

Quarterly Supplement To  
**Business, Legal,  
And Tax Planning  
for the Dental Practice**

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The purpose of the Quarterly Supplement is to continually update the material contained in **Business, Legal, And Tax Planning for the Dental Practice**, Second Edition, as "free-standing" articles relative to current business, legal, tax and pending legislative matters that affect your practice. These Quarterly Supplements also reflect my ongoing experiences as an attorney representing dental and dental specialty practices. At times, articles will be written by friends who consist of tax attorneys, accountants, actuaries and dentists. The articles contained in the Quarterly Supplements are consistent with the chapters contained in my book, which I hope you will purchase after reading this Supplement if you haven't already.



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**FALL, 2005  
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## **PLANNING ASSOCIATE BUY-INS & OWNER BUY-OUTS**

Can co-ownership work? It can, provided that the parties deal with the key issues. Those issues are listed in Exhibit A. While co-ownership can be more rewarding than solo practices for purposes of coverage, efficiency (although in reality this is questionable) and another doctor to work with, it is clearly more complex.

Co-ownership works best for large and specialty practices. Large practices are difficult to sell in their entirety because no one or two doctors can complete all of the production. Therefore, these practices are transferred by way of associates being elevated to owners. Specialty practices generally have substantial demand for professional services and new owners can often be admitted without the existing owner(s) incurring a drop in compensation.

### **Why Do Co-Ownership Arrangements Fail?**

As a former dental equipment and supply salesman of almost 17 years, I remember the dental groups of the mid-1970's that did not survive into the 1980's. From my observations, those co-ownership relationships failed and continue to fail today for the same reasons. These reasons are listed in Exhibit B. If the reasons for co-ownership failures are considered in addition to the key issues above, the arrangement should prove successful. Time will tell! As an observation, I find it interesting that the reasons for successful co-ownership are different from the reasons why co-ownership arrangements fail.

### **Succession and Entry Options**

The available exit and practice options are: (a) a complete sale; (b) hire the associate with a complete sale in one to two years; (c) enter into a solo group arrangement; (d) enter into co-ownership; or (e) work for an additional one to two years and close the practice. The incoming doctor has one additional option, which is to establish a practice. Prior to entering into a co-ownership relationship, the practice owner should examine all options in light of what the practice owner wants in life and how long and how many days per week that the practice owner would choose to work. Please note that while a practitioner may now be in a co-ownership relationship, it could fail and the practice owner should have a second tier of "succession" plan in place should that happen.

If you are or will be in a co-ownership relationship, your "partner(s)", co-shareholder(s) or associate doctor(s) should agree to be obligated to buy the practice owner out upon the earlier of death, permanent disability or election to retire on or after a specified future date. The two succession problems here are: (a) the incoming partner has no need to buy-out the senior owner once the incoming owner has reached full revenue capacity; and (b) the partners may be approximately the same age and plan to retire within a short time of each other. If co-ownership is contemplated, the practice owner should make it clear to the associate that the future buy-out obligation is mandatory.

If you plan to practice with another doctor roughly the same age, understand well in advance that continuous increases in revenues will be required to ultimately hire, train and mentor two or more replacements, who desire to practice with each other. As an alternative, solo group arrangements can allow each group practice owner to hire an associate and sell such doctor's respective practice interest at an appropriate time. Thereafter, each new practice owner would be a party to a solo group arrangement. However, just because two or more group practice owners are roughly the same age, does not mean that each doctor will desire to sell his or her practice interest at the same time.

With a minimum of 15 years for a practice owner to plan for his or her succession, the difficulty of candidate selection and completion of the succession process should be less stressful than otherwise. What is an interesting and healthy trend is that professionals are not completely retiring, but continuing to work on a reduced schedule. Continued work should not present a problem, assuming that the practice valuation and timing of payments consider the continuation of work on a reduced schedule, post-closing, of the practice sale. Nevertheless, the continued employment or engagement of the retired doctor should be within the control of the remaining doctor(s). Therefore, if you, as the senior owner, believe that you need to remain in practice because you need the income, don't know what you will do with your time or for other reasons, then don't retire.

### **Solo Group Arrangements**

By the late 1970's, Dr. Jim Pride, founder of Pride Institute, recognized the failures of group practice, particularly where the remaining doctor(s) were left in the costly facility that the departing doctor(s) left when the high producers would leave. As a result, the solo group arrangement was developed as a more desirable practice form than group practice. In my view, it remains so today.

