for $14.4 million. The preferred accrues an 8% annual return, compounding, paid only at exit. At exit the family takes the greater of its accrued preference or 40% as converted. The put after year 7 is never reached because the company exits in year 5. - Offer B: the family office buys 70% as common equity and the owners roll 30%. - The model follows these stated mechanics. Run your actual term sheet through the same steps, because conversion and distribution wording changes the result.

Term	Offer A: minority preferred	Offer B: majority recap
Enterprise value (equals equity value, no debt)	9x × $4M = $36.0M	10x × $4M = $40.0M
Stake sold by owners	40%	70%
Cash to owners at close	40% × $36.0M = $14.4M	70% × $40.0M = $28.0M
Owners keep	60% and control	30% rolled, no control
Family office asks for	Board seat, 8% preferred return, put after year 7	Board majority, employment agreements

Offer A exit waterfall

Step	Calculation	Value
Preference at exit	$14.4M × 1.08^5 (factor 1.4693)	$21.2M
Exit value at which the family converts	$21.2M ÷ 40%	$52.9M
Exit below $52.9M	Family takes $21.2M, owners take the rest	Owners get exit value - $21.2M
Exit at or above $52.9M	Family converts to 40%	Owners get 60% of exit value

Owner proceeds before discounting, two exit cases

Case	Exit value	Offer A total to owners	Offer B total to owners
Growth: EBITDA reaches $8M, sells at 11x (inside Sikich's 11 to 13x band)	$88.0M	$14.4M + 60% × $88.0M = $67.2M (family converts, takes $35.2M)	$28.0M + 30% × $88.0M = $54.4M
No growth: EBITDA stays at $4M, sells at 10x	$40.0M	$14.4M + ($40.0M - $21.2M) = $33.2M (family takes its preference)	$28.0M + 30% × $40.0M = $40.0M

In the no-growth case the preference costs owners $5.2 million against a plain 40% common stake: the family takes $21.2 million instead of the $16.0 million that 40% of $40.0 million would pay. Add

the lower entry price and Offer B wins this case by $6.8 million ($40.0M - $33.2M).

Break-even exit value, undiscounted. Below $52.9M: $14.4M + (X - $21.2M) = $28.0M + 0.30X, so 0.70X = $34.8M and X = **$49.7M**. Offer A wins above $49.7M, Offer B below it.

Adjusting for timing. Offer B pays its extra $13.6 million ($28.0M - $14.4M) at close. Offer A's advantage arrives five years later. Discount exit proceeds at the owners' required return, r. When the break-even lands above $52.9M, it equals $13.6M × (1 + r)^5 ÷ 0.30.

Required return	Break-even exit value	Growth case, present value to owners, Offer A	Growth case, present value to owners, Offer B
r = 0%	$49.7M	$67.2M	$54.4M
r = 10% (factor 1.611)	$73.0M	$14.4M + $32.8M = $47.2M	$28.0M + $16.4M = $44.4M
r = 15% (factor 2.011)	$91.2M	$14.4M + $26.3M = $40.7M	$28.0M + $13.1M = $41.1M

At a 15% required return the $88.0 million growth exit falls below break-even and Offer B wins on present value. Three terms can move the answer further:

- **Participating preference.** The family takes its $21.2 million and 40% of the remainder, which lowers owner proceeds under Offer A at every exit value.
- **Put exercised in year 7.** If valuations are low when the family exercises, the company sells on the family's timeline.
- **Levered recap under Offer B.** Debt raises cash at close and changes the value of the rolled 30%.

Full multiple tables are in Healthcare Valuation Multiples by Sector and Specialty.

Offer comparison scorecard. Run every indication of interest through the same five lines before you compare headlines.

Line	What to compute	Where it comes from
Cash at close	Price × stake sold, minus debt repaid, fees and escrow	Letter of intent and closing funds flow
Value at exit, discounted	Owner share of exit value in a growth case and a flat case, at your required return	Waterfall model as above
Break-even exit value	Exit value at which two offers pay owners the same	Same model
Control terms	Board, consent rights, drag-along	Term sheet

Line	What to compute	Where it comes from
Liquidity terms	Put, redemption, liquidity window	Term sheet

6. Regulatory areas that shape structure and timing

Regulatory questions can decide who can invest, how the entity is built and when the deal can close, whether the money comes from a family or a fund. For referral, kickback and practice-ownership questions see healthcare compliance due diligence guide, and for antitrust and state transaction reviews see healthcare M&A process guide. Take the questions those pages raise to your own attorney before outreach.

