White Paper: The Physician Practice Recapitalization Playbook

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

A physician practice recapitalization sells part or all of the practice's equity to outside capital while the physicians keep practicing and keep a stake. For most groups the decision comes down to one trade. A majority recap pays far more cash today, but the physicians accept a permanent pay cut and give up control. A minority deal keeps pay and control, but the owners take little or no cash. In our worked example of an 8-physician group with $3.0 million of EBITDA, the majority recap pays the owners $34.2 million at close. The minority deal pays them nothing at close and leaves $1.5 million a year of pay in place. The sections below give the multiples, the reset math, the rollover terms and the 16-week sequence that decide which side of that trade wins.

Data as of November 20, 2026. Every market figure names its source, population and period. Worked examples are hypothetical, and the arithmetic in them is ours.

Executive summary: five points that set 2026 recap terms

- **Size sets the multiple.** Sikich's Q3 2026 healthcare M&A update gives indicative physician practice ranges from 5 to 7x EBITDA below $1 million up to 11 to 13x above $5 million. Hypothetical: at $3 million of EBITDA, moving from 8x to 10x adds $6 million of enterprise value.
- **Buyers are selective.** Physician groups fell from 28% of global provider deals in 2021 to 23% in 2025, per Bain & Company's Global Healthcare Private Equity Report 2026. Of the 1,029 PE-backed US healthcare deals PESP tracked in calendar 2025, 664 were add-ons, about 65% by our arithmetic.
- **The compensation reset is the biggest lever.** Hypothetical: each $100,000 of physician pay permanently converted into EBITDA sells for $1.0 million at 10x. It also costs that $100,000 every year after close, and part of the value arrives as rolled equity, not cash.
- **Cash at close differs more than headline value.** In our worked example, a majority recap pays the eight owners $34.2 million at close. A minority growth deal on the same practice pays them

nothing at close, because the investor's $6 million goes into the practice.

- **Regulatory work can set the calendar.** State transaction notice laws, federal antitrust review for larger deals and corporate practice rules can each move the closing date or change the structure. Map them before the LOI, not after it.

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1. Six recap structures and what each one costs the physician owner

Structure	What owners sell	Cash to owners at close	Who controls after close	Typical counterparty	Main cost to physicians
Majority recap with rollover	Control of the practice or MSO, with a minority stake rolled into holdco	Highest	Investor	PE platform or add-on buyer	Comp reset, loss of control, holdco debt sits ahead of rolled equity
Minority growth recap	Less than 50%, usually as new shares	Little or none if the investment is primary capital	Physicians, with investor vetoes	Growth equity, family office	Lower price per point, protective provisions, preferred return
Dividend recap	No equity	Moderate, funded by debt	Physicians	Bank, private credit	Debt service, covenants, personal guarantees in small deals
MSO affiliation	Nonclinical assets and management rights. The professional entity stays physician-owned	Moderate to high	MSO runs the business side	PE-backed MSO	Management fee, state corporate practice limits
Hospital acquisition	The whole practice. Physicians become employees	Low for small groups	Hospital	Health system	Small primary care practices can price near asset value
Minority equity plus revenue participation	A minority stake plus a share of revenue, where the law allows	Little or none if primary capital	Physicians	Family office	Legal availability is narrow, and the payment comes off the top line

Choose the structure by objective:

If your priority is	Lead with	Why it fits	What to watch
Maximum cash now	Majority recap with rollover	Priced on pro forma EBITDA after the reset	The pay cut is permanent
Keeping control and current pay	Minority growth recap	Priced on reported EBITDA, no reset	No owner liquidity unless the investor also buys existing shares
Liquidity without selling equity	Dividend recap	Debt funds the payout	Covenants and guarantees
Growth capital with no fund clock	Family office minority stake	No forced sale in year five	Preferred return and redemption terms
Ending management burden	MSO affiliation or hospital employment	Someone else runs the business side	Management fee, or a low price for small groups

See the healthcare capital stack chart.

How a majority recap pays, and at which multiple. A majority recap pays twice: once in cash at close and again through rolled equity at exit. The two payments are priced at different multiples. A group sold as an add-on receives an add-on multiple at close. If the physicians roll into the platform holdco rather than their own operating company, that equity rides the platform's multiple at exit. Only a group large enough to anchor a new platform gets platform pricing at close. Groups approaching the $5 million EBITDA band should test the market as a platform candidate before accepting add-on terms. Below $1 million of EBITDA, the majority recap competes with hospital employment and with small-business sale prices. The healthcare recapitalization guide covers minority, majority and dividend mechanics in more detail.

Hospitals are a weak bid for small groups. Kaufman Hall's Q3 2026 M&A Quarterly Activity Report press release (October 13, 2026) reports a year-to-date hospital operating margin of 2.5% including allocations, with nearly 43% of hospitals operating at a loss, both as of August 2026. Non-labor expense per adjusted discharge rose 6% year to date over 2025, with drug expense up 6% and supply expense up 5%. Hospital M&A is concentrated at the top. The 16 hospital and health system deals announced in Q3 2026 carried $8.2 billion of transacted revenue, and the average seller had nearly $586 million in annual revenue.

