



CREG Healthcare | Provident
Healthcare Partners

Capital Real Estate Group | Healthcare Investment Banking

AN EDUCATIONAL WHITEPAPER • 2026

When Private Equity Exits, Your Real Estate Stays Behind

**What physician-owners of both a
practice and a building need to know
— before either transaction closes.**

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EXECUTIVE SUMMARY

For physician-owners who hold both a practice and the real estate it occupies, a transaction is not one decision — it is two. The practice has its own buyer universe, its own valuation methodology, and its own advisory process. So does the building. When each is handled by specialists working in coordination, the physician captures full value from both. When the two are bundled, or addressed sequentially, value is reliably left behind.

This whitepaper is built around a straightforward thesis: engaging a healthcare investment banker and a specialized real estate advisor in parallel — early in the process, before either transaction is underway — is the single most effective way for a physician-owner to maximize the total outcome from both assets.

Key Finding

In our experience, physicians who engage independent, specialized advisors for both the practice and the real estate consistently realize materially more value from the real estate component than those who bundle the transactions or allow the practice buyer to determine real estate terms.

Physician-owners who engage a specialized real estate advisor and a healthcare investment banker in parallel — before either transaction closes — are consistently better positioned to maximize value in both of their key assets: the practice and the building.

Provident Healthcare Partners advises physician-owners on the practice side — from initial strategic assessment through partner selection, diligence, and closing. CREG Healthcare advises on the real estate side — from lease structuring through competitive institutional marketing and closing. This paper reflects what both advisory teams see across the transactions they work on together: the coordination dividend is real, measurable, and available to any physician who engages both advisors early enough.

This whitepaper covers:

- The current physician practice transaction market — who is buying, what specialties command the strongest interest, and how buyer type affects the real estate decision
- Why the practice and the real estate must be treated as separate transactions with separate advisors
- The window of maximum real estate value and how to capture it
- The coordination dividend — what happens when both advisory processes are aligned
- What institutional buyers of medical real estate are paying in 2026
- How to build the right advisory team for both transactions



1.

THE PHYSICIAN PRACTICE TRANSACTION MARKET IN 2026

PE Has Pulled Back — But the Buyer Universe Is Broader Than Ever

In 2021, private equity firms completed 851 acquisitions of physician practices across the United States. By the first half of 2026, that pace has fallen to approximately 105 PE-led transactions — a contraction driven by higher interest rates and compressed exit markets.

But the headline number obscures an important reality: the overall market for physician practice transactions has not collapsed. It has evolved. Health systems, large publicly traded companies such as payors and drug distributors, and other strategic buyers have become increasingly active acquirers — in many cases competing aggressively for high-quality groups and paying multiples that rival or exceed what PE was offering at its peak. The physician who assumes the market has broadly softened may be leaving a significant transaction opportunity on the table.

Why Specialty Mix Drives Valuation More Than Anything Else

Physician practice valuations in 2026 are highly specialty-specific, and the macro PE narrative does not capture the full picture. Buyer appetite and transaction multiples vary dramatically depending on the specialty, subspecialty mix, payer profile, growth trajectory, and ancillary revenue of the group:

- Cardiology, urology, oncology, gastroenterology, and orthopedics are seeing strong strategic and PE interest, with multiples frequently reaching into the teens for well-positioned groups.
- Vision care outcomes are highly subspecialty-dependent — a group with retina typically commands a meaningfully higher multiple than a general ophthalmology practice, even within the same market.
- Retail-oriented business models, such as urgent care, can see a wide range of multiples depending on geography and same-store growth, with strategic buyers stretching into teens multiples for uniquely positioned businesses.
- Primary care organizations are often valued utilizing metrics other than a multiple of EBITDA, as the number of patient lives covered drives strategic interest.

Physician practice valuations are nuanced to the specific group and sector — the specialty mix, the payer profile, and the competitive process run by the M&A advisor will ultimately dictate value. An experienced healthcare investment banker understands which buyer types are active in which specialties and structures a process that captures the full range of interest.