Worked example (hypothetical, our arithmetic): what a late close or a late re-price costs owners

Issues that surface after the letter of intent cost owners in two ways. The cash arrives later, or the family re-prices. Both can be put in dollars with the Section 5 figures.

Assumptions: - Offers A and B from Section 5: $14.4 million and $28.0 million of cash to owners at close. - Owners' required return of 10%, as in Section 5. - A slip is any delay past the agreed closing date, whatever the cause. The months are illustrations, not estimates of any review period. - Lost return = cash at close × (factor - 1), the return owners would have earned on that cash during the delay.

Closing slips by	Factor at 10%	Lost return, Offer A ($14.4M)	Lost return, Offer B ($28.0M)
3 months	1.10^0.25 = 1.024	$0.35M	$0.68M
6 months	1.10^0.5 = 1.049	$0.70M	$1.37M
9 months	1.10^0.75 = 1.074	$1.07M	$2.07M

Late re-price	Calculation	Offer A (40% stake)	Offer B (70% stake)
Half a turn off the multiple on $4M of EBITDA	0.5x × $4M = $2.0M of enterprise value	40% × $2.0M = $0.8M less cash at close	70% × $2.0M = $1.4M less cash at close

A half-turn re-price on Offer B costs about what a six-month slip costs. The larger the cash at close, the more both risks cost, so majority recaps carry the most exposure. Both shrink when the referral map, fair market value support for leases and fees, and transaction review coverage are settled before the letter of intent. The tables below schedule that work. Set the no-shop window long enough to cover the slip you think is realistic, not the best case.

Deeper coverage: healthcare compliance due diligence guide, healthcare M&A process guide, Capital Raising for Healthcare Companies and How to Choose a Healthcare Investment Banker.

Seven questions to put to each family office in writing

Question	Effect on price or timing	A usable answer
Which family members, trusts or entities will hold the stake?	Your cap table, consent list and referral map depend on who owns the shares	A named investing entity and the individuals behind it
Does anyone in the family practice medicine, or own a business that refers patients to you or receives referrals from you?	A referral tie found late can force a restructure at a lower price	A written yes or no for each individual, before the first data room login
Does the family own other healthcare businesses in your markets?	Overlapping holdings can lengthen review and push the closing date	Holdings by state and service line
Has anyone been paid or promised a fee for the introduction?	Introducer fees cut your net proceeds	Every introducer named, with how and when they are paid
Will the family use acquisition debt?	Debt changes the check: $19.2M instead of $24M for 60% in the Section 3 example	Yes or no, plus leverage on its last deal
Who signs, and how long did the last investment committee take?	Sets the no-shop window you can accept	Decision makers' names and dates of the last deal from offer to close
Which QoE firm and regulatory advisers will the family hire?	Healthcare specialists raise fewer late surprises and late price changes	Firm names and recent healthcare deals

Work that protects price and timeline

Task	Finish by	Why it protects value
Map every physician investor, family member and referral relationship	First investor meeting	A referral conflict found in diligence can kill the deal or cut the price
Back every lease and MSO fee with fair market value evidence	Data room opening	Above-market rent or fees can look like referral payments and inflate EBITDA
Confirm with counsel which transaction reviews cover the deal	Letter of intent	Sets a realistic closing date and a no-shop window long enough to reach it
Draft any filings counsel identifies alongside the purchase agreement	Definitive documents	Filing the week terms are final keeps the calendar intact

Task	Finish by	Why it protects value
Model after-tax proceeds for each structure	Offer comparison	Two offers with the same headline can differ sharply after tax

7. Targeting: a 10-point screen for the right family offices

The best targets already understand healthcare and value independent practices because so few remain. PAI-Avalere data reported by Axia Growth show 82.0% of physicians were employed by hospitals (59.7%) or corporate entities (22.3%) as of January 1, 2026. Per the same source, hospitals and corporate entities acquired 85,000 more practices from 2018 to 2026, bringing their total to 157,200, or 63.9% of all practices, with corporate owners at 33.2% and hospitals at 30.6%. Axia also reports AMA survey data showing 6.5% of physicians described their practice as PE-owned in 2024, up from about 4.5% in 2020 and 2022.