At the practice level, Buckhead FMV's database of 187 US healthcare services control transactions announced January 2023 to October 2026 shows hospital purchases of individual primary care practices, largely in West Virginia, clustering at 0.05x to 0.15x revenue. Buckhead reads that range as payment for equipment and records rather than goodwill. These deals drive the same dataset's primary care segment median of 0.11x revenue. Both figures describe a small set of hospital-bought primary care practices and do not carry over to specialty groups or other markets.

2. Who is buying physician groups in 2026: deal counts by buyer and specialty

Metric	Figure	Population	Source and date
Physician groups' share of provider deals	28% (2021) to 23% (2025)	Global provider transactions	Bain, Global Healthcare PE Report 2026
PE-backed healthcare deals	1,029 (151 buyouts, 664 add-ons, 214 growth)	US healthcare, all subsectors, calendar 2025	PESP, 2025 in Review
Outpatient care provider deals	148, including 119 add-ons	US outpatient providers, PE-backed, 2025	PESP data reported by Becker's ASC Review
Top outpatient subsectors by deal count	Dermatology 24, eye care 22, oncology 9	Same as above	PESP data reported by Becker's ASC Review
Physicians employed by hospitals or corporate entities	82.0% (59.7% hospitals, 22.3% corporate entities)	US physicians, as of January 1, 2026	PAI-Avalere data reported by Axia Growth
Physicians in a PE-owned practice	6.5% in 2024, up from about 4.5% in 2020 and 2022	US physicians, AMA Physician Practice Benchmark Survey	AMA data reported by Axia Growth
Hospital and health system deals announced	16 in Q3 2026, $8.2 billion transacted revenue	US hospitals and health systems	Kaufman Hall press release, October 13, 2026
Hospital transactions announced, annual	46 in 2025 (lowest since tracking began in 2011), 56 through Q3 2026	US hospitals and health systems	Kaufman Hall data reported by Becker's Hospital Review
Physician and clinical services spending	$1,109.7 billion in 2024. Projected 5.5% average annual growth, 2025 to 2034	US national health expenditure	CMS NHE fact sheet

Five conclusions follow.

Add-ons dominate. Add-ons were 119 of 148 PE-backed outpatient provider deals in 2025, or 80% by our arithmetic on PESP data reported by Becker's ASC Review. Most independent groups will be priced as add-ons into an existing platform. Dermatology and eye care, with 46 of the 148 deals between them, had the most buyer activity. A group in those specialties should expect more than one platform to look.

Independent groups are now the minority. With 82.0% of US physicians employed by hospitals or corporate entities as of January 1, 2026, per PAI-Avalere data reported by Axia Growth, an independent group with clean data and a stable roster is a scarce asset. Buyers compete for those groups. They discount the rest.

The spending base still grows. The CMS National Health Expenditure fact sheet puts physician and clinical services spending at $1,109.7 billion in 2024 and projects 5.5% average annual growth from 2025 to 2034. Medicare spending reached $1,118.0 billion in 2024, 21% of total health spending. Medicare's share of a practice's collections drives its exposure to annual fee schedule changes, and buyers price that directly.

The value-creation thesis has changed. Bain reports that the playbook now extends beyond buy-and-build to operational efficiency, including AI and analytics. Buyers will underwrite your revenue cycle, scheduling and coding data alongside your physician count. Bain also cites Cardinal Health's acquisition of GI Alliance from its physician owners and Apollo Global Management, a strategic exit for a PE-backed physician platform.

Hospital-based groups carry contract risk. Georgetown CHIR reports that PeaceHealth replaced its long-standing emergency group, Eugene Emergency Physicians, with Lane Emergency Physicians, a practice solely owned by an Illinois physician affiliated with the MSO ApolloMD. Buyers of anesthesia, emergency and hospitalist groups price the hospital contract term and renewal history before they price EBITDA.

The US is the market. Bain notes that scale physician group investment is far less common in Europe, where national markets and regulation are fragmented. In Asia-Pacific, physician groups are an uncommon theme and provider deals center on health systems.

3. Valuation: EBITDA size bands set the multiple before specialty does

The bands below are Sikich's indicative ranges for physician practices in its Q3 2026 update. Treat them as directional. Specialty, payer mix and ancillary revenue move a specific group within a band.