In a solo group, the associate is hired and works through the associate period that is based upon the associate attaining and maintaining predetermined quality and performance standards. The patients treated by the incoming doctor during this period become the new doctor's "developing patient base". The associate acquires the associate's developing patient base for a purchase price equal to its "goodwill" value. The associate also acquires an "undivided interest" in the jointly used dental equipment, office equipment, furniture, supplies and instruments at the fair market or "in place" value. The tangible assets used only by the associate are purchased in their entirety for their fair market value. The doctors then operate their respective practices separately, and share the services of certain staff members, the practice facility and operational expenses under the provisions of an office sharing arrangement. The office sharing arrangement designates whether the various expense categories are equally shared or paid pro-rata on the basis of respective of practice productivity. Additionally, the office sharing agreement should provide who remains and who leaves the practice location in the event of a dispute.

The new practice owner(s) would also be a party to the facility lease and if the facility is owned by the founding practice owner, a separate right of first refusal, option or mandatory real estate purchase agreement at a later date may also be entered into.

The respective practices and owners would also be parties to a buy-sell agreement. The buy-sell agreement would provide for the mandatory purchase of the assets of a deceased or disabled owner's practice, with an optional purchase of the assets of a retiring owner's practice. In the event that the remaining practice owner would not elect to acquire the retiring owner's practice, such doctor would have the right to sell his or her practice to a third party dentist, provided that the dentist is licensed in the particular state. Any departing practice owner would be permitted to relocate his or her practice, provided that such relocating practice owner would continue to pay his or her rent obligations under the facility lease. Each practice owner would retain the right to hire an associate subject to the provisions of the office sharing agreement that designates use of the facility.

If one practice owner relocates or does not sell his or her practice interest to the remaining practice owner, the buy-sell agreement would provide for the mandatory purchase of such departing or relocating owner's interest in the jointly owned tangible assets at fair market or in place value.

Although retirement plan contribution calculations can be somewhat "cumbersome" to calculate for the shared employees, they can be properly allocated.<sup>1</sup>

The reasons why solo group arrangements work well are first, the associate always purchases his or her developing patient base or goodwill for fair market value. Second, the respective practice owners keep their "noses" out of each other's checkbooks and business. Finally, such an arrangement recognizes that the practice owner's associate today may have little interest in purchasing the second half of the practice in the future, once such doctor becomes sufficiently busy as an owner.

## **Joining the Practice**

### **Associate Employment**

Unless the practice is planning to hire a permanent associate, the practice owner should make sure that his or her succession plan is in place, the valuation is completed and the tax and business structure of the succession plan is specifically delineated prior to the new doctor commencing employment. This is particularly important where the associate will later be admitted as an owner. If the succession plan is properly designed for the practice owner in advance of hiring the associate, both parties will understand their future relationship, assuming that the associate period is successful. If it is not, a failed associateship should not change the practice owner's succession plan and a new candidate would be considered.

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<sup>1</sup> Business, Legal, And Tax Planning for the Dental Practice, Second Edition, PennWell Books, 2001, William B. Prescott, M.B.A., J.D., page 98.

In the event that the incoming doctor desires to review any tax, financial or other confidential information relative to a particular practice, the candidate should be required to sign a written confidentiality letter prior to such information being provided.

From the practice owner's perspective, the first step is to complete a thorough interview of qualified candidate(s). This may include the use of personality profiling and testing tools. The candidate's background and references should then be investigated pursuant to a written release. Upon accepting a written employment proposal, the associate doctor signs a written employment agreement that sets forth compensation and any bonuses, benefits, duties, responsibilities, work schedule and on-call responsibilities, vacations and other time-off, payment of malpractice, continuing education and other expenses and termination of employment.

Four additional comments on associate employment are worth mentioning. First, associate bonuses should not generally be productivity based; they should be discretionary in order to measure the associate's total contribution to the practice in light of its cash and financial position. Measuring only productivity completely misses quality of work, effort, working relationships with staff members, patient responsibility, community efforts to further develop the practice, among other things. A discretionary bonus forces the practice owner to communicate with the associate doctor and rate him or her on a multitude of factors, inclusive of productivity, and justify the outcome.