How Buyer Type Affects the Real Estate Decision

The type of buyer who acquires a practice has direct implications for how the real estate transaction should be structured. A large publicly traded health system may approach lease negotiations differently than a PE-backed platform or a regional strategic acquirer. Some buyers have internal real estate teams; others defer entirely to their legal counsel. In each case, the dynamic is the same: the buyer's economic interest is in minimizing occupancy cost, and the physician's economic interest is in maximizing the building's investment value. These interests require separate representation — regardless of who the buyer is.

The physician who has already engaged a real estate advisor — and structured the lease independently before the practice buyer arrives — retains negotiating leverage that the physician who waits does not. This is true whether the practice is sold to PE, a health system, or a publicly traded strategic. The window of real estate value does not stay open waiting for the practice deal to close.



2.

TWO MARKETS, ONE DECISION — WHY THEY MUST BE TREATED SEPARATELY

The Physician's Unique Position

Before a practice sale, a physician-owner of both a practice and the building it occupies holds a position that is genuinely rare in commercial real estate. The physician controls both sides of the landlord-tenant relationship. The lease terms, the rent level, the lease structure — all of it is within the physician's power to set or restructure before any buyer arrives.

This control is the most valuable and most overlooked asset in the entire transaction. It exists only during the window between when the physician begins exploring a sale and when the practice sale closes. Once the practice sale closes, a new tenant is in place — one with its own advisors, its own rent benchmarks, and its own economic interest in keeping occupancy costs low.

How the Practice Sale Changes the Real Estate — Permanently

Once the practice sale closes, here is what changes:

- The new tenant has its own advisors, legal team, and rent benchmarks — and will negotiate the lease from a position of strength.
- The building's value becomes a function of whatever lease terms were agreed to during the practice transaction — not what the market would have supported if negotiated separately.
- The physician loses the owner-occupant premium that institutional buyers of medical real estate specifically seek and pay for.
- Rent set at the low end of fair market value during the practice sale can permanently impair the building's value by hundreds of thousands or millions of dollars.

After Practice Sale (Typical)

- Lease terms set by buyer's team
- Rent set at the low end of FMV — minimizing practice overhead at the expense of building value
- Short initial term or flexibility provisions for tenant
- Building valued at cap rate assigned to the lease
- Physician negotiates alone against professional deal team
- One buyer: the practice acquirer or their preferred REIT

Before Practice Sale (Optimal)

- Lease terms set by independent real estate advisor
- Rent independently established at the favorable end of FMV, NNN structure, documented appraisal
- 10-15 year NNN lease, limited landlord obligations
- Building marketed competitively to institutional buyers at peak value
- Physician represented by specialist healthcare RE advisory firm
- Multiple institutional bidders in competitive process — 250+ outreach

The Math of Below-Market Rent

Consider a physician who owns a 40,000 RSF medical office building. Market rent, based on comparable healthcare leases in the submarket, is \$28 per square foot NNN — \$1,120,000 per year in NOI to the landlord.

The practice sale closes. The buyer's team negotiates rent at \$22 per square foot — at the low end of what can be characterized as fair market value, designed to minimize the practice's occupancy cost. Annual NOI: \$880,000. The physician accepts this because the practice multiple looks compelling and real estate feels secondary. Note: buyers in healthcare transactions involving physician referrals are required to set rent within a fair market value band under Stark Law — but FMV has a range, and how that range is determined, and by whom, matters enormously.

When the physician later tries to sell the building, institutional buyers price it on the NOI the lease produces. At a 6.5% cap rate:

- At \$28 PSF rent: Building value = **\$17,230,000**
- At \$22 PSF rent: Building value = **\$13,538,000**
- Value difference from a single rent negotiation: **\$3,692,000**

A rent negotiation settled in days during a complex practice transaction determined over \$3.5 million of real estate value. This is precisely why independent real estate representation — concurrent with the practice advisory process — produces a materially different outcome.



3.