Practice EBITDA	Indicative EV/EBITDA (Sikich, Q3 2026)	Value at band midpoint (hypothetical, our arithmetic)
Below $1 million	5 to 7x	$0.8M EBITDA at 6x = $4.8M
$1 to 3 million	7 to 9x	$2.0M EBITDA at 8x = $16.0M
$3 to 5 million	9 to 11x	$4.0M EBITDA at 10x = $40.0M
Above $5 million	11 to 13x	$6.0M EBITDA at 12x = $72.0M

How the platform premium fits the bands. Sikich also reports that, by specialty, platforms command a four- to eight-turn premium over add-on practices. The two findings describe overlapping effects. Platforms are usually the larger groups, so most of that premium is the distance between the bottom and top size bands. Read the premium as the payoff for growing into platform scale, not as turns added on top of your band. A $3 million group bought as a tuck-in prices off the $1 to 3 million or $3 to 5 million band. It does not earn 15x because a platform in its specialty did.

Specialty and adjacent segments. Sikich's Q3 2026 update gives sub-sector ranges that show the platform-versus-add-on spread inside a single specialty.

Segment (Sikich, Q3 2026)	Indicative EV/EBITDA	Trend vs 2025
Ambulatory surgery centers	Single-specialty 5 to 8x, multispecialty 6 to 10x, regional operators 11 to 17x. Median ASC multiple 7.9x in 2025, the highest in at least eight years	Up
Dental (DSOs)	Platforms 9 to 11x, add-ons 5 to 8x, practices 5 to 9x	Flat
Urgent care	3 to 7x under $10M revenue, 6 to 11x at $10 to 50M revenue	Not compared
Home health and hospice	Small agencies typically mid-single digits. Enhabit take-private at 10.2x	Down

Dental shows the pattern most clearly. The same specialty prices at 5 to 8x as an add-on and 9 to 11x as a platform. Buckhead FMV's ASC segment median of 12.4x EBITDA sits above Sikich's 7.9× 2025 median because Buckhead's figure covers control transactions with disclosed EBITDA from January 2023 to October 2026, a population that leans toward larger deals. The two figures measure different populations and are not a like-for-like comparison.

For market context, Sikich reports PitchBook's median for PE-backed healthcare services buyouts at 13.6x EBITDA in 2025, on an implied median target EBITDA of roughly $33 million. That population is far larger than a typical practice, so it sits above every band in the practice table.

See the healthcare multiples by segment and size chart.

A second size view, from closed small-business sales. Axia Growth's healthcare-sector closed-sale data (as of October 28, 2026) shows the same step-up in a different population. The table covers closed sales in the healthcare sector as a whole, not physician practices alone, drawn from Axia's dataset of 4,554 de-identified closed small-business sales. The first three bands are priced on seller's discretionary earnings (SDE), which includes owner pay, so they are not comparable to EBITDA multiples. Axia reports no $3 million to $5 million band.

Size band (healthcare sector, Axia Growth)	Deals	Median multiple	Middle half (25th to 75th percentile)
Under $500K SDE	182	3.4x SDE	2.7x to 4.2x
$500K to $1M SDE	42	3.4x SDE	2.5x to 4.4x
$1M to $2M SDE	22	3.3x SDE	2.7x to 7.5x
$2M to $3M EBITDA	13	5.1x EBITDA	3.1x to 10.9x
$5M to $10M EBITDA	14	8.8x EBITDA	3.4x to 10.7x
$10M+ EBITDA	17	12.9x EBITDA	9.4x to 18.5x

The spread inside each band is wide and the samples are small. A median is a starting point, not a price.

A third view, across all healthcare services. Buckhead FMV's 187 control transactions (announced January 2023 to October 2026) produced an overall median of 9.6x EBITDA across the 68 deals with positive EBITDA, and 10.1x excluding distressed sales. Buckhead sorts this view by deal value, not by EBITDA. Deals above $200 million traded at a median 11.2x EBITDA. Deals below $10 million traded at a median 2.8x EBITDA and 0.27x revenue. That small-deal bucket includes the hospital purchases of primary care practices priced near asset value, and Buckhead notes that many state-filing prices reflect partial interests or negotiated terms rather than market tests. It sits well below Sikich's 5 to 7x band because it measures a different population. A healthy specialty group with $1 million of EBITDA should not price off it.

Revenue multiples mislead in physician deals. Damodaran's January 2026 data on US public companies shows healthcare support services (104 firms) at 0.46x EV/sales and a 2.99% pre-tax operating margin, against 1.69x and 12.86% for hospitals and healthcare facilities (31 firms). Margin drives the gap. Buyers price practices on adjusted EBITDA. Run your own band check with the practice valuation calculator and compare segment benchmarks in the valuation multiples guide.

What moves a practice up within its band:

- [ ] Ancillary revenue (imaging, lab, infusion, ASC) with a completed compliance review for each line
- [ ] Payer mix and contract rates at or above market, with contracts that are assignable
- [ ] A physician roster with signed post-close employment terms and no planned departures inside the hold period
- [ ] Three years of accrual financials and a sell-side quality of earnings report
- [ ] Multiple sites and a credible add-on pipeline, which makes the group a platform candidate

4. The compensation reset: how pro forma EBITDA is built and what it costs

In a physician recap, the buyer pays for profit after physician pay is reset to a post-close level. Reported EBITDA already deducts what the physicians are paid today. The reset deducts a lower post-close amount instead. The difference becomes EBITDA, and the buyer pays a multiple on it.

