The Trajectory To Partner

QUICK REFERENCE • The Ladder • The Four Phases • What Owners Watch For • Incentive Guardrails • Provider Margins • Due Diligence

Pediatric Management Institute
Helping Pediatricians Succeed
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1 | THE LADDER

Four steps from employed physician to owner — the top step is a starting line, not a finish line

HOW TO READ THE LADDER

Tread — how the physician is paid, and when
Riser — the gate to clear before the next step
Rail — what the employment and partnership agreements define
Full cost — base salary + every benefit the practice pays for that physician + allocated overhead
Shortcut — the common one is Phase 2 straight to Phase 4: the practice never learns whether the physician covers their cost under owner-level risk, and finds out after the vote.

ONE LADDER FOR EVERY PHYSICIAN

Share it so each can see where they stand.
No guarantees — each step looks for a behavior.

PHASE 1 · NEW ASSOCIATE — 1
Year 1
Flat salary + discretionary bonus
WHAT IT TESTS fit and clinical footing

GATE 1 → 2
Covers full compensation cost base + all benefits + allocated overhead
No subsidizing an individual physician's earnings

PHASE 2 · PRODUCING ASSOCIATE — 2
Years 2–5
Salary + production incentive
WHAT IT TESTS response to an incentive

95% · 48 hrs
of charts closed — the citizenship gate on any incentive

GATE 2 → 3
Still covers full cost; delivers on the incentive with citizenship intact

PHASE 3 · ASSOCIATE PARTNER — 3
After about year 5
Lower base + straight % of revenue
WHAT IT TESTS covering full cost under owner-level risk

step back allowed — no harm

GATE 3 → 4
Covers full cost under owner-level risk, sustained

PHASE 4 · FULL PARTNER — 4
When Phase 3 is proven
Covers full cost + shares practice profits
WHAT IT TESTS thinking like an owner

TRAP · THE HOT RAIL
If ownership nets less than Phase 3 pay after the buy-in's debt service, the math could be wrong.

Shares practice profits
employed-provider + vaccine drug margin, per the agreement

Not the finish line
Phases 1–3 are the warm-up. The real journey starts here.

SET IN THE AGREEMENTS Call Rotation · Citizenship Gates · Pay Formulas — Each defined in the employment and partnership agreements

2 | THE FOUR PHASES IN DETAIL

What each phase pays, what it credits and what it is testing

	PHASE 1 · NEW ASSOCIATE	PHASE 2 · PRODUCING ASSOCIATE	PHASE 3 · ASSOCIATE PARTNER	PHASE 4 · FULL PARTNER
WHEN AND HOW THE PHYSICIAN IS PAID				
Timing	Year 1	Year 2 onward, once a trailing 12 months clears the gate — adjust the ranges to the practice	After about year 5 — the year ranges are adjustable	Only after Phase 3 proves the physician covers their own full cost
Base pay	Flat salary	Flat salary	Reduced base, paid as a draw against the amount earned — the physician earns the greater of the two	Set by the partners — ideally still covers full compensation cost from own production
Incentive	Discretionary bonus	Production incentive — % of revenue, RVUs, charges or visits; the bonus % can step up with each year in the phase	Straight % of revenue — lower floor, much higher ceiling; the % can step up with each year in the phase	Shares in the overall profits of the practice
Vaccines	—	**Administration counts toward production** · vaccine drugs and lab stay out	% applies to revenue generated: administration in; **vaccine drugs and labs out**	Shares the margin on vaccine drugs
Employed providers	—	—	No share of their margin	Shares their margin — a main driver of practice profits
Practice liabilities	Not attached	Not attached	Not attached — why this step should come before ownership	Legally attached to all — bank debt, lease guarantees, buyouts
WHAT EACH PHASE IS TESTING				
The question	Does the physician fit, stabilize clinically and live the culture?	Can they respond to an incentive without their behavior drifting?	Can they cover their full compensation cost and carry owner-level risk before holding owner-level rights?	Will they think like an owner — see how a change affects the practice and move to fix it?
What to watch	Gets along · works problems with the owners · no patient, staff or colleague complaints	Chart closure · complaints · how the physician treats colleagues and their patients	Appetite to generate revenue · contributes to practice-wide efficiency · time off planned around coverage	Puts the practice's interest ahead of their own on coverage, call and spending
Entry gate	Hired	**Covers their full compensation cost** — base salary, all practice-paid benefits, allocated overhead; the practice cannot subsidize an individual physician's earnings	Still covers full compensation cost; delivered on the Phase 2 incentive with citizenship intact	Sustained period covering full cost under owner-level risk; buy-in priced so ownership beats Phase 3 pay