THE WINDOW OF MAXIMUM VALUE

Why Timing Is Not Optional

There is a specific window in every practice transition when the physician's real estate value is at its absolute peak. That window opens when the physician begins seriously exploring a practice sale and closes — usually permanently — when the practice sale closes or the new tenant takes over the lease.

During that window, the physician holds something institutional real estate buyers genuinely cannot find anywhere else: a healthcare property where the owner controls all lease terms, where the building comes with a committed long-term healthcare tenant on day one, and where the sale can be positioned as a true sale-leaseback with the credibility of an active operating practice behind it.

The Three Timing Scenarios

A

SCENARIO

Real Estate Marketed Before or Alongside Practice Sale (Optimal)

The physician engages a specialized healthcare real estate advisory firm at the same time as — or before — engaging a practice M&A advisor. The real estate team structures an institutional-quality lease, markets the building to 250+ institutional buyers through a competitive process, and closes either before or concurrent with the practice sale. Physician captures full owner-occupant premium. Total transaction value maximized across both components.

B

SCENARIO

Real Estate Addressed After Practice Sale (Common, Suboptimal)

The practice sale closes first. Lease terms are set during the practice deal — reflecting the buyer's interests, not the real estate market's requirements. When the physician later markets the building, institutional buyers underwrite the lease as it exists. The owner-occupant premium is no longer available. Value relative to Scenario A is permanently impaired.

C

SCENARIO

Real Estate Addressed Much Later or Not at All

The practice sale closes. The buyer assumes or negotiates the lease. The physician discovers years later that the building was undervalued, that lease terms preclude a clean institutional sale, or that the opportunity to run a competitive marketing process has long since passed.

The single most common response from physicians who did not engage a real estate advisor before their practice sale: "I didn't realize my building was worth that much, and I didn't realize the lease terms would matter so much to buyers."

4.

THE COORDINATION DIVIDEND

Why Two Independent Advisors, Working Together, Outperform One

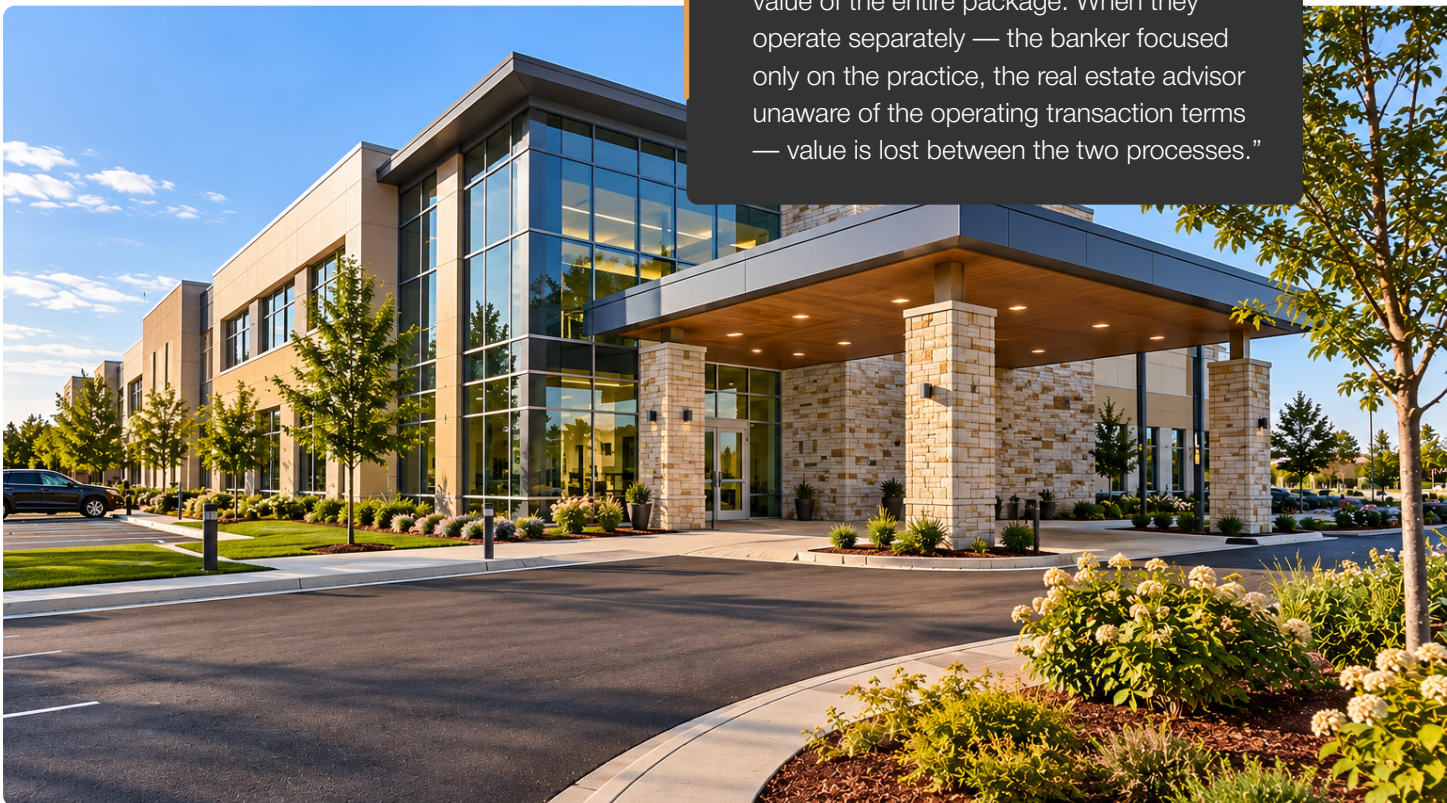
The principle is straightforward: the M&A advisor and the real estate advisor each run their own independent process, but they coordinate on the decisions that sit at the intersection of both. The coordination dividend is the additional value that emerges from that intersection — and it belongs to the physician.