Worked example (hypothetical, our arithmetic), 8-physician group. Physician pay means all salary, bonus and benefits paid to the eight owner-physicians for clinical and administrative work. Distributions of profit above that are not an expense and are not deducted. The post-close pay level of $312,500 is an assumption chosen for illustration, a 37.5% cut. The right level depends on specialty and market.

Line	Before close (reported)	After close (pro forma)
Net collections	$20.0 million	$20.0 million
Operating costs other than physician pay (staff, rent at market, supplies, overhead)	$13.0 million	$13.0 million
Physician pay, 8 physicians	$4.0 million ($500,000 each)	$2.5 million ($312,500 each, assumed)
EBITDA	$3.0 million	$4.5 million
Change in EBITDA		+$1.5 million ($187,500 per physician)

Valuation step	Amount
Pro forma EBITDA	$4.5 million
Multiple (within Sikich's $3 to 5 million band)	10x
Enterprise value	$45.0 million
Value created by the reset ($1.5 million × 10)	$15.0 million
Value of reported EBITDA alone ($3.0 million × 10)	$30.0 million
Annual pay forgone by the physicians, every year after close	$1.5 million

The reset is a sale of future income. The $15.0 million equals ten years of forgone pay, but not all of it arrives as cash.

How much of the reset value is cash (hypothetical, our arithmetic, base case from Section 6). At 4.0x entry debt, the physicians take $34.2 million in cash and roll $10.8 million of equity. The cash is funded by $18.0 million of new debt plus the sponsor's $16.2 million share of the $27.0 million equity, so it already reflects the entry debt. Cash is 76% of the $45.0 million enterprise value. Allocating the reset in the same proportion, $11.4 million of the $15.0 million arrives as cash at close and $3.6 million sits in rolled equity until exit.

Reset breakeven on the cash portion (our arithmetic, this scenario only). Assumptions, stated in the table: illustrative tax rates rather than any owner's actual rates, no state or payroll tax, no fees or escrow, no investment return on proceeds and no discounting. The result describes this example, not a general threshold.

Line	Pre-tax	After tax
Reset value paid in cash at close (76% of $15.0 million)	$11.4 million	$8.66 million (assumes an illustrative 24% tax rate on all of it)
Reset value held in rolled equity	$3.6 million	Recovered only at exit (assumes tax-deferred rollover)
Pay forgone each year	$1.5 million	$0.945 million (assumes an illustrative 37% tax rate on pay)
Years until forgone pay equals the cash portion	7.6	9.2

On these assumptions, the cash alone covers about nine years of after-tax forgone pay. A lower tax rate on the sale lengthens the breakeven and a higher one shortens it. The actual tax treatment of sale and rollover proceeds depends on the transaction structure, so confirm it with your own tax advisor. Physicians who expect to practice longer than that are relying on the rolled equity to make up the difference. Any portion of the price taxed as ordinary income shortens the breakeven. Investing the proceeds lengthens it. Without growth in the rolled equity, the reset is an advance against your own salary. The deal proceeds calculator converts headline value to cash at close.

Post-close pay has to stand on its own. Benchmark the reset against independent specialty survey data before you agree to it, such as the Medscape Physician Compensation Report, which is published each spring. The 2025 edition was released April 15, 2025. Use the most recent edition available when you benchmark. Check the staff wage assumptions behind the $13.0 million cost line against current BLS data for the health care and social assistance sector. A comp plan that pays below market loses physicians, and departing production comes straight out of EBITDA. Referral questions about the comp formula belong in the Section 5 review and are covered in the healthcare compliance due diligence guide.

Quality of earnings items that move pro forma EBITDA:

Item	Buyer's treatment
Personal expenses run through the practice	Added back if documented
Rent paid to a physician-owned real estate entity	Reset to market. Below-market rent lowers EBITDA when reset. Above-market rent raises it
Routine copay waivers	Flagged. Buyers want a written waiver policy and a file showing the basis for each waiver
Ancillary income from arrangements without a completed compliance review	Excluded or escrowed
One-time payer settlements	Removed
Departing physician production	Set by the transition terms. Buyers remove it unless a signed replacement, a patient transition plan or an earnout supports retention

Prepare before the buyer's accountants arrive. The QoE prep checklist lists the schedules.

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5. Regulatory gates: what to settle before the LOI

Regulatory review can set the closing date and change the structure. Which reviews apply depends on deal size, buyer type and every state where the group has sites, patients or billing. Build the review map into the LOI's outside date, not the closing checklist. A deal whose outside date falls before a required review ends gets re-traded or dies.

