

WHITE PAPER

# Assessing Intangible Value in a Physician Practice Acquisition

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**Introduction** Due in large part to concerns over healthcare reform and declining reimbursement rates, physicians are increasingly looking for opportunities to sell their practices to hospitals and work as employees. Similarly, hospital systems are interested in acquiring key practices to solidify or expand their provider networks. These transactions are clearly subject to the regulatory restrictions of commercial reasonableness and Fair Market Value (“FMV”) imposed by the Stark Law<sup>1</sup> and the Anti-Kickback Statute (“AKS”)<sup>2</sup>, as well as the Internal Revenue Code Section 501(c)(3) regulations if the hospital is a not-for-profit entity.

Many practices have very low or sometimes negative projected post-transaction earnings after adjusting for the physician’s anticipated post-transaction compensation. Accordingly, an Income Approach valuation methodology, such as the Discounted Cash Flow (“DCF”) method, will generally result in zero or a very low value for the practice. In such cases, the Cost Approach will be utilized instead. However, the problem arises when the Cost Approach results in substantial values being attributed to intangible assets,<sup>3</sup> such as physician workforce, that are not supported by an appropriate level of net cash flow needed to provide an economic return to the hypothetical buyer.

This paper addresses the appropriateness of assigning substantial value to intangible assets such as physician workforce, under the FMV standard, and going concern premise of value, without such amounts being appropriately supported by net cash flow under the Income Approach. The paper first defines the key terms used and describes typical intangible assets, then looks at the theoretical underpinning of the Cost Approach as described in accepted valuation texts and court cases, then examines, critiques and ultimately dismisses the sole use of the Cost Approach to value physician workforce as both a violation of professional standards and the regulatory structure for FMV.

<sup>1</sup>42 U.S.C. Sec. 1395nn

<sup>2</sup>42 U.S.C. Sec. 1320a-7b

<sup>3</sup>There are certain specifically identifiable assets (such as a Certificate of Need or EMR systems) that may have value even in the absence of DCF value to the existing owner.

**Key Concepts & Definitions** The following key concepts and definitions are important for understanding the analysis and conclusions expressed in this paper.

**Commercial Reasonableness** Transactions between hospitals and physicians with the ability to refer designated health services (“DHS”) must be commercially reasonable. The Stark regulations explain commercial reasonableness as: “An arrangement will be considered commercially

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reasonable, in the absence of referrals, if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty, even if there were no potential designated health services referrals.”<sup>4</sup>

Accordingly, the commercial reasonableness requirement means the transaction must make good business sense *without* the potential of future referrals from either party.

<sup>4</sup>69 Fed. Reg. 16093 (March 26, 2004)

**Fair Market Value** The most widely used definition of FMV is: *“The price at which property or service would change hands between a willing buyer and a willing seller, neither being under a compulsion to buy or sell and both having reasonable knowledge of the relevant facts.”*<sup>5</sup>

The Stark regulations define FMV similarly as: *“The value in arm’s length transactions, consistent with the General Market Value.”* General Market Value (“GMV”) is defined as: *“The price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of the acquisition of the asset or at the time of the service agreement.”*<sup>6</sup>

<sup>5</sup>Estate Tax Reg. 20.2031.1-1(b); Revenue Ruling 59-60, 1959-1, C.B. 237

<sup>6</sup>420 CFR 411.351. See also: Section 1877(h)(3) of the Social Security Act.

**Strategic Value** In contrast to FMV, strategic value is the value to a particular buyer rather than to a hypothetical buyer. There are a variety of strategic considerations that a specific buyer may employ in determining strategic value, some of which would likely not violate the Stark Law and others of which almost certainly would. For example, a tax-exempt hospital would have access to tax-exempt bonds to acquire a practice, providing a low cost of capital and a correspondingly higher multiple of value. It would also not pay any income tax on income from the practice if the transaction were properly structured resulting in a higher cashflow and strategic value. Although they do not violate the Stark law, these two items likely violate the anti-inurement rules. When compared to a hypothetical nonhospital buyer, a hospital obtains various inpatient referrals from a physician practice, of course, but consideration of these referrals directly or indirectly is prohibited.