The most important intersection is the lease. The rent established in the lease by the real estate advisor directly affects the practice's EBITDA — and therefore the value assessed by the M&A advisor. If rent is set without considering applicable valuation multiples and capitalization rates, significant value may be left on the table. The rent that maximizes real estate value is not always identical to the rent that maximizes practice EBITDA — and the optimal outcome requires both advisors to understand the other's math.

Similarly, the lease terms required by the practice buyer become key drivers of the real estate's value. If those terms are negotiated by the M&A advisor and legal counsel without input from the real estate advisor, the property's future value and marketability may be constrained before it is ever offered for sale.

Transaction sequencing also requires coordination. Selling the practice and the real estate simultaneously, or in deliberate sequence, has different implications for taxes, valuation, and the marketability of both assets. The physician who selects a path without evaluating all three dimensions may find it more costly than any individual negotiation point.

“When the advisors work together, the owner is better positioned to maximize the value of the entire package. When they operate separately — the banker focused only on the practice, the real estate advisor unaware of the operating transaction terms — value is lost between the two processes.”



The Optimal Process — Step by Step

- Step 1: Physician engages both practice M&A advisor and real estate advisor simultaneously — typically 12-24 months before target closing
- Step 2: Real estate advisor completes BOV and lease analysis; M&A advisor begins practice valuation and buyer identification in parallel
- Step 3: Both advisors align on rent structure: the rate that maximizes real estate value while preserving or enhancing practice EBITDA multiples
- Step 4: Institutional-quality lease executed between physician entity and practice entity — at market rent, proper NNN terms, 10-15 year initial term
- Step 5: Building marketed to 250+ institutional buyers through competitive sealed-bid process; practice marketed to PE and strategic buyers simultaneously
- Step 6: Both transactions negotiated in parallel — real estate advisor and M&A advisor aligned on timing and sequencing
- Step 7: Both transactions close: physician receives optimal value from each independently maximized process

The physician who closes both transactions correctly does not leave money on either table. The practice buyer gets a clean, arms-length lease. The real estate buyer gets an institutional-quality asset with a creditworthy healthcare tenant. The physician captures full value from both.