Families with healthcare wealth make the strongest first calls. Clear each one for physician referral ties before the data room opens. Raising Capital from Physician Investors covers investors who refer.

Screen each family office on these 10 points:

1. Wealth from healthcare, life sciences or a related service business.
2. A direct investing team, not only fund commitments.
3. At least one earlier healthcare direct deal or co-investment you can verify.
4. Appetite for your structure (control, minority, preferred or debt).
5. Size of its last check, compared with the Section 3 table for your enterprise value.
6. Hold period and liquidity expectations that match your plan.
7. No physician in the family who refers to your business, or a referral structure cleared in diligence.
8. Governance style: a board seat only, or an operating partner on site.
9. References from founders the family has backed, including one company that missed plan.
10. Decision process: who signs, how many committee steps, how long the last deal took.

How to score the list. Score points 2, 3 and 5 first. A family that fails any of them cannot lead your deal, however well it fits otherwise.

Points 2, 3 and 5	Healthcare wealth (point 1)	Role in your raise
Passes all three	Yes	Lead investor, first calls
Passes all three	No	Lead investor or second investor in a club
Fails point 5 only	Either	Club member or co-investor

Points 2, 3 and 5	Healthcare wealth (point 1)	Role in your raise
Fails point 2 or 3	Either	Follow-on investor once a lead is signed

Verify point 3 yourself. Family offices publish little, so build your own evidence:

- Search SEC EDGAR full-text search for the family office's name and its principals. Form D notices show which private companies raised capital, how much and who sits on the board. A principal named as a director of a healthcare company is a lead to follow up.
- Ask for the last three direct deals in writing: company, check size, stake, whether the family led, hold period and outcome.
- Call the founders on that list yourself, not only the references the family offers.

Run full reverse diligence with Reverse Due Diligence: How to Vet a Healthcare Buyer or Investor.

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8. The family office data package: 12 documents

Families with direct teams run diligence the way PE firms do. Families without them lean on outside advisers and on their read of the people. Prepare for both.

#	Document	What the family office checks
1	Three years of reviewed or audited financial statements	Revenue quality, add-backs, owner compensation
2	Quality of earnings report	Adjusted EBITDA that holds up to the buyer's own QoE
3	Payer mix by revenue and by visit	Concentration in Medicare, Medicaid and commercial payers
4	Provider roster with compensation and contract terms, benchmarked against current BLS health care wage data	Key-person risk, non-competes, productivity, wage pressure
5	Map of every physician financial relationship	Referral exposure for current owners and new investors
6	Leases for every site, with term, rent basis and fair market value support	Real estate terms and referral risk in leases
7	MSO and professional entity agreements, where used	Practice ownership compliance and fee structure
8	Licenses, accreditations and CMS enrollment	Change-of-ownership filings needed at close

#	Document	What the family office checks
9	Billing and coding audit covering the last 24 months	Overpayment and recoupment risk
10	Federal and state transaction notice analysis	Coverage and timing in each state of operation
11	Use-of-proceeds model and five-year plan	How new capital turns into EBITDA
12	Cap table and existing investor rights	Pre-emptive rights, drag-along, required consents

The full list is in the Family Office Pitch Prep Checklist for Healthcare Companies.

9. Process from first call to close

The steps follow a standard sell-side process or capital raise. Three things differ with families: fewer bidders run in parallel, principals attend more meetings, and terms can move late if the family's own advisers raise concerns.

Healthcare sell-side process, start to close



Steps overlap in practice; regulatory clocks often run in parallel with confirmatory diligence.

▶ **Text version**

1. **1. Readiness (before going to market)**: Sell-side QoE, billing and coding audit, contracts and licenses cleaned up, data room built
2. **2. Positioning and buyer list**: Teaser, confidential information memorandum, model; PE platforms, add-on buyers, strategics, family offices
3. **3. First-round bids**: NDA, management materials, indications of interest; narrow to a short list
4. **4. Management meetings and LOI**: Site visits, second-round bids, negotiate price mechanics, rollover, earnout; sign LOI with exclusivity
5. **5. Confirmatory diligence**: Buyer QoE, legal, regulatory, payer and provider diligence, RWI underwriting
6. **6. Regulatory reviews (if any apply)**: Some deals need federal or state filings before closing. Whether any apply, and how long they take, depends on the deal, so the timing comes from your healthcare attorney

7. **7. Definitive agreement and close**: Purchase agreement, employment and rollover documents, funds flow, escrow; post-close integration and earnout period

HealthcareInvestmentBanking.com process map

The chart shows the order of steps, not deadlines. Regulatory review periods vary by state and by deal. Set the closing date with counsel, and size the no-shop window with the closing-date example in Section 6.