**Income Approach Valuation Methodology** The Income Approach is a general way of determining an indication of value based on the future income (benefits) expected to be generated by the asset. This approach is based on the fundamental valuation principle that an asset's worth is directly related to the present value of the future benefits of ownership.

The most common Income Approach methodology is the DCF method, which discounts anticipated future net cash flow to present value by using a discount rate that reflects the time value of money and the risk associated with the asset.

The Income Approach is generally used to value operating companies that produce positive cash flow under the going concern premise of value.


**Cost Approach Valuation Methodology** The Asset Approach, which is also commonly referred to as the Cost Approach,<sup>7</sup> is a general way of determining an indication of value based on the entity's underlying assets and liabilities. This approach is based on the theory that an asset's worth is directly related to the amount that would be required to reproduce or replace it. The Cost Approach generally results in an upper limit of value for assets that can be easily replaced or reproduced, since no prudent investor would pay more for an asset than the cost to create a comparable one. Similarly, no prudent investor would pay to create an asset that would not generate an income return under the regulatory structure commensurate with the outlay that is allowed.

<sup>7</sup>The terms are used interchangeably.

<sup>8</sup>Hitchner, James R., *Financial Valuation Applications and Models*, John Wiley & Sons, Inc., 2003, p. 13.


**Intangible Asset** Intangible assets are non-physical assets, such as trademarks, patents, securities, contracts, and goodwill that have rights and provide economic benefits to the owner.<sup>8</sup>

**Goodwill** Goodwill is a type of intangible asset that is related to the entity's name, reputation, customer loyalty and similar factors not separately identified.<sup>9</sup> Assembled workforce is generally considered to be an integral part of goodwill and not identifiable as a separate asset.<sup>10</sup>

Typical Physician Practice Assets – Least Controversial to Most Controversial 

1. Furniture & Equipment
2. Accounts Receivable
3. Leasehold Improvements
4. Trade Name
5. Telephone Numbers
6. Patient Charts
7. Non-Physician Workforce
8. Physician Workforce

<sup>9</sup>Ibid.

<sup>10</sup>See Statement of Financial Accounting Standards No. 164, *Not-for-Profit Entities: Mergers and Acquisitions*, paragraph A54; the IRS may recognize assembled workforce as a separate intangible when there is a DCF value to support it. 

### The Context for Valuing Physician Workforce

While the proper premises of value to apply may be debated, there is little argument that tangible assets such as furniture and equipment and accounts receivable have some value in this context. Reasonable minds may differ on the proper treatment or value of intangible assets such as trade name and telephone numbers – intangible assets that may often be differentiated because they possess the potential for being both legally protectable and separately marketable.

Other intangible assets or economic phenomena that may not meet the definition of an intangible asset are of particular concern as you move further along in the list. Some appraisers make the mistake of not only assigning value to these items in the absence of cash flows, but also in attaching value to something that may not be an asset in the first place. In their book, “Valuing Intangible Assets,” Robert Reilly and Robert Schweihs note that, in order for an intangible asset to exist from a valuation perspective, it must include the following:

1. “It should be subject to specific identification and recognizable description.
2. It should be subject to legal existence and protection.
3. It should be subject to the right of private ownership, and the private ownership should be legally transferable.
4. There should be some tangible evidence or manifestation of the existence of the intangible asset (e.g., a contract, a license, a registration document, a computer diskette, a listing of customers, a set of financial statements, etc.).
5. It should have been created or have come into existence at an identifiable time or as the result of an identifiable event.
6. It should be subject to being destroyed or to a termination of existence at an identifiable time or as the result of an identifiable event.”<sup>11</sup>

It is in this area that we see some valuations incorrectly assign value to phenomena such as a workforce in place where no legal right exists, such as in the case of a physician without an employment agreement

<sup>11</sup>Valuing Intangible Assets. Reilly, Robert F. and Schweihs, Robert P. McGraw-Hill (New York, 1999), p. 5.

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or the non-physician workforce of a physician practice in an at-will employment state.