5.

WHAT INSTITUTIONAL BUYERS ARE PAYING IN 2026

The Healthcare Real Estate Buyer Universe

Despite the broader commercial real estate challenges of 2022-2025, healthcare real estate has maintained a distinct institutional buyer class that does not compete in office, retail, or multifamily: healthcare REITs, net-lease funds, and institutional separate accounts focused on medical assets. These buyers are actively acquiring physician-occupied medical real estate in 2026.

The reason is structural. Healthcare utilization continues to shift from inpatient hospital settings to outpatient physician-owned facilities. The demographic wave of aging baby boomers is driving sustained demand for specialty medical services. Institutional investors who understand this dynamic allocate to physician-occupied healthcare real estate because the fundamental demand drivers are insulated from the economic cycles that affect other property categories.

Current Cap Rate Ranges by Property Type

Property / Lease Profile	Typical Cap Rate Range (2026)
Single-tenant MOB, NNN lease, 12+ year term	6.6% – 6.9%
Ambulatory Surgery Center, NNN lease, 12+ years	6.4% – 6.7%
Multi-tenant MOB, strong anchor tenant	6.0% – 7.0%
MOB adjacent to major health system campus	5.75% – 6.25%

The lease structure — not the building itself — is the primary driver of where in these ranges a property prices. A building generating \$700,000 in annual NOI from a properly structured 12-year NNN lease trades at \$10.1M to \$10.6M at current cap rates. The same building with a below-market modified gross lease generating \$530,000 in NOI trades at \$7.6M to \$8.8M. The lease negotiation, not the real estate market, determines \$1.5M to \$3M of value difference on a single asset.

What Competitive Marketing Adds

CREG Healthcare's experience across \$2 billion in healthcare real estate transactions consistently demonstrates that competitive bidding processes — where 250 or more institutional buyers receive the offering simultaneously — generate materially higher prices than direct negotiations with a single counterparty.

A physician who accepts the first institutional offer without running a competitive process should assume they have left a meaningful percentage of value on the table. In our experience, that percentage ranges from 8% to 22% depending on market conditions and asset quality. The institution making a direct approach is not doing so to pay maximum price.



6.

COMMON MISTAKES THAT COST PHYSICIANS MILLIONS

MISTAKE

01

Treating the Two Transactions as One

The practice and the real estate are two separate assets with two separate buyer universes and two separate optimal processes. Treating them as one — or allowing the practice transaction to set the terms for the real estate — almost always optimizes one component at the expense of the other. The physician who engages independent advisors for each, with coordinated timing, routinely captures 15-25% more total value than the physician who accepts a bundled approach.

MISTAKE

02

Allowing Lease Terms to Be Set Without Independent Real Estate Representation

Healthcare transactions involving physician referrals require that rent be set within a fair market value band under Stark Law — but FMV has a range, and that range can span hundreds of thousands of dollars on a single asset. Practice buyers have a direct economic interest in landing at the low end of that range. Every dollar of rent reduction that stays within FMV shifts value from the building to the practice — in the buyer's favor. The physician who allows this determination to happen without an independent real estate advisor is ceding significant negotiating leverage on one of the most consequential variables in the transaction.

MISTAKE

03

Accepting a Direct Offer Without a Competitive Process

Healthcare REITs and institutional buyers routinely approach physicians directly, offering to acquire a building at what appears to be a fair price. In the absence of a competitive process, there is no way to know what fair means. Competitive bidding among 250+ simultaneous buyers generates materially higher prices than direct negotiations with a single counterparty — consistently, and regardless of how credible the initial offer appears.

MISTAKE

04

Starting Too Late

Optimal real estate transaction timing is typically 12-24 months before a practice sale — not concurrent with it, and not after. Starting early allows the real estate advisor to identify lease adjustments that will maximize institutional buyer interest, execute those changes before the marketing process begins, and run a full competitive process without the time pressure of a pending practice closing. The physician who begins the real estate conversation at the same time as the practice sale conversation has options. The physician who begins it after the practice deal is signed has whatever the market will pay for the asset as it currently exists.