> **High-risk area: questions to take to your own attorney before the LOI is drafted.** Rules on referrals, practice ownership and transaction review can affect timing or structure, and they differ by state.
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> 1. Which transaction reviews or notices apply to this deal, given its size, the buyer type and every state where we have sites, patients or billing, and how long could each one take?
> 2. Does any state where we practice limit investor or MSO control of a physician practice, and does that push us toward an MSO affiliation?
> 3. Will our ancillary lines, leases and medical director agreements hold up in a buyer's compliance review?
> 4. Is the proposed post-close comp formula consistent with fair market value, and does any part of it vary with referrals?
> 5. Can a revenue-based payment to an investor be used in every state where we bill?
> 6. Will our existing and proposed restrictive covenants hold in each state where our physicians practice?

The healthcare compliance due diligence guide covers the referral, ancillary and ownership questions, and the healthcare M&A process guide covers review timing. Georgetown CHIR describes Oregon as one state that has tightened limits on investor and MSO control.

What a longer review calendar costs the 8-physician group (hypothetical, our arithmetic on the Section 4 and Section 6 figures). Time itself is cheap. The risk is what can happen to the price while the review runs.

While the review runs	Effect on the owners	Value in the 8-physician example
Each month the close slips	Owners keep pre-reset pay until close	$125,000 a month of pay above the post-close level ($1.5 million ÷ 12)
Each month the close slips	Cash at close arrives later	About $114,000 a month of forgone return on $34.2 million, assuming 4% a year
Net monthly effect of delay	Retained pay slightly exceeds the forgone return	About $11,000 a month in the owners' favor, before fees
One physician leaves before close, equal production assumed	Buyer removes that physician's share of pro forma EBITDA	$562,500 of EBITDA ($4.5 million ÷ 8), or $5.6 million of value at 10x
Buyer re-trades the multiple from 10x to 9x	Price falls on the same pro forma EBITDA	$4.5 million less enterprise value ($45.0 million to $40.5 million)
Exclusivity runs out with no competing bid still live	Owners lose their main source of leverage	Not priced, but every line above becomes easier for the buyer to ask for

On these figures, delay by itself is close to neutral for the owners, but that result is fragile. It compares pre-tax pay with a pre-tax return, ignores that the rolled equity's exit clock may start later, and reverses if the assumed return is a little above 4%. A single physician departure during a long review costs $5.6 million of value, which no monthly carrying effect comes close to offsetting. The calendar matters less than how well the LOI holds the price while it runs.

Protections to put in the LOI before the review starts:

- [ ] Multiple fixed on a defined pro forma EBITDA, with the add-back schedule attached (Section 8, point 1)
- [ ] Signed retention intent from every physician before the LOI is signed, not after
- [ ] An outside date set from the mapped review calendar, with a buffer
- [ ] Exclusivity that falls away if the buyer re-trades the price
- [ ] Interim operating covenants that let the practice keep recruiting and running normally until close
- [ ] At least one alternative bidder kept warm until the review is complete

Documents the review needs in week 1. The calendar can only be mapped as fast as the practice produces the facts.

- [ ] Every site, every state where patients are seen and every state where the practice bills
- [ ] An entity chart covering the professional entity, any MSO, real estate entities and ancillary entities, with each physician's ownership in each
- [ ] Every lease, medical director agreement, ancillary arrangement and services contract with a referral source or a physician-owned entity
- [ ] Current physician employment agreements, the comp formula and the proposed post-close pay level from Section 4
- [ ] Existing restrictive covenants for every physician
- [ ] The structures under consideration from Section 1, including any revenue-based payment
- [ ] The bidder list by type: PE platform, MSO, hospital, family office
- [ ] The intended outside date and exclusivity term

How review findings reprice the LOI (hypothetical, our arithmetic on the Section 4 example):

If the review finds	What changes in the deal	What it is worth in the 8-physician example
An additional transaction review on the calendar	Outside date, exclusivity and interim operating covenants extend to cover it	Price holds only if the LOI fixes the multiple on a defined pro forma EBITDA (Section 8, point 1)
An ancillary line that has not been cleared	Buyer excludes or escrows its income	Each $100,000 of EBITDA excluded removes $1.0 million of value at 10x
Limits on investor control of the practice	Deal moves toward an MSO affiliation, with a management fee in place of direct ownership	Structure and fee replace the control premium in Section 1
Questions about the post-close comp formula	Reset terms are redrafted before the LOI	The $1.5 million reset carries $15.0 million of enterprise value at 10x
A revenue-based payment that cannot be used in every billing state	Fallback to a fixed fee or pure equity	A 4% royalty on $20 million costs $800,000 a year, so the equity price must move with it (Section 7)
A covenant unlikely to hold in a key state	Retention shifts to rollover vesting or an earnout	Departing production comes out of EBITDA at the buyer's multiple

If the deal moves toward an MSO affiliation, the management services organizations guide covers how those structures are set up.