The disparity of treatment and the rather large magnitude in associated value, however, approaches darker shades of gray as you approach the physician workforce in place. Our attempt here is not to minimize the need to properly treat each of the tangible and intangible asset classes, but the most controversial asset in this context also happens to be the item that some appraisers are attaching the greatest magnitude of value to – the physician workforce. When practice acquisition valuations based on the Cost Approach imply intangible value attributable to physician workforce in the observed range of \$50,000 to more than \$400,000, there is cause for concern over the validity of the valuation analysis and the intentions of the parties.

**Example** The argument for the attachment of significant value to the physician workforce in place arises out of a legitimate business consideration for hospitals in some scenarios. The scenario goes something like this:

Hospital X's CEO in a two hospital town relies almost exclusively on Heart Group, the only cardiology group of substance in the area, to generate volume (i.e., referrals) for Hospital X's cardiology line of business. Heart Group currently splits business between Hospital X and Hospital Y. Heart Group informs both Hospital X and their competitor, Hospital Y, that they want to entertain the sale of their practice and employment. Faced with the potential loss of the cardiologists that generate all of the volumes in the cardiology lines of business at his hospital, Hospital X's CEO argues that if he doesn't buy Heart Group, he'll have to recruit and employ physicians to practice at Hospital X – absorbing recruiting costs and significant losses in the process. To further complicate the fact pattern, Hospital Y has retained a valuation firm that values these costs to recreate the physician workforce at \$300,000 per physician despite that firm's analysis that there will be little to no cash flow from the cardiology practice after paying the cardiologists' salaries. Hospital X's CEO is really left with no choice, they feel they must at least match their competitor's offer.

As is explained in more detail on the coming pages, the sole reliance on the Cost Approach to value intangible assets is generally inappropriate. Whether the intangible assets are related to payments for physician

workforce, noncompete agreements or compensation, they must be viewed in the context of an even exchange between the parties with no benefit, directly or indirectly, ascribed to referrals. In the absence of an expectation of income from the acquired physician practice, the only source of income necessary to meet the FMV standard is from future referrals associated with that practice.

### **A Review of the Significant Issues**

Among the many problems with relying solely on the Cost Approach to value intangible assets related to an on-going business enterprise is that it is inconsistent with valuation theory and the valuation guidance offered by the Stark Regulations. While not necessarily exhaustive, the following is a list of the significant issues that would all need to be resolved favorably in order to attach significant value to the physician workforce in place.

1. Assuming a hospital can be considered the typical or likely buyer is inconsistent with both the classical and regulatory definitions of FMV.

One argument often cited as a reason for hospitals paying for a physician workforce is the avoidance of costs related to recruiting and employing such physicians in order to meet their community need. The momentum of many of the concepts associated with healthcare reform such as bundled payments and accountable care organizations (“ACOs”) generates additional support for the business case for hospital employment of physicians. Given that hospitals will likely need to employ physicians and provided there are strong contractual relationships in place to secure it, there is little question or argument that securing a physician workforce in place brings strategic value (as distinguished earlier herein from FMV) to a hospital in that it allows a hospital to precede the costs associated with recruiting and ramping up a physician workforce. However, this is inconsistent with both the classical and regulatory definitions of FMV in the context of the acquisition of the assets of a physician practice since those assets must be shown to generate income and that income must not be proscribed by applicable regulations. For business appraisals performed in the context of hospitals purchasing physician practices, healthcare regulations and statutes require any transaction to occur at FMV.

As stated earlier, FMV is classically defined as the price at which an asset would exchange between a willing buyer and a willing seller, neither being under compulsion to buy or sell, each having reasonable knowledge of all

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relevant facts, and with equity to both. Based on the guidelines established by the Stark II regulations, we typically expand our definition of FMV to encompass GMV, which is the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement (42 C.F.R. 411.351) and where the compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals and where the arrangement would be commercially reasonable even if no referrals were made to the employer.<sup>12</sup>

Given the definition of FMV, the practice of simply assuming that a hospital is avoiding a significant cost by simply paying for a physician workforce or that a hospital should be considered the most likely buyer of the physician practice appears to be somewhat inconsistent with the classical definition of FMV in that there is some compulsion for hospitals to buy physician practices. Even if one is somehow able to get comfortable with being consistent with the classical definition of FMV, the assumption that a hospital is the only typical or likely buyer of a physician practice appears to be even more directly inconsistent with the further restrictions under Stark II that the assumed buyer not be in a position to benefit from the business generated by the seller.