Phase	How family offices differ	Owner action
Preparation	Families ask about the founder's goals early	Write a one-page statement: cash, control, a partner, an exit
Outreach	Warm introductions beat cold decks	Start with physician, operator and adviser networks
First meetings	Principals attend, not only associates	Bring the clinical lead and the CFO
Indication of interest	Structures vary more than PE offers	Run each offer through the Section 5 scorecard
Diligence	The family hires an outside QoE firm and regulatory advisers	Have the 12-document package ready before the letter of intent
Regulatory review	Review periods can run before closing	File as soon as definitive terms allow
Close	Family committees may add a final review	Put signing deadlines and a no-shop window in the letter of intent

Action plan: the first 120 days

Days	Action	Output	Owner
1 to 10	Decide the goal: liquidity, growth capital or both	One-page objectives memo	Founders
1 to 20	Benchmark value against the Section 5 tables for your size band and segment	Valuation range by structure	CFO
10 to 30	Commission a sell-side QoE	Adjusted EBITDA that holds up to review	CFO and accounting firm

Days	Action	Output	Owner
10 to 40	Work through the Section 6 preparation table with counsel: referral map, leases and MSO fees with fair market value support, transaction review coverage	Referral matrix, clean document set, timeline to close	Founders and legal team
30 to 50	Build the target list with the 10-point screen and check-size table	Ranked family office targets	Founders and adviser
40 to 60	Finish the deck, model and data room	Investor-ready package	CFO
50 to 80	Warm outreach and first meetings, with the seven written questions	Qualified interested investors	Founders
70 to 90	Reverse diligence: EDGAR search, deal list, founder calls	Verified track record notes	Founders
80 to 100	Collect indications and run each through the scorecard, including preference waterfalls	Side-by-side cash at close, discounted exit value and terms	CFO and adviser
100 to 120	Negotiate the letter of intent, then make the filings the review identified	Signed letter of intent and filings	Founders and legal team

Related reading: the Healthcare Capital Raising Playbook white paper and Finding Healthcare Investors.

Questions owners ask about family office capital

What size healthcare company do family offices invest in directly?

The family's check size matters more than any fixed company size. A family that wants control has to fund a majority of the equity value, either alone or in a club with other families. With no acquisition debt, a $40 million company needs a $24 million check for a 60% stake. A family that writes smaller checks joins as a minority investor or co-invests beside a sponsor. Ask every family office what it wrote on its last healthcare deal and whether it led. The answer tells you which structure is realistic.

Will a family office pay less than a private equity firm?

Not as a rule. Family offices price off the same private-market evidence as PE buyers, and size and segment move the multiple more than the type of investor does. Sikich's Q3 2026 indicative ranges for physician practices run from 5 to 7x EBITDA below $1 million of EBITDA to 11 to 13x above $5 million. A family office can match a PE multiple on a minority stake and ask for a preferred return, a

board seat or a put right in exchange. Compare offers on cash at close, discounted value at exit and terms. The headline multiple alone does not tell you which offer is better.

Do state healthcare transaction notice laws apply to family office deals?

They can. Coverage depends on the parties, the deal and the states involved, not on whether the money comes from a family or a fund. A state review period can set the earliest closing date. Confirm coverage in every state where you operate before you agree to a closing date or a no-shop window.

Why target family offices whose wealth came from healthcare?

They understand reimbursement, staffing and compliance risk, so diligence moves faster and the questions are sharper. Independent practices are also scarce. PAI-Avalere data reported by Axia Growth show 82.0% of physicians were employed by hospitals or corporate entities as of January 1, 2026. The trade-off is referral exposure. Map every investor's physician ties before you accept the capital.

How do I check a family office's track record when it does not announce deals?

Ask for its last three direct deals in writing, with check size, stake and hold period. Then verify. SEC EDGAR full-text search is free and shows the Form D notices private companies file when they raise capital, including the amount raised and the directors. Call founders the family has backed, including one whose company missed its plan.

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