THE ONE PROOF EVERY STEP UP REQUIRES. Before any move to the next phase, the physician covers their full compensation cost — base salary plus every benefit the practice pays on their behalf (health, retirement, malpractice, CME, payroll taxes) — plus allocated overhead. The practice cannot subsidize an individual physician's earnings.

3 | WHAT THE PRACTICE IS WATCHING FOR

Money and time off are fixable with a formula — owner thinking is what the practice is screening for

THE ATTRIBUTES OF A GOOD PARTNER

- **Entrepreneurial instinct.** It cannot be taught — PMI's best predictor of a productive partner.
- **Reads the business, not just the schedule.** Sees how a change affects the practice and moves to fix the problem without being asked.
- **Brings alternatives, not objections.** Contributes ideas and follows through on the ones adopted.
- **Judged by the people closest to the work.** Colleagues and staff see this more clearly than any outside advisor.

THREE TESTS BEFORE ANY ADMISSION DECISION

TEST	HOW TO RUN IT	WHAT IT SHOWS
1 · The partner conversation	Imagine the candidate seated with the owners as they weigh a future partner.	Would they add judgment to that discussion, or only argue their own terms?
2 · The staff read	Consider how the whole team would react to hearing this physician is now an owner.	Positive, negative or neutral — the staff's read is data about leadership.
3 · The project	Assign a real, time-bound project the practice needs — a workflow, a recall process, a system rollout.	Whether the candidate executes and finishes — not whether the idea was theirs.

THE ESSENTIAL QUESTION: MOTIVATION

- **Money and time off are both fixable** with a formula. Neither is a reason to make or refuse a partner.
- **Time off and earnings are linked.** Under any production-based pay, revenue stops when the physician is out — the model enforces the trade-off on its own.
- **Culture can outrank the numbers.** Declining to admit a strong producer is legitimate when the owners decide it knowingly and record why.

WHY THE DECISION IS HARD TO REVERSE

Ownership entrenches behavior. A habit the owners hesitate over in an employee hardens once the physician holds a vote.
Admission is a fundamental decision. Well-drafted agreements reserve it for a supermajority of the owners.
Removal is slow by design — peer review, a chance to cure, then a high supermajority.

4 | GUARDRAILS ON ANY INCENTIVE

Incentives change behavior — build the guardrails into the formula before the first payout

CITIZENSHIP GATES

- **No unresolved patient, employee or colleague complaints.**
- **95% of charts closed within 48 hours** — PMI's standard.
- **Culture alignment** is a judgment the owners record in writing; the measurable gates are chart closure and complaints.

Keep every gate objective and measurable.

WHEN A COMPLAINT LANDS

- **Severity first.** A scheduling complaint, a communication complaint and a clinical-conduct complaint carry different weight.
- **Talk before pay moves,** then document it — the concern, delivered, with a chance to cure.
- **No if-this-then-that table exists.** Judgment is required; apply it most closely wherever the incentive is high.

DEFINED IN THE AGREEMENTS

- **Call rotation.** A change in pay architecture or title never changes the call obligation, unless explicitly allowed in the partnership agreement.
- **The way back.** A physician who struggles on a percent of revenue (Phase 3) returns to salary plus incentive (Phase 2) with no penalty — build the return path into the agreement.
- **No guarantees.** The track describes a path, never a promise, and the agreement says so.