2. Replication cost as a valuation methodology has significant weaknesses, and its use to value the physician workforce is inconsistent with all premises of value other than going concern.

A book looked upon as an authoritative text in the valuation profession is *Valuing a Business: The Analysis and Appraisal of Closely Held Businesses.*<sup>13</sup> Chapter 14 provides guidance to appraisers in conducting the Cost Approach. According to the authors, conducting the Cost Approach requires the appraiser to not only choose the proper standard of value, but also to choose the proper premise of value. The four premises of value delineated include:

<sup>12</sup>42 C.F.R. 411.351  
and 42 C.F.R. 411.357(c)

<sup>13</sup>Valuing a Business: The Analysis and Appraisal of Closely Held Businesses, Shannon P. Pratt, 4th Edition

- Value in continued use as part of a going concern;
- Value in place as part of a mass assemblage of assets;



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- Value in exchange, as part of an orderly disposition; and
- Value in exchange, as part of a forced liquidation.

Based on generally accepted interpretations of the guidance provided by this authoritative text, the only of the four premises of value above that would ultimately result in any significant value for the physician workforce in place is value in continued use as part of a going concern. According to the authors, “Under this premise, it is assumed that the subject assets are sold as a mass assemblage and as part of an *income producing* (emphasis added), business enterprise.”<sup>14</sup> The assumption that the practice is income producing is in complete contradiction to the reasoning used to rely exclusively on the Cost Approach. As previously discussed, relying exclusively on the Cost Approach is a function of the fact that considering the proposed compensation arrangement with the physician(s), there is either no income or at least not enough income to justify any value over and above the value of the tangible assets.

The weaknesses of the Cost Approach in differentiating what has value and what does not have value are not limited to physician workforce. Michael Crain, CPA/ABV, ASA, CFA, a well-known and highly regarded member of the appraisal community observes:

“Some criticize the Cost Approach by arguing that the evidence of a relationship between cost and price is weak and, thus, the Cost Approach is not a reliable way to estimate the value of something. One example of weak relationships is the decline in real estate prices in the late 2000s. It is conceivable that the costs of building some homes were higher than their market prices. Further, these downward price movements were weakly correlated with the costs of building a home. *A closely-related argument is that the Cost Approach is overly simplistic and can violate the first principle of valuation that says the value of something is the expected future benefits expected from it, discounted to the present. This principle links value to future returns whereas the Cost Approach has strictly a historical perspective.*” (Emphasis added)

“Another argument criticizing the Cost Approach is that it assumes that if a firm develops something, it is valuable. We know from theory and observation that firm managers use trial and error in their operations. Simply put, some things managers do work and some

<sup>14</sup>Ibid, Chapter 14, page 314

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do not. *The Cost Approach is unable to distinguish between the costs of successful and unsuccessful efforts.*<sup>15</sup> (Emphasis Added)

The 2008 Tax Court case *Derby*<sup>16</sup> specifically addresses the Cost Approach issue for tax-exempt hospitals and related entities. Although the valuation in that case was a misuse<sup>17</sup> of the Income Approach, the principle that FMV constitutes an even exchange between hypothetical buyer and seller is the same.

“The Dutcher appraisal takes no account of the \$35,000 ‘Physician Access Bonus’ payable to each SWMG physician over the initial 2 years of the affiliation. Ignoring these payments when computing distributable earnings that SWMG would generate results in a overstatement of those earnings and a corresponding overstatement of the value of SWMG’s intangible assets (since, under Mr. Dutcher’s analysis, intangible asset value equals present value of future distributable earnings, less tangible assets and implied working capital).”

The point here, of course, is not limited to the physician access bonus. Any transaction involving the purchase of a medical practice must consider all the elements of that transfer in determining whether the transaction meets the FMV standard, as modified by the Stark law. This includes post-transaction compensation in addition to the purchase price and contractual terms.