Second, given the profitability of the particular practice in light of the market for or availability of quality candidates, the practice must earn an administrative profit on the associate. An overpaid associate is a disaster to future ownership. If the practice owner(s) does not earn an administrative profit of roughly 15% from the associate, there will be insufficient profitability to admit the associate as a future owner. Because the associate will not desire to take reduced compensation as an owner, the only available revenue to pay for the future ownership is the "spread" between owner compensation in all forms and associate compensation. This is why practice profitability is so important to future associate ownership.

Practice management consultants can be instrumental and extremely helpful in system development, staff training, computer integration, goal setting, fee determination, coding, insurance documentation, revenue enhancement and many other factors. With the assistance of the management consultant, each owner should take the initiative to become a leader of and learn how to ultimately manage the practice. Like any other business expenditure, the management consultant should provide the practice with a return on investment. An improved bottom line assists in allowing any associate to grow into an ownership role.

Finally, no associate begins work until the associate employment agreement is signed. Failure to sign the employment agreement can make any later agreed to non-competition/non-disclosure provisions null and void unless consideration, in the form of compensation or a bonus, is paid for the later promise not to compete.

## Associate Buy-In

The valuation of the practice in co-ownership or a group arrangement is identical to the valuation in a complete sale, except that the incoming doctor acquires a proportionate interest in the practice. For example, if the incoming doctor produces 50% of the doctor revenues, the incoming doctor may acquire a 50% interest in the practice. Alternatively, if the incoming doctor produces 25% or 33 $\frac{1}{3}$ % of the practice revenues, such incoming doctor may purchase a 25% or 33 $\frac{1}{3}$ % interest in the practice. In short, the interest acquired by the incoming doctor will often match his or her percentage of practice productivity. This allows the new doctor to both pay for the practice interest and not reduce compensation below the associate level, assuming that the practice is not overvalued.

Where two or more professionals desire to become co-owners, the mechanism to accomplish such a result is for the new doctor to acquire some percentage of the professional corporation's stock or an interest in the practice that operates as a limited liability company. If the practice operates as a sole proprietorship prior to co-ownership, the incoming doctor may acquire a proportionate interest in the assets of the practice and both or all owners would contribute such assets to a newly formed limited liability company or S-corporation. For those practices not already operating as professional corporations, the limited liability company format may provide for greater flexibility for admitting new owners and paying out departing owners than do professional corporations. The reason for this is that limited liability companies are permitted to be taxed as partnerships, yet provide the limited liability for the acts of other owners and employees in the same manner as do professional corporations. Additionally, the "check the box" tax regulations now provide greater flexibility than ever in entity selection. If the practice already operates as a professional corporation, there are usually negative tax affects associated with liquidation and then forming a limited liability company. However, this problem may be minimized in the future, pending the direction of the taxation on personal goodwill attributable to the shareholder(s) of a professional corporation.

Where the incoming doctor acquires stock in a professional corporation, particularly where the goodwill is included in the value, it can be burdensome for such doctor to make payments, as such payments are made in after-tax dollars. A solution is as follows. Balance of tax benefit to the seller who receives favorable capital gains treatment, with the tax detriment to the purchaser who pays for stock in after-tax dollars. Then adjust the purchase price of the stock to reflect the tax benefit to the seller and the tax detriment to the purchaser. A properly completed practice valuation should indicate what the incoming owner can afford to pay, within a measured time period, without reducing compensation and benefits. However, the valuation absolutely should be reviewed by the incoming owner's licensed CPA to ensure accuracy.

By valuing the stock at its fair market value inclusive of goodwill, the purchase price can be guaranteed under a promissory note and secured by a "pledge" of the incoming owner's stock under a pledge and security agreement. This assumes that there is some significant component of seller assisted financing as is typical in co-ownership arrangements.

Although the seller receives less for stock appraised at fair market value inclusive of goodwill because the purchaser pays the purchase price in after-tax dollars, the seller does receive capital gains treatment and security for payment of the purchase price. Additionally, by structuring the transaction in this manner, neither the seller nor purchaser need to be concerned with any recharacterization in the event of an audit. Finally, if the new owner leaves the practice, the departing doctor cannot argue that his or her interest did not include goodwill.