VACCINE DRUGS AND LAB STAY OUT

- **Pay may track what the physician does,** never what they refer — the self-referral law's employment exception.
- **Drafted in:** the bonus base excludes vaccine drugs, clinical lab and all designated health services.
- **That is why Phases 2 and 3 credit administration** but never the vaccine drugs or lab.
- **Partners split vaccine drug and lab profits** in accordance with their partnership agreement.
- **The exit follows the formula.** A departing partner's AR payout includes vaccine drug and lab revenue only if the pay formula charged them the cost; otherwise it stays out, and a flat percentage haircut is not a substitute.

TRAP · EXTREME INCENTIVES

- **A straight percent of revenue is an extreme structure.** It belongs late in the track, never in an offer letter.
- **Extreme incentives can turn colleagues into competitors** for the same patients and slots — watch scheduling wherever the incentive is high.
- **Pure productivity is blind** to citizenship, complex panels, payer mix and mentoring.
- **Watch the E&M levels.** An incentive on revenue or RVUs rewards a 99214 over a 99213 — audit a sample of charts against documentation each quarter. Upcoding is a compliance problem before it is a pay problem.

5 | WATCH EVERY PROVIDER'S MARGIN, FROM PHASE 1 FORWARD

The same two formulas gate every step — run on a trailing 12 months for each physician and APP

Breakeven Revenue = Provider Cost ÷ (1 – Overhead Rate) · **Threshold = Breakeven + Desired Practice Margin**

Provider cost is the full compensation cost — base salary, every benefit the practice pays for that provider, payroll taxes. **Overhead rate** is the practice's published non-vaccine operating overhead, applied to every provider the same way. **Desired margin** is the cushion above breakeven (5–10% of revenue) before any incentive dollar is paid. Every incentive dollar is paid from collections above the threshold — never below it.

WHY THE MARGIN IS THE GATE

- **Phase 2:** collections above breakeven clear the gate; incentive dollars are paid only above the threshold. Below breakeven the physician is being subsidized and is not ready for Phase 2.
- **Phase 3:** the margin proves the physician covers full cost under owner-level risk on a rolling 12-month basis.
- **Phase 4:** partners read the same report for every employed physician and APP — it is where their profit share comes from.
- **Budget the incentive backwards.** Decide what the practice must keep, find the collections that deliver it, share honestly above that line.

ONE PHYSICIAN'S MARGIN REPORT · ILLUSTRATIVE

LINE · T12M, 62.5% OVERHEAD RATE	AMOUNT
Collections (net of vaccine drugs, lab)	$500,000
Allocated overhead at 62.5%	($312,500)
Full compensation cost	($160,000)
Pre-bonus margin	$27,500
Threshold (breakeven $426,667 + margin)	$450,000
Bonus: 15% of collections above it	($7,500)
Practice margin after bonus	$20,000

MEASURING PHYSICIAN MARGIN

- **Every calculation here uses a trailing 12 months (T12M).** A single month or quarter is distorted by seasonality — flu and physical seasons — and by payment timing, since collections arrive weeks to months after the visit.
- **Roll the window forward monthly** so every provider is judged on the same 12-month basis.
- **Year one is hard to calculate honestly.** The practice carries 12 months of expense for a new physician but normally collects only about 10 months of revenue — credentialing lag and the ramp to a full panel eat the rest. Read year one as a ramp against budget, not as a margin verdict.

TRAP · THE UNAUDITABLE ALLOCATION

- **Expenses allocated "at the employer's discretion"** turn a margin report into an argument. One top producer with $462,000 of collections received a $1,364 bonus that way — legal, correct, indefensible.
- **The repair:** the practice's published overhead rate, applied uniformly, in writing.
- **Vaccine drugs, lab and other designated health services** stay out of every margin and bonus base.

THE CADENCE

Same report, three clocks — every figure on a trailing 12 months (T12M) where possible.