MISTAKE

05

Engaging Advisors Sequentially Instead of in Parallel

The coordination dividend only accrues when both advisors are in the room at the same time. An M&A advisor who has already negotiated lease terms before the real estate advisor is engaged has inadvertently constrained the real estate's value. A real estate advisor who markets the building without understanding the practice transaction's timing and structure may create complications for the M&A process. Parallel engagement, with deliberate coordination at the points of intersection, is what produces the optimal outcome for both assets.

7.

BUILDING THE RIGHT ADVISORY TEAM

The Core: M&A Advisor and Real Estate Advisor

The decision to sell is rarely about a single skill. It is a coordinated effort across specialists, and the value comes as much from how they work together as from what each does alone. The two most critical advisors in a physician practice transition that involves real estate are the healthcare M&A advisor and the healthcare real estate advisor. Both must be engaged early — and both must understand what the other is doing.

The Real Estate Advisor — CREG Healthcare

CREG Healthcare (Capital Real Estate Group) is a national advisory firm that exclusively represents physicians in the sale of clinical real estate to institutional buyers. With \$2B+ in completed physician real estate transactions and 50+ years of combined team experience, CREG brings specialized expertise in lease structuring, competitive institutional marketing, and closing physician-owned medical office buildings and ambulatory surgery centers.

CREG does not represent buyers. Every engagement is on the physician's side of the table — running competitive processes among 250+ institutional buyers simultaneously to capture the premium that physician-occupied medical real estate commands in this market.

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The M&A Advisor — Provident Healthcare Partners

Provident Healthcare Partners is a nationally recognized healthcare investment banking firm with over two decades of experience advising physician-owned practices through mergers, acquisitions, and private equity transactions. Provident brings dedicated healthcare M&A expertise — from initial strategic assessment through partner identification, valuation, diligence, and closing.

For practice owners evaluating a transaction involving a private equity firm, health system, or strategic buyer, Provident educates owners on the full range of transaction structures, evaluates the strengths and tradeoffs of each option, and guides the organization through the process. Senior-level attention throughout — not handoffs to junior staff.

Offices in Boston, Minneapolis, and New York | providenthp.com

The Coordination Dividend — Why Both Must Work Together

The reason these advisors must work together is that the most important decisions often sit at the intersection of their responsibilities. The rent established in the lease by the real estate advisor directly affects the practice's EBITDA — and therefore the value assessed by the M&A advisor. The lease terms required by the practice buyer become key drivers of the real estate's value. Transaction sequencing affects taxes, valuation, and the marketability of both assets.

When the advisors work together, the owner is better positioned to maximize the value of the entire package. Effective coordination is therefore essential to achieving the strongest overall outcome for the physician.



CONCLUSION

EVALUATE THE WHOLE PACKAGE, TOGETHER

The physician who owns both a practice and a building holds two assets that are individually valuable, jointly complex, and together capable of producing a generational wealth outcome — if handled correctly. In this environment, the real estate component is not a secondary consideration. It is often the most improvable variable in the entire transaction.

The solution is not complicated. It is a coordinated advisory team — one that understands both the practice and the real estate, runs two independent competitive processes, and coordinates on the decisions that determine value across both. That coordination is the difference between a good transaction and an optimal one.

Provident Healthcare Partners and CREG Healthcare have been involved in physician practice transitions that demonstrate this coordination dividend. The physicians who engage both advisory teams early — before the practice buyer arrives, before the lease is negotiated, before the window closes — capture value that no amount of after-the-fact optimization can recover.

The real estate is not a footnote to the practice sale. For most physician property owners, it is the most improvable variable in the entire transaction. The question is whether you engage the right team to improve it — or accept the default outcome.

Let's Evaluate the Whole Package, Together

If you own both your practice and the real estate it occupies and are considering a transaction, both teams are available for a confidential conversation — separately or together.

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