6. Rollover equity: 10 terms that decide whether the second bite pays

#	Term	What to ask	What it changes
1	Entity	Do we roll into the operating company or the top holdco?	Holdco rollover shares in add-on value and the platform exit multiple
2	Price	Is the rollover valued at the same price as the cash portion?	A discount to the cash price hands value to the sponsor on day one
3	Security class	Is it the same class as the sponsor's?	Preferred ahead of common changes the exit split
4	Leverage	How much debt sits ahead of us, now and after add-ons?	Sikich reports PitchBook median entry leverage of 5.2x for PE-backed healthcare services buyouts in 2025. A single-group recap typically carries less
5	Dilution	What are the option pool and add-on issuance rules?	Unpriced dilution shrinks your percentage
6	Departure	What happens to rolled equity on death, disability or termination?	Repurchase at cost instead of fair value is a forfeiture
7	Tag and drag	Can we sell when the sponsor sells, and on the same terms?	This protects your exit price
8	Restrictive covenants	How long and how wide is the noncompete?	A covenant that will not hold in your state is a negotiating chip, not protection
9	Information	Do we get quarterly financials and a board observer seat?	You cannot value what you cannot see
10	Exit horizon	What is the sponsor's fund life and target hold period?	It sets when the second bite arrives

Second-bite math (hypothetical, our arithmetic, continuing Section 4). Assumptions:

- The group anchors a new platform at 10x pro forma EBITDA of $4.5 million. The practice has no debt before close.
- Base case entry debt is 4.0x pro forma EBITDA, below the 5.2x PitchBook median Sikich reports for buyouts with roughly $33 million of EBITDA. The comparison case uses 5.2x.
- The physicians roll 40% of holdco equity. In the base case that is $10.8 million, 24% of the $45.0 million price. Debt funds part of the price, so a 24% rollover of value buys a 40% equity stake. The 40% is an assumption for illustration.

- Over five years the platform buys add-on groups with $4.5 million of combined EBITDA at 7x, the low end of Sikich's $1 to 3 million band. Purchase cost is $31.5 million, funded entirely with new debt. No new equity is issued, so the physicians' 40% is not diluted. This is the best case for the physicians' share.
- Free cash flow after interest repays $10.0 million of debt in the base case. The 5.2x case carries $5.4 million more entry debt. At an assumed constant 9% rate on that extra balance, interest rises about $0.49 million a year, or about $2.4 million over five years, so repayment falls to $7.6 million. Debt balances are simplified to these totals.
- No organic growth. Exit EBITDA of $9.0 million comes from the base group plus the add-ons.
- Exit at 12x, inside Sikich's above-$5 million band.
- All figures are pre-tax and ignore transaction fees, escrow and working capital adjustments.

Step	Base case: 4.0x entry leverage	Comparison: 5.2x entry leverage
Enterprise value at close	$45.0 million	$45.0 million
Entry debt	$18.0 million	$23.4 million
Equity value at close	$27.0 million	$21.6 million
Physicians roll 40% of equity	$10.8 million	$8.64 million
Rollover as a share of the $45.0 million price	24%	19%
Cash to physicians at close (entry debt plus the sponsor's 60% equity check, which equals EV less rolled equity, before fees, escrow, working capital and tax)	$34.2 million ($18.0M debt + $16.2M sponsor equity)	$36.36 million ($23.4M debt + $12.96M sponsor equity)
Plus add-on debt	$31.5 million	$31.5 million
Less debt repaid from free cash flow	$10.0 million	$7.6 million
Debt at exit	$39.5 million (4.4x exit EBITDA)	$47.3 million (5.3x exit EBITDA)
Exit enterprise value ($9.0 million × 12)	$108.0 million	$108.0 million
Equity at exit	$68.5 million	$60.7 million
Physicians' 40%	$27.4 million	$24.28 million
Multiple on rolled equity	2.5x	2.8x
Total to physicians, cash plus roll at exit (pre-tax, undiscounted)	$61.6 million	$60.64 million

Sensitivity to the exit multiple (same assumptions, our arithmetic):

Exit multiple	Exit EV	Base: physicians' 40%	Base: multiple on roll	Base: total to physicians	5.2x: physicians' 40%	5.2x: multiple on roll	5.2x: total to physicians
12x	$108.0M	$27.4M	2.5x	$61.6M	$24.28M	2.8x	$60.64M
10x	$90.0M	$20.2M	1.9x	$54.4M	$17.08M	2.0x	$53.44M
8x	$72.0M	$13.0M	1.2x	$47.2M	$9.88M	1.1x	$46.24M

Read the base case as the headline. Higher entry leverage pays $2.16 million more cash at close and lifts the multiple on a smaller roll at a 10x or 12x exit. It loses at 8x. The physicians' total is about $0.96 million lower in every row, which is their 40% share of the extra interest. A higher multiple on the roll is not a better outcome.

The second bite comes from two sources: buying add-ons at 7x and selling the combined EBITDA at 12x, and moving the platform into a higher size band. The reset was already paid for at close. A full-debt add-on program puts 4.4x to 5.3x leverage on the platform at exit. If the sponsor funds add-ons partly with new equity, leverage falls but the physicians' 40% is diluted and the multiple on the roll falls with it. Run your own case in the rollover equity calculator and work through the physician rollover equity checklist before signing.