MONTHLY

Margin report per physician and APP on a T12M basis at the published overhead rate; collections vs. threshold; chart-closure and complaint gates alongside the numbers.

QUARTERLY

Accrue incentives cumulatively; pay no more than 80% of accrual and true up at year end. Scan the red flags: comp ÷ collections past 20–40%, a provider below breakeven two quarters running, an APP margin inverting, a bonus off budget.

ANNUALLY

Re-run the affordability math for every provider against actual production; refresh benchmarks; confirm overhead % + compensation % stays at or under 100% of collections; step incentive percentages for tenure in the phase.

READ THE REPORT · THE SIGNAL	WHAT IT USUALLY MEANS	FIRST MOVE
Collections below breakeven two quarters running	The provider is being subsidized; the incentive has no funding	Hold the incentive; review template, volume and payer mix before touching pay
Comp ÷ collections drifting above 40%	The package is too rich, or production is understated	Run the three-way check — comp per wRVU, comp ÷ collections, collections per wRVU; when they disagree, check the data before questioning the deal.
An APP's margin turns negative	Per-capita overhead, uncredited incident-to work, or vaccine cost in the pool	Recompute at the practice rate on the APP's own revenue before any staffing conclusion
Bonus materially over budget	Threshold set too low, or the overhead rate is stale	Reset the threshold at renewal; publish the new overhead rate first

6 | TIMING, EXPERIENCE AND DEFERRAL

Time at the practice governs — liabilities that attach to a partner are a legitimate reason to wait

TIME AT THE PRACTICE GOVERNS

- **Count years at this practice first.** Tenure elsewhere can move the incentive date, not the partnership date.
- **The clinical plateau.** Most pediatricians reach stable clinical footing 3 to 4 years out of residency; beyond that, temperament shapes visit quality more than added years.
- **Where prior years count:** stabilizing on a high production incentive sooner — which can move the incentive date.
- **Audit the track against history** — a stated track nobody has completed is fiction.

SAME START DATE, DIFFERENT READINESS

	FROM RESIDENCY	10 YRS ELSEWHERE
At this practice	2 years	2 years
Before joining	Residency	10 years in practice
Production incentive today	Less likely to handle one	More likely to handle one

WHEN "WE NEED MORE TIME" IS LEGITIMATE

- **A new partner inherits every liability:** practice debt, personal guarantees on leases and loans, buyouts of former partners still being paid.
- **Attachment is not optional.** A partner shielded from any practice liability is unfair to the partners who carry it.
- **Large, long obligations weigh most** — a multi-year lease guarantee or bank loan more than a small buyout.
- **Allocate guarantees by formula** — pro rata by ownership, with release terms when a partner exits.

WHEN A PHYSICIAN ASKS BEFORE COMPLETING THE TRACK

- **Never defer with silence** — pair it with a written interim plan and a revisit date.
- **For a Phase 2 physician,** the interim step is the associate-partner percentage. For a Phase 3 physician, it is continuing Phase 3 with a tenure step-up in the percentage and a written revisit date.
- **Name the proof.** Readiness means covering own costs, sustained — say so in writing.
- **The response is a test.** How a candidate takes a reasoned deferral reveals more than any interview.

	PARTNER-READINESS CHECKLIST · SCORE BEFORE ANY ADMISSION DECISION	EVIDENCE THE OWNERS SHOULD HOLD
1	Covers full compensation cost 12+ months — base, benefits, overhead	Provider margin report at the practice overhead rate
2	Delivered on a production incentive without behavior drift	Incentive history · complaint log · coverage record
3	Citizenship gates met — no open complaints; 95% of charts closed in 48 hours	Chart-closure report · complaint log
4	Completed one practice project end to end	Project scope, dates and outcome

	CHECKLIST, CONTINUED	EVIDENCE THE OWNERS SHOULD HOLD
5	Coverage and call obligations met without exception	Call and coverage schedule
6	Has run the buy-in math and can restate it	Worked example, initialed by the candidate
7	Has seen the practice's liabilities and accepted attachment	Signed disclosure schedule
8	Owners' vote meets the admission threshold	Supermajority per the agreement