Historically, a mechanism has been used to admit incoming owners to professional corporations by valuing the professional corporation's stock at its "lowest reasonable value". The reason for this has been and continues to be to admit the new shareholder at the lowest possible "tax" cost, which results in a pretax buy-in. The incoming doctor(s) may receive disproportionately less compensation than the senior doctor(s) during the first few years of ownership. The effective result is that the new doctor's(s) interest is increased by compensation adjustments for the value of the personal services rendered to the professional corporation, over time.<sup>2,3</sup> For example, the new doctor(s) may be required to meet certain performance or productivity standards prior to sharing equally with the other doctor(s)/owner(s) in the compensation pool. Over five consecutive years, for example, the senior doctor(s) and new doctor(s) could allocate available compensation on the basis of: (a) seventy percent / thirty percent (70% / 30%); (b) sixty-five / thirty-five percent (65% / 35%); (c) sixty percent / forty percent (60% / 40%); (d) fifty-five percent / forty-five percent (55% / 45%); and (e) fifty percent / fifty percent (50% / 50%) in year five and thereafter. As an alternative, there may be a "guaranteed" bonus to the senior doctor(s) who is arguably worth more to the professional corporation than the new doctor(s). Assuming that the senior doctor(s) actually provides management and administrative services to the professional corporation, such doctor(s) could be compensated for such services pursuant to a management services agreement(s) with the practice. However, there is also a risk to the existing doctor(s) of not receiving the disproportionate compensation, as such payments should not be guaranteed by the incoming doctor(s).<sup>4</sup>

In the event of a dispute among doctors, a consideration is that the doctor who acquires a stock interest at its lowest reasonable value, coupled with the use of compensation adjustments, may argue that his or her interest is actually worth a higher fair market value.<sup>5</sup> The argument would be that the value of the professional corporation should now include goodwill. In the event that the new doctor(s) would leave the corporation's employ by way of a dispute, such doctor(s) could receive more upon the departure than he or she initially paid for the stock, irrespective of any buy-sell agreement that states otherwise.

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<sup>2</sup> Muskogee Radiological Group, Inc. v. Commissioner, T.C. Memo, 1987-490.

<sup>3</sup> Tax Planning For Corporations and Shareholders, Second Edition, Zolman, Cavitch, Lexis Publishing, Matthew Bunder & Company, Inc., 13.04[1], [2], [3].

<sup>4</sup> Technical Advice Memorandum 944003.

<sup>5</sup> Contemporary Obstetrics & Gynecology, Inc. (1996), 113 Oh. App. 3d 75.

If it is determined that the incoming doctor or practice pays a bargain price for the stock, either through the associate buy-in or in the owner buy-out process, there could be a significant problem. The difference between the price paid and the fair market value could be "recharacterized" to constitute ordinary income to the incoming doctor, not to mention other unpleasant difficulties, such as the compensation being recharacterized as non-deductible dividends to a professional C-corporation. One way to avoid this problem would be to ensure that any compensation paid to any shareholder/employee is reflective of the services actually rendered. The Pediatric Surgical Associates case<sup>6</sup> highlights the necessity that compensation to shareholder/employees of a professional C-corporation equate to the value of both professional and non-professional services actually rendered.

The Pediatric Surgical Associates case is not only relevant to the payment of dividends versus compensation through the efforts of non-shareholder employees, but also directly impacts any compensatory arrangements reflecting a younger doctor's increasing or older doctor's decreasing worth of the professional C-corporation. A "safe" approach in light of the Pediatric Surgical Associates case may be to: (a) pay a meaningful dividend each year; (b) document any and all non-professional services rendered by the professional C-corporation's shareholder/employee(s) and (c) value the professional corporation's stock at its fair market value and adjust the purchase price to reflect the tax benefit to the senior doctor receiving favorable capital gains treatment and the tax detriment to the incoming doctor in paying for stock and after-tax dollars. Forget about valuing the stock in its lowest reasonable value and the use of compensation adjustments, other than for the actual value of services rendered by the shareholder/doctor(s).

Some consulting companies promote that the practice owner should "tie" his or her succession plan to elevate an associate to owner in order to fund the senior owner's retirement plan. The idea here is that the incoming doctor receives less compensation than the senior owner for several years, with the excess compensation being contributed to the practice entity's retirement plan. Depending upon the age and income of the doctor/owners and staff, the benefit can be very significant to the senior owner. However, this mechanism is one "tool" in a large "toolbox" and is applicable only to a small number of practice owners. Yet, this mechanism is being promoted on a "wholesale" basis. The issues, as I see them, are listed in Exhibit C.