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7. Family office minority capital, and where revenue participation fits

Family offices buy minority stakes in physician groups without a fund clock forcing a sale in year five. The physicians keep control and skip the compensation reset. The trade is liquidity. The investor's money usually goes into the practice, not to the owners.

Hypothetical minority deal (our arithmetic), same 8-physician group as Section 4. A family office invests $6 million of new capital for 20% of the equity. That implies a $30 million post-money and $24 million pre-money equity value. The practice carries no debt, so pre-money equity equals enterprise value. The $6 million is primary capital and goes onto the practice balance sheet. The deal is pure equity with no revenue-based payment, so EBITDA stays at the reported $3.0 million.

What the eight physicians hold the day after close (our arithmetic):

Item	Majority recap (Section 6 base case)	Minority equity stake
Cash to physicians at close, before fees, escrow and tax	$34.2 million	$0

Item	Majority recap (Section 6 base case)	Minority equity stake
New capital into the practice	$0	$6.0 million
Equity kept	40% of holdco, $10.8 million	80% of the practice, $24.0 million at post-money
Annual physician pay	$2.5 million	$4.0 million
Control	Investor	Physicians

Liquidity is the larger difference. The minority deal funds growth or retires practice obligations. It does not put money in the owners' hands unless the investor also buys existing shares, which is a separate negotiation and a separate price. Before taking a family office's term sheet, search its fund vehicles on SEC EDGAR for Form D filings to see what it has raised and backed.

Why the minority deal prices below the $45 million majority recap. The comparison holds because neither structure carries practice-level debt before close, so equity value and enterprise value match. If the practice has debt, compare enterprise values, not equity checks. The minority deal is priced on reported EBITDA of $3.0 million because the physicians keep their $4.0 million of pay. $24 million is 8.0x reported EBITDA. At exactly $3.0 million, the group sits on the boundary between Sikich's $1 to 3 million and $3 to 5 million bands, so the 8x reflects two effects together: a lower size band than the $4.5 million pro forma figure and a minority stake without control. The $21 million gap breaks down as follows (our arithmetic):

Driver	Value
Compensation reset not made ($1.5 million × 10x)	$15.0 million
Lower multiple on $3.0 million of reported EBITDA, 8x rather than 10x (size band and minority position combined, not separable here)	$6.0 million
Total gap	$21.0 million

The physicians keep $1.5 million a year of pay and control in exchange.

Revenue participation: narrow, and priced as part of the stake. Some family offices ask for a percentage of revenue alongside the equity. In physician practices this structure is the exception, and a practice that bills in several states may not be able to use it everywhere. Whether it can be used at all is a question to take from the healthcare compliance due diligence guide to your own attorney. Where it is used, it comes off the top line before staff, rent or physicians are paid.

Royalty on $20 million of revenue (hypothetical, our arithmetic)	Annual payment	Share of EBITDA at 15% margin ($3.0M)	Share of EBITDA at 25% margin ($5.0M)
1%	$200,000	6.7%	4.0%
2%	$400,000	13.3%	8.0%
3%	$600,000	20.0%	12.0%
4%	$800,000	26.7%	16.0%

A royalty is a second price for the same stake. In the example above, a 4% royalty at flat revenue would take $800,000 a year and cut EBITDA available to the owners from $3.0 million to $2.2 million. At the same 8x, that is $17.6 million of pre-money value instead of $24 million. Uncapped, the royalty stream is worth about $6.4 million to the investor at that multiple. An investor asking for 20% at $24 million pre-money plus a 4% royalty is asking for that $6.4 million on top. Owners should either raise the equity price, lower the stake or cap the royalty. A cap shortens the stream and lowers its value. If the structure goes forward, define the base as net collections rather than gross charges, state the cap and step-down rate, and agree a fixed-fee or pure-equity fallback in the term sheet.

The family office healthcare investing guide and the family office capital white paper cover how these investors source and underwrite deals.

8. Term sheet negotiation: 12 points to settle before signing the LOI

Exclusivity moves the leverage to the buyer. Settle these points while competing bids are still live.

#	Point	Owner's target
1	Valuation basis	Multiple stated on a defined pro forma EBITDA, with the add-back schedule and post-close pay level attached
2	Compensation reset	Pay per physician, the productivity formula and the term in writing
3	Cash and rollover split	Fixed percentages, with the rollover priced the same as the cash
4	Working capital peg	Trailing 12-month average, not a seasonal high
5	Escrow and indemnity	Size, survival period and R&W insurance
6	Earnout	Metrics the physicians control, with a cap and an end date

#	Point	Owner's target
7	Exclusivity	A short, fixed term with a fall-away if the price is re-traded
8	Regulatory timing	Outside date that covers every mapped review, plus a buffer for extended review
9	Governance	Board seats and clinical decisions reserved to physicians
10	Restrictive covenants	Scope and duration your counsel expects to hold in your state
11	Real estate	Separate lease at fair market rent, or a separate sale
12	Minority investor rights	Preferred return, liquidation preference and any redemption or put right, each with a stated rate and schedule