DUE DILIGENCE BEFORE ADMITTING A NEW PARTNER

Pages 3 and 4 — what the practice should expect, prepare and share when a Phase 3 physician asks to move to Phase 4

Why it matters. Admitting a partner is the one step that can be very expensive to walk back, and buying in is one of the most significant financial and professional decisions a physician ever makes. Due diligence replaces assumption with verified facts on both sides: the candidate learns what they are buying and what they will owe, and the practice proves with documents, not assurances, that the numbers behind the buy-in are real. Full disclosure before the transaction is executed is the cheapest protection either side will buy against a dispute after closing.

7 | WHY THE OWNERS SHOULD WELCOME THE REQUEST

The candidate who asks for the whole package is behaving like a partner already

THE OWNERS' FRAME

- **A thorough buyer is the partner you want** — serious, methodical, committed to making an informed decision.
- **Healthy numbers speak for themselves.** A well-run, financially healthy practice is easily conveyed by the practice's own documents.
- **Silence costs the practice the candidate.** Buyers who cannot get the information they need walk away or drag the process out.
- **Full disclosure is the owners' own protection** against post-closing disputes.
- **Openness sets the foundation** the practice will run on for years.
- **The trust test.** If the owners hesitate to share detailed information beyond the exclusions the agreement names, that hesitation says the candidate cannot be trusted — and a physician who cannot be trusted with the numbers should not be made a partner.

"Trust is important in any partnership, but it is not a substitute for verified facts."
PMI, *Why Due Diligence Matters Before You Buy Into a Pediatric Practice*

SCOPE · INTERNAL BUYER, NOT AN ACQUIRER

- **This is the internal-buyer version.** The PMI checklist is geared toward a physician buying into an existing independent practice.
- **A third-party entity acquiring or investing** in the practice runs a far more extensive scope — do not size this request against that one.
- **The candidate is already inside.** Much of the operating picture has been visible for years; the request is for the documents behind it.
- **Transparency is the practice's case.** It shows strength, speeds the transaction, protects the practice legally and starts the partnership honestly.

WHAT THE PACKAGE SETTLES

- **The buy-in math** — the candidate has run it and can restate it, initialed against the worked example (readiness checklist, page 2).
- **The liabilities** — the candidate has seen the practice's liabilities and accepted attachment, on a signed schedule (readiness checklist, page 2).
- **The four buy-in questions (next page),** answered in writing: price method · payment structure · timeline and track · rights conveyed.
- **Symmetry.** The method that prices the way in prices the way out, with a worked example for every signatory.
- **What it does not settle:** the admission vote. Diligence informs the decision; the agreement's threshold still makes it (the owners' vote, readiness checklist page 2).

8 | WHAT THE PRACTICE SHOULD BE PREPARED TO SHARE

One row per category of the PMI checklist — every item, condensed; the full checklist is at www.PediatricSupport.com