“Petitioners have not shown that the value of what they transferred to SMF exceeded the value of the benefits they received in return. As noted above, those benefits included, in the first instance, employment that was compensated with shares of revenue (47 to 57.75 percent) that significantly exceeded the median share of revenue (45.18 percent) devoted to physician compensation in petitioners’ specialties; a \$35,000 ‘Physician Access Bonus’ for each SWMG physician, including petitioners; an absence of restrictions on establishing a competing medical practice in the event of cessation of employment with SMF; and greater economic security in the managed care environment.”

<sup>15</sup>Michael A. Crain, “Study Guide, Business Valuation for Forensic Accountants” (working paper, School of Accounting, Florida Atlantic University, 2010) used with permission.

<sup>16</sup>T.C. Memo. 2008-45

<sup>17</sup>Given the Court’s detailed rejection of the assumptions utilized.

3. Financial reporting, court cases and other guidance point to *allocating* value to workforce in place, not separately valuing it.

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Similarly, it should be noted that while using replication costs to estimate the value of the workforce in place is widely accepted in valuation texts and other sources of guidance when allocating value, it is not necessarily sanctioned as proper for assigning value in the Cost Approach. Nowhere is this more clear than in the application of the Financial Accounting Standard Board's Statements on Financial Accounting Standards ("SFAS"). Citing SFAS 141, Valuation for Financial Reporting notes that, "SFAS 141 specifically prohibits the recognition of assembled workforce as an intangible asset apart from goodwill" (Michael J. Mard, 2002). The IRS has also offered several pieces of guidance regarding the valuation of physician practices. One of the often referenced pieces of guidance used for valuation of physician practices is Valuing Physician Practices (Charles F. Kaiser, 1996). It should be noted that while this article discusses at length the value of various tangible and intangible assets such as equipment, trade name, patient charts and workforce in place utilizing cost to recreate in an the Cost Approach, the context is clearly one *of allocating the value obtained from the Income Approach* (DCF method) and not one of using the Cost Approach in isolation.

#### 4. Ability to terminate without cause may limit ability to protect value.

In the previous phase of physician practice transactions, many of the employment agreements included terms of five or more years without the ability for either party to terminate without cause. In addition, many of the employment agreements included trailing covenants not to compete, that combined with inability to terminate without cause, made it not only virtually impossible for either party to terminate the agreement during the initial term, but also extremely difficult for the physicians to remain in a community following the initial term, absent employment with the hospital. One feature in the current phase of physician practice transactions that distinguishes it from the previous phase is that, in many cases, the employment agreements permit either party to terminate the employment agreement without cause with only 90 to 180 days notice, with no restrictions on future competition. This is certainly not always the case. However, if the subject employment agreements include the ability to terminate without cause and permit a physician to remain in the community, the potential inability to legally protect the physician workforce beyond the rolling 90 to 180 day virtual term of the employment agreements should be considered.

The Tax Court case *Derby* specifically addresses this issue for tax-exempt hospitals and related entities. Failure to follow these principles raises

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the specter of the Intermediate Sanctions Provisions and anti-inurement provisions of the Internal Revenue Code, particularly with the post-reform emphasis on disclosure in Form 990 – and the public access to those forms, including by potential *qui tam* plaintiffs and their attorneys.

“There is no adjustment for the fact that the SWMG physicians were not required to execute noncompete agreements. Mr. Dutcher treated each SWMG physician as transferring an allocable share of SWMG’s intangibles, including goodwill, which was not treated as diminished in any way by the physicians’ not having executed noncompete agreements with respect to SWMG or SMF. However, in *Norwalk v. Commissioner*, T.C. Memo. 1998-279, we found that there is no transferable or salable goodwill where a company’s business depends on its employees’ personal relationships with clients and the employees have not provided covenants not to compete... *We also believe that, under the willing buyer/willing seller standard of FMV enunciated in Rev. Proc. 59-60, 1959-1 C.B. 237, to which Mr. Dutcher purportedly adhered, a willing buyer of SWMG on the transaction date would have insisted on a significant discount with respect to the value of the entity’s intangible assets, precisely on account of the absence of noncompete agreements from the SWMG physicians. Indeed, the SWMG physicians not only did not execute noncompete agreements; they had the benefit of the “free to compete” provision in the PSA which facilitated their reclaiming their patients in the event they decided to cease working for SWMG/SMF. Mr. Dutcher’s failure to account for the risk to his estimated 5-year stream of earnings posed by SWMG physicians’ departing with their patients is contrary to well-established valuation principles and common sense, and results in an inflated value for the SWMG physicians’ goodwill.*” (Emphasis added)