## **Operational Considerations<sup>7</sup>**

### **Allocation of Compensation**

Compensation, bonuses, fringe benefits and retirement plan contributions are usually allocated in one of five ways or through a combination as follows: (a) by the respective

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<sup>6</sup> Pediatric Surgical Associates, P.C. v. Commissioner, T.C. Memo 2011-81 (April 2, 2001)

<sup>7</sup> Reprinted, in part, from Business, Legal, And Tax Planning for the General Practice, Second Edition, PennWell Corporation, William P. Prescott, M.B.A., J.D., Chapter 6.

collections or productivity of one owner as a percentage of the collections or productivity of all owners; (b) by ownership percentage; (c) equally; (d) by management and administrative responsibilities; and/or (e) by the number of days, half-days or time spent working in the practice. Note that retirement plan contributions are based on total compensation by law and it is sometimes difficult for multiple owners to agree on the same plan design and funding level. Nevertheless, owners can be written out of a retirement plan by proper design, assuming that such owner(s) does not desire to make contributions.

The owner-employee or shareholder employment agreements allocate owner compensation and bonuses. Such agreements usually contain the similar provisions provided for in an associate employment agreement with the following exceptions: (a) the compensation is more generous for owners than associates; (b) the restrictive covenants are generally for a longer period of time for owners than for associates; (c) fringe benefits, expense and time-off policies are generally more liberal for owners than associates; and (d) it is usually more difficult to terminate the employment of an owner versus an associate.

### **Decision Making Control**

Decision making control casually be equally allocated among the owners or vested in one owner under the particular state's close corporation or shareholder agreement statutes. Please note that not every state has such a statute in effect. For those approximately sixteen states that do, the "founder" or owner can avoid the request of retaining a 51% ownership interest in the practice for maintaining control or the use of a separate class of stock for voting and non-voting interests. If the practice operates in corporate format under such a statute, operational control or the "tie-breaking" vote can be vested in the founder(s) or senior doctor(s) so long as such doctor(s) owns at least one share of the professional corporation's stock. Voting control can also be allocated to the other doctors in order of seniority or by some agreed upon method. For those practices operating as a limited liability company, management control can usually be allocated through the operating agreement, depending upon the state.

The incoming doctor(s), however, would usually desire to share equally in decision making or operational control of the practice. If not, the incoming doctor(s) should propose to reduce the practice value to reflect a "lack of control" discount. From the incoming doctor's perspective, any interest in the practice should be equal to any other owner, e.g., fifty percent in a two-doctor practice. Otherwise, the relationship is not a true "partnership" and perhaps should not be entered into.

Almost all associate buy-ins are internally financed, as any lender would require the practice as security. This would mean that the existing owner(s) would be guaranteeing the loan for the buy-in. While this is sometimes done, it is more likely that the associate buy-in will be internally financed. Assuming that the associate buy-in is internally financed or the loan guaranteed by the existing owner(s), then the existing owner(s) may retain decision making control in the practice until the buy-in is fully paid. This is an exception to equal ownership, as the interest has not yet been paid for. However, certain decisions would require the unanimous consent of all owners, e.g., the hiring of an additional dentist or specialist, expenditures over a

threshold amount, relocation of the practice and/or the acquisition of an additional practice. Thereafter, equal decision making control is acceptable, assuming that dispute resolution controls are built into the shareholder or operating agreements. An example of such a control would be a determination of who would remain in the practice location and who would relocate relative to any buy-out provisions in the event of a dispute.

### **Dispute Resolution**

Dispute resolution devices should always be in place in co-ownership arrangements and provide an important role in resolution of problems. Dispute resolution devices can also resolve voting control and decision making deadlock. The buy-sell agreement, close corporation or other shareholder or operating agreement for a limited liability company would typically contain one or multiple dispute resolution devices which would affect an owner's buy-out or departure from the practice.

For co-ownership to be successful, the shareholders, members or partners must commit to holding regularly scheduled board, member or partner meetings with a written, typed agenda to discuss practice business. Further, a yearly meeting should be held with a CPA and attorney and any other "key" advisors to summarize the current fiscal or calendar year and plan for the subsequent and future years in accordance with the written strategic practice plan.