CATEGORY	ITEMS · CONDENSED FROM THE PMI DUE DILIGENCE CHECKLIST	MOST LIKELY TO HAVE READY TO SHARE
Financial records & performance	P&L statements, 3–5 yrs · balance sheets, 3–5 yrs · federal and state tax returns, 3–5 yrs · A/R aging · A/P aging · revenue by payer (commercial, Medicaid, self-pay) · monthly revenue and collection trends · outstanding debt and lines of credit · capital-expenditure history and upcoming needs · bank statements, last 12 months	The accounting system and the CPA · managing partner
Practice valuation	independent valuation report · methodology (DCF, market comps, asset-based) · goodwill calculation and rationale · tangible-asset inventory and appraisals · asking price vs. industry benchmarks	Independent valuation firm · managing partner
Legal structure & governance	operating / partnership agreement or bylaws · ownership structure and equity % · decision-making and voting provisions · profit-distribution method · buy-sell agreement and triggers · non-compete and non-solicitation · articles of incorporation / organization · recent board or partner minutes	Practice counsel · corporate minute book
Payer contracts & revenue cycle	major payer contracts and fee schedules · renewal and termination dates · pending or recent payer audits (requests and results) · overpayment demands or recoupments · credentialing status, every provider, every payer · value-based / incentive program participation, metrics and history · billing and coding compliance audit history	Contract file and credentialing binder · practice manager, billing lead
Patient panel & operations	active patient count and 3-yr trend · new patients per month · retention and attrition · referral sources and relationships · daily visit volume by provider · no-show and cancellation rates · patient satisfaction results	PM system reports · practice manager
Staffing & employment	physician and APP employment contracts · staff roster with roles, tenure and compensation · benefit obligations (health, retirement, PTO) · pending or recent HR complaints or litigation · staff turnover · independent-contractor agreements	HR and payroll files · practice manager
Malpractice & litigation	current policy and limits · claims-made vs. occurrence · tail-coverage obligations · all claims, open and closed · pending lawsuits or regulatory actions · NPDB reports for all providers	Carrier declarations · each provider's NPDB self-query · manager
Real estate & facilities	leases and terms · renewal options and escalators · personal guarantees on leases · fair-market rent review if a partner is the landlord · facility condition and upcoming maintenance / renovation · zoning and regulatory compliance	Lease file · landlord · managing partner
Regulatory compliance	HIPAA program documentation · OSHA records · CLIA certificate (if lab) · state licensure and DEA registrations · OIG exclusion checks for all staff · compliance training records	Compliance binder · compliance officer or manager
Technology & infrastructure	EHR contract, details and costs · practice-management software · IT infrastructure and cybersecurity · telehealth platform and utilization · upcoming technology capital needs · backup and disaster-recovery plan	Vendor contracts · IT vendor · practice manager
Exit & transition provisions	buyout formula and terms on departure · mandatory hold period before sale of interest · non-compete on exit · disability and death provisions · dispute resolution (mediation, arbitration) · transition timeline and onboarding plan for the new partner · AR payout basis at departure (vaccine drug and lab revenue in or out)	The agreement · practice counsel
Transaction key provisions	stock vs. asset purchase · up-front payment vs. paid over time · disposition of cash in bank at closing · disposition of A/R at closing · new partner's right or requirement to buy into practice-owned real estate	Term sheet · counsel and CPA on both sides

9 | WHAT STAYS OUT OF THE PACKAGE

Reasonable has an edge — the candidate is an employee with HIPAA obligations, not yet a partner

PATIENT DATA STAYS OUT

- **No protected health information, no patient-identifiable data** — not charts, not claim-level detail, not a panel roster.
- **De-identified and aggregate reports answer every question the package asks** — counts, trends, rates, revenue by payer.
- **Clinical access is not diligence access.** Treating a patient is not permission to review the panel as a buyer.

STAFF, NOT PERSONNEL FILES

- **Roles, tenure and compensation are in.** Staff members' personal and medical information is out.
- **HR matters travel as summaries** — the existence, status and exposure of a complaint or claim, not the file.
- **Physician and APP contracts are in,** because the buyer is buying the obligations inside them.

THE PARTNERS' OWN FINANCES

- **The practice's returns are in.** Other partners' personal tax returns and personal finances are not.
- **Practice money that reaches a partner is in** — compensation, distributions, related-party rent, payments to a vendor a partner owns.
- **A partner who is also the landlord** discloses the lease and a fair-market rent review, not a personal balance sheet.

WHAT THE AGREEMENT RESERVES

- **Some documents are reserved to admitted partners** until admission — that is a legitimate boundary when the agreement says so.
- **Name the boundary in writing, then hold it.** Give every exclusion its own line in the index with one sentence of reason; a listed exclusion reads as governance, one withheld quietly reads as a problem.
- **Do not invent boundaries for convenience.** "Reserved to partners" has to point at a legitimate reason.
- **If a reserved document sets the price,** it stops being reserved. No buyer can accept a number produced by a document they are not allowed to read.