“... and rather than a noncompete agreement, the ‘free to compete’ provision, which secured for each petitioner the express right, upon his or her termination of employment with SWMG/SMF, to have his or her patients as of the date of affiliation with SMF notified of the departure and given the option of having the patient’s medical records transferred to the departing physician. In addition, when petitioners’ circumstances before the transaction are considered, a second tier of benefits they secured in the transaction with SMF becomes apparent. First, petitioners solved their core economic problem arising from the advent

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of managed care; namely, the risk of loss from having patients requiring extraordinary care. After the transaction, by virtue of the minimum compensation guaranties, this risk was largely transferred to SMF, which could better manage it given SMF's greater patient population and resources. Second, as a result of their affiliation with a relatively large health care organization, petitioners secured the benefits of greater leverage in negotiating contracts with HMO's and greater efficiencies in providing care, with any resulting enhancement in revenues inuring to their benefit by virtue of SWMG's compensation being determined as a percentage of net revenues. In sum, by transferring their practices to SMF in the transaction at issue, petitioners ensured for themselves the continued ability to maintain or improve their accustomed level of earnings from the practice of medicine—something they had concluded was not likely to be possible had they continued to maintain solo or small group practices.”

The example described earlier of a hospital relying upon a single heart group for admissions parallels to a large extent the recent *qui tam* case *Bradford Regional Medical Center* in which the Federal District Court for Western Pennsylvania granted summary judgment to the *qui tam* plaintiffs on violations of the Stark Law. That case involved the “lease” of a nuclear medicine camera from two internists who were responsible for a significant share of the hospital's high tech imaging, inpatient and outpatient referrals. There, the hospital was confronted with the loss of the nuclear medicine scans which severely restricted its ability to recruit a cardiologist. Further risk apparently existed with respect to the possibility that the physicians might acquire their own MR or CT scanner, both of which have cardiac applications.

Part of the court's analysis was that the record indicated that the defendant hospital had clearly considered the volume and value of referrals in the price paid for the nuclear medicine camera sublease, *which price included a noncompete agreement*. As such, the valuation prepared in connection with that sublease was irrelevant, since the FMV exception could only be used if the sublease did not consider referrals in the first instance. Further, the valuation also discussed loss of referrals, and there the definition of FMV was not consistent with the modifications of the Stark law.

5. Lack of any evidence indicating hospitals could sell physician workforce back for any significant value.

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Another key to valuing physician practices is consistent treatment of controversial items, regardless of which party is on the buyer side and which party is on the seller side. We believe collectively performing hundreds of valuations for both potential purchases from physicians and sales to physicians provides a balanced perspective to approaching these issues. We are not aware of a single instance, even in situations where enforceable employment agreements and covenants exist, where hospitals have successfully sold a physician workforce to the physicians. The accepted method for establishing the value of a noncompete covenant is to use the Income Approach.

6. Analyses typically include no consideration for physician age, need to amortize the asset.

Like #4, another concept that may often be ignored in assigning value to physician workforce is that of inevitability – it is inevitable that eventually the physician workforce must be replenished and the employer will incur the costs associated with recruitment and ramp up. In this sense, any cost to recreate the physician workforce is simply a present value exercise. Ignoring the other five factors or even assuming an appraiser is comfortable with their ability to successfully navigate the mine field, this must be considered.

**Conclusion** Under the FMV standard of value, there is no basis for exclusive reliance on the Cost Approach in valuing intangible assets in general and physician workforce in particular when there is no expectation of income from the underlying assets of a going concern. The professional literature of valuation theory that serves as the basis for FMV provides no support. Additionally, the commercial reasonableness requirement under the Stark law that a transaction make sense in the absence of referrals would almost assuredly be violated by paying for physician workforce without such values being adequately supported by cash flows under the Income Approach. Given that both the economic value and the FMV of an asset is the present value of expected future benefits of ownership, implicit in the use of the Cost Approach – and in our view explicitly assumed – is income from the referrals to be received.

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