### **Employment of Family Members**

While in certain situations, the employment of family member(s), e.g., an owner's spouse as office manager, in a co-ownership arrangement can work well, there are those situations where it does not. Employment of family member(s) should always be discussed prior to entering into the co-ownership arrangement.

### **Leaving The Practice<sup>8</sup>**

The buy-out of a departing owner(s) presents the single biggest challenge in co-ownership for continuance of future practice operations. As a general proposition, the structure and terms of the associates'(s) buy-in(s) should track the structure and terms of the owner'(s) buy-out(s).

### **Buy-Sell Agreements**

The buy-sell agreement should provide for the remaining owner'(s) or practice's mandatory or optional purchase of an owner's interest in the practice entity if a specified triggering event occurs. The decision between a mandatory or optional purchase and sale is often determined by the type of triggering event. An involuntary triggering event such as death, permanent disability or attaining a predetermined retirement age whereby the owner then elects to retire, typically would require a mandatory buy-out. Any other termination of employment

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<sup>8</sup> *Ibid.*

with the practice, voting deadlock or dispute may, but not always, provide for a buy-out at the option of the practice entity or the non-departing practice owner(s). Attached as Exhibit D is a matrix which describes those variables generally included in buy-sell agreements relative to triggering events, mandatory or optional buy-outs, payment terms and use of insurance for death or permanent disability.

The method of determining the price of a departing owner's interest may be the most difficult determination for the owners to agree upon, particularly where the shortage of doctors is reducing practice values. The purchase price would either be based upon a formula which would reflect future growth of the practice, depending upon the anticipated retirement date of existing practice owner(s), or would provide for a specified purchase price if the buy-out of the senior doctor is negotiated by the incoming doctor at the time of the buy-in. Both fixed values and formulas should be reviewed by the owners each year as an agenda item at the annual meeting with the lawyer and CPA for the practice.

The buy-out agreements are crucial to successful group practice or co-ownership. Keep in mind that group practice or co-ownership will not work if the incoming doctor(s) will not buy-out the retiring or departing doctor(s). The buy-sell agreement, possibly coupled with an agreement to acquire the personal goodwill of the departing doctor(s) or deferred compensation agreement should contain a formula to account for the future growth in the retiring or departing doctor's interest in the practice. If the entity practices in a limited liability company format, the buy-sell provisions of the operating agreement would provide a similar formula with an Internal Revenue Code Section 754 election in place for favorable tax treatment. In California or Hawaii, the limited liability company format is not yet permitted and such practice form would be maintained pursuant to a partnership. However, if the newly admitted owner departs, the collective buy-out agreements could grant an option to the new owner to practice outside of any restricted covenant area and be bought out for full fair market value, less any amounts owed to the existing owner(s). Alternatively, the new owner could elect to be bought out for fair market value of only the tangible assets on a pro rata basis and be permitted to contact those patients of record typically treated by such newly admitted owner within the restrictive covenant radius. It is important to note that a new owner who departs from the practice without buying out the senior owner(s) would not receive a "windfall". For example, an owner who leaves the practice without buying out the senior owner's(s) interest(s) would receive significantly less than an owner who meets the definition of retirement contained in the agreements and who elects to do so. However, the buy-out agreements may provide for mandatory retirement if an owner does not elect to retire by a specific age, e.g., age 65 or 70.

Each triggering event may utilize a different purchase price for the departing owner's interest in the practice. For example, it may be appropriate to adjust the purchase price downward where the practice owner voluntarily departs or quits. The list, below, describes various methods for determining the purchase price under a buy-sell agreement.

Book Value. Although this method is simple, it measures only tangible assets which were paid for, then only at their cost and not their fair market value. Additionally, book value does not value intangible assets, e.g., goodwill or going concern value.

Where book value is used, it is sometimes used in conjunction with a deferred compensation arrangement.

Agreed Value. A specific price or formula determined by agreement of all practice owners may be used. A buy-sell agreement using the agreed value method requires periodic updating. Further, self-executing mechanisms for adjusting the purchase price or formula when practice owners do not update the agreed value or cannot agree on an updated agreed value should be drafted into the buy-sell agreement. A common self-executing mechanism is one that adjusts the most recent agreed value by increasing or decreasing it by the percentage change in annual practice revenues since the last agreed value. A virtue of agreed value is its certainty.