10 | PROPOSED STRUCTURE TO SHARE DOCUMENTS

One indexed folder mirroring the twelve categories — every document dated and version-stamped

ONE INDEXED FOLDER
- **Twelve subfolders, the categories of section 8,** numbered in the same order so both sides cite the same index.
- **Date and version-stamp every document.** Two versions of a fee schedule in one folder is how a diligence file becomes an argument.
- **The agreement sits on top.** The operating or partnership agreement is the rulebook for the candidate's investment — put it first, not last.
- **One point of contact,** named in writing, for every question about every folder — normally the managing partner or the practice manager.

SIGN THE CONFIDENTIALITY AGREEMENT
- **Yes, even though the candidate is an employee.** The package carries partner-level detail no employee has seen — compensation across the group, payer rates, guarantees, claims history.
- **Signed before the first folder opens.** It costs nothing and settles the question once.
- **A routine boundary, not a sign of distrust.** Deliver the package after the confidentiality agreement is executed.
- **One agreement protects everything shared.** A properly drafted and signed confidentiality agreement protects the practice for all information shared, across every folder.

MOST OF IT IS ALREADY BUILT
- **Already on the shelf from Phases 2 and 3:** T12M margin reports per provider · the published overhead rate · chart-closure and complaint logs · coverage and call records · incentive history.
- **Already owed to the candidate:** the worked buy-in example (readiness item 6) and the liability disclosure schedule (readiness item 7).
- **What is actually new** is the legal, payer, facility and regulatory side — the folders a clinician has never had a reason to open.
- **Build the missing folders once.** They are the same folders the practice will need at the next admission.

	FOLDER INDEX · MIRRORS SECTION 8	READY	DATED	OWNER		FOLDER INDEX, CONTINUED	READY	DATED	OWNER
01	Financial records & performance				07	Malpractice & litigation			
02	Practice valuation				08	Real estate & facilities			
03	Legal structure & governance				09	Regulatory compliance			
04	Payer contracts & revenue cycle				10	Technology & infrastructure			
05	Patient panel & operations				11	Exit & transition provisions			
06	Staffing & employment				12	Transaction key provisions			

11 | THE EXCHANGE

Deliver by a date, in writing — take the follow-up questions in writing and answer them in writing

SET A DATE AND PUT IT IN WRITING
- **Name the delivery date** for the standard package, in writing, when the request arrives.
- **Follow-ups in writing, answered in writing,** each with its own date. A verbal answer to a diligence question is not an answer.
- **"We'll get to it" is the failure mode.** It is what makes a buyer walk or stretch the process out.
- **No day count is standard,** and none is implied here — what matters is that a date exists, both sides know it, and the practice meets it.

ADVISORS ON BOTH SIDES
- **The candidate retains their own** healthcare attorney and a CPA experienced in medical practice transactions.
- **The practice uses its own.** Shared counsel on a buy-in is how both sides end up unrepresented.

"Both parties benefit when the transaction is grounded in facts, transparency, and professional guidance."
PMI, *Why Due Diligence Matters Before You Buy Into a Pediatric Practice*

WALK THE BUY-IN MATH TOGETHER
- **Against the worked example** already in the package, line by line, until the candidate can restate it (readiness item 6).
- **Affordability is the reality check.** What the practice earns, less what the incoming partner must take home and what operations cost, is the residual available for debt service — and debt service prices the deal.

THE FOUR BUY-IN QUESTIONS, IN WRITING
- **1 · Price method.** The valuation standard, applied the same way to every admission and every exit.
- **2 · Payment structure.** Salary differential, practice-financed note, bank financing or equity in lieu of bonus — tax character modeled by both sides' accountants first.
- **3 · Timeline and track.** Stated associate period, objective criteria, named admission vote threshold.
- **4 · Rights conveyed.** Voting, distributions, sale-proceeds participation, FTE thresholds.