Compare offers on one table. Bidders quote headline value in different ways. Convert every offer to the same five lines before you rank them:

Line	What to compute
Enterprise value	Multiple × the EBITDA definition in the offer, adjusted to a common pro forma basis
Cash at close	EV less rolled equity, less escrow, fees and working capital adjustment
Rolled equity	Dollar amount, percentage of holdco, security class and debt ahead of it
Annual physician pay after close	Per physician and in total
Recurring cost to the practice	Management fees, preferred returns or any revenue-based payment

The LOI red flags checklist lists the terms that most often reprice a deal after exclusivity.

One-page action plan: 16 weeks from decision to signed LOI

The plan ends at a signed LOI. Closing follows the longest applicable regulatory review, which is mapped in weeks 1 to 3.

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

Week	Action	Output	Lead
1 to 2	Choose a structure: majority, minority, dividend, MSO or family office	Written objectives on cash at close, control, pay and exit	Physician owners
1 to 3	Map federal and state review, corporate practice rules and notice requirements in every state with a site	Regulatory calendar and minimum outside date	Healthcare regulatory counsel
2 to 4	Review every ancillary line, lease and billing arrangement against the self-referral and anti-kickback rules	Compliance memo and gap list	Regulatory counsel, compliance officer
2 to 6	Build three years of accrual financials and normalize EBITDA	Add-back schedule with physician pay shown as its own line	CFO, accounting firm
4 to 8	Commission a sell-side quality of earnings report	QoE report	Independent accounting firm
4 to 6	Model the compensation reset per physician, pre-tax and after tax, split between cash and rolled equity	Pay plan benchmarked to specialty survey data	Owners, comp consultant, tax advisor
5 to 7	Check where EBITDA falls in the size bands and test growth to the next band	Valuation range	Owners, advisor
6 to 8	Collect signed retention intent from every physician	Roster commitment letters	Managing partner
6 to 9	Build the data room	Indexed data room	Practice administrator
8 to 10	Approach PE platforms, MSOs and family offices in parallel. Verify any sell-side advisor on FINRA BrokerCheck	Comparable indications of interest	Owners, registered advisor if engaged
10 to 12	Run reverse diligence on each bidder, including Form D searches on SEC EDGAR	Reference calls, portfolio exits, fund life	Owners
11 to 13	Model cash at close, rollover outcomes, add-on funding and recurring costs for each offer	The five-line comparison table from Section 8	Owners, advisor

Week	Action	Output	Lead
12 to 14	Negotiate the 12 LOI points	Marked LOI drafts	Owners, deal counsel
14 to 16	Sign the LOI. Schedule each required filing so its review ends before the outside date	Signed LOI and filing calendar through closing	Deal counsel

> **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.

Questions physician owners ask about recaps

What is a physician practice recapitalization?

A recapitalization changes who owns the practice and how it is funded. The physicians keep practicing. In a majority recap, an investor buys control and the physicians roll part of their proceeds into the new holding company. In a minority recap, the physicians keep control and sell a smaller stake, often as new capital that goes into the practice and not to the owners. A dividend recap uses debt to fund a payout.

How much of my practice should I sell in a recap?

Work backward from three numbers: the cash you need at close, how much control you want to keep, and the exit value your rolled equity needs to reach. Majority deals pay the most cash today but require a permanent pay reset. Minority growth deals keep control and pay, but the investor's money usually goes into the practice, so the owners take little or no cash at close. Model both with post-close compensation built in before you compare offers.

What EBITDA multiple will my physician practice sell for?

Size sets the starting range. Sikich's Q3 2026 healthcare M&A update gives indicative physician practice ranges of 5 to 7x EBITDA below $1 million, 7 to 9x at $1 to 3 million, 9 to 11x at $3 to 5 million and 11 to 13x above $5 million. Specialty, payer mix and ancillary revenue move a group within its band. Sikich also reports a four- to eight-turn premium for platforms over add-on practices. Platforms are usually the larger groups, so that premium overlaps with the size bands and should not be added on top of them. Most independent groups are priced as add-ons.

How does a gross revenue royalty differ from selling equity?

A royalty pays the investor a fixed percentage of revenue every period until a return cap is reached or, in some deals, with no end date. It is paid before expenses. By our arithmetic, a 3% royalty in a practice running a 15% EBITDA margin takes 20% of EBITDA. A payment measured on professional fees raises regulatory questions, so many physician practices rule the structure out early.

Which laws can delay a physician practice recap?

Three areas most often move the closing date or the structure: state healthcare transaction notice laws, federal antitrust premerger notice for larger deals, and state corporate practice of medicine rules. Which ones apply depends on deal size, buyer type and every state where the group has sites. Map them before you agree to an outside date in the LOI.

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