LIABILITIES ON A SIGNED SCHEDULE
- **List them and have the candidate sign** — readiness item 7 closes here.
- **What goes on the schedule:** practice debt and lines of credit · personal guarantees on leases and loans · buyouts of former partners still being paid · open claims and audits.
- **Attachment is not optional** — and the allocation formula belongs in the agreement, not in the conversation.
- **Disclose the ones that will end,** too. A buyout being paid off changes what the new partner is actually joining.

THE SEQUENCE	WHAT HAPPENS	WHAT GOES IN WRITING
1 · The request arrives — or the owners open the Phase 4 discussion	Usually as a list, or as a question about price. Read it as the candidate stepping into the owners' chair, not as a challenge to answer.	An acknowledgment naming the delivery date and the single point of contact
2 · Index, then acknowledge	Build or refresh the twelve folders; date and version-stamp every document; put the agreement on top.	The folder index, shared · a signed confidentiality agreement before the first folder opens
3 · Deliver in one piece	The whole standard package at once. A package delivered in fragments reads as a package being managed.	A transmittal listing what was sent, and what was excluded and why
4 · Follow-ups	Questions in writing, answers in writing, each dated. A verbal answer to a diligence question is not an answer.	A running question-and-answer log both sides can see
5 · Advisors review	The candidate's healthcare attorney and CPA work the package; the practice's own advisors work the same documents.	Comments and redlines routed through the single point of contact
6 · The buy-in walk-through	Price method, payment structure, timeline and track, rights conveyed — and the symmetry principle said out loud.	The four answers, plus the worked example initialed by the candidate (readiness item 6)
7 · Liabilities, then the vote	Debt, guarantees, buyouts still being paid and open claims disclosed; then admission at the agreement's threshold.	The signed disclosure schedule (readiness item 7) · minutes recording the vote (readiness item 8)

12 | SIGNALS ON BOTH SIDES

How each side handles the package is itself the last piece of diligence

TRAP · OWNERS WHO STALL
- **The pattern:** repeated follow-ups, documents that never arrive, "we'll get to it", a package delivered in pieces with no date attached.
- **What it costs.** The buyer walks away or drags the process out, and the practice loses the candidate it spent years developing.
- **What it signals** — either the numbers will not survive review, or the owners do not intend to share control. Neither reading is recoverable later.
- **Read the pattern, not a single delay.** One late document with a new date promised is housekeeping. Several late documents with no dates promised is the owners' answer: they do not intend to share.

THE CANDIDATE WHO ASKS FOR NOTHING
- **A buyer who runs no diligence is not showing owner thinking.** The physician who reads the business, not just the schedule, reads it here too (section 3).
- **Hand over the package anyway** — unasked, indexed, complete — and watch what comes back.
- **Read the response, not the silence.** Questions about overhead allocation, payer renewal dates, guarantees and the buyout formula are the questions an owner asks.
- **No questions at all is data,** and it belongs in the admission discussion alongside the readiness checklist.
- **Deferral is still on the table** — a reasoned wait with a written interim plan beats admitting a physician who never looked (section 6).

CLOSING THE LOOP
- **The package is the last riser before Phase 4.** Readiness items 6 and 7 close here — the buy-in math restated, the liabilities seen and accepted.
- **Then the vote,** at the admission threshold the agreement names (readiness item 8).
- **The top step is a starting line, not a finish line.** What is disclosed now is what the new partner helps carry.

"Buying into a pediatric practice is one of the most significant financial and professional decisions a physician will ever make."
PMI, *Why Due Diligence Matters Before You Buy Into a Pediatric Practice*

BEFORE ANYTHING IS SIGNED. This card is general guidance, not legal, financial or accounting advice. Both sides should retain a qualified healthcare attorney and a CPA experienced in medical practice transactions before making any investment decision — the practice's own advisors included. The full PMI Due Diligence Checklist, with a notes column for tracking status item by item, is at www.PediatricSupport.com.