Appraised Value. An appraisal of the practice owner's interest as of a specific date may be used. The purchaser and seller may each choose one appraiser and average the values or agree on a single appraiser. If the purchaser and seller each choose an appraiser, the buy-sell agreement sometimes provides for the two appraisers to select a third appraiser, whose appraisal is final and binding. While paying appraisers may be an expensive way of determining the value, it may result in the most accurate determination of true practice value. One problem with appraisals is that they take time to complete.

Earnings Capitalization. This method determines value by multiplying earnings by an agreed multiple. Specifically, first determine average earnings, less appropriate owner compensation, averaged for the prior three to five fiscal years of the practice. The average earnings are then capitalized at a rate or return which would be required by a knowledgeable investor familiar with the risks of the particular practice. The reciprocal of the capitalization rate is the price/earnings ratio, "P/E". For example, a capitalization rate of 20% equals a P/E of five times, and a capitalization rate of 25% equals a P/E ratio of four times. If the capitalization of earnings approach is used, the buy-sell agreement should define: (a) the capitalization rate; (b) weighted average earnings; and (c) any adjustments to be made to earnings.

Combinations. Because each of the foregoing valuation methods have their own benefits and detriments, a combination of the above-described approaches may be advisable.

If a cash transaction for the purchase of the practice interest is unrealistic, the payment terms would provide for the payment of the purchase price in installments over a period of time, e.g., 60 months. The length of the installments would be determined, in part, on the purchaser's ability to finance the purchase. However, cash buy-outs are becoming much more common than in the past, as the remaining owner(s) can pledge the practice as security. In such case, the departing or retiring doctor receives cash and has no risk of default, although there may be some issues with the alternative minimum tax that the retiring or departing doctor's CPA should consider and calculate. In a cash buy-out, either the purchase price will be for: (a) the stock or membership interest; or (b) the stock in the professional corporation at its lowest reasonable

value, with payment for personal goodwill to the retiring or departing owner outside of the professional corporation and arguably at favorable capital gains rates.

The use of the funding mechanism of life insurance or disability buy-out insurance influences payment terms where death and disability are triggering events. Typically, all insurance proceeds constitute the down payment and the remaining purchase price is paid in installments, over some affordable term.

It is not unusual for the triggering event to influence the length of installment payments. For example, a practice owner who voluntarily leaves employment may be paid off, if at all, more slowly than one who dies or becomes permanently disabled.

In addition, installment payments require that interest be paid at certain minimal rates to avoid imputed interest. For example, the buy-sell agreement could provide that the interest would be equal to two percentage points below the prime rate, but in no event shall the interest rate be less than the amount necessary to avoid the imputation of interest under the IRS.

If the purchase price is paid in installments, the seller must consider the type of security he or she desires for the installment payments. First, any promissory note should be cognovit, not subject to any defenses, if the particular state permits this. In addition, the remaining or new owner should personally guarantee the practice's installment payments for stock. Also, installment payments may be secured by a pledge of the ownership interest purchased. Further, it must be determined whether the terms should restrict the practice's ability to borrow money, make distributions to owners, participate in mergers, sell substantially all assets, etc. In other words, it may be reasonable for the buy-sell payment terms to include, in effect, loan covenants.

A typical device for funding buy-out in the event of death is life insurance. Any life insurance policy(s) should be periodically reviewed to ensure that it is appropriate in terms of amount for purposes of the buy-sell agreement.

In recent years, disability buy-out insurance has become more prevalent, available and less costly than in past years. In general, there is a one or two year waiting period of required disability before the disability buy-out insurance pays off. While disability buy-out insurance is more available and less costly than in the past, it is not usually available in amounts as large as life insurance policies. Nevertheless, it is a useful idea to help supply liquidity. Disability buy-out insurance may be payable in a lump sum or over a period of time, usually five years.

To ensure that the departing owner does not enter into direct competition following the buy-out, the buy-sell agreement should include non-competition provisions. In addition, the buy-sell agreement should include non-disclosure covenants, whereby the departing owner agrees not to disclose or use for any purpose any of the practice trade secrets or other confidential information, e.g., patient and/or referral source list(s). If the buy-out is paid over time, the payments would be discontinued in the event of a breach of the restrictive covenants.

## **Deferred Compensation Arrangements**

Payments for stock in a professional corporation are non-deductible for federal tax purposes. However, in certain circumstances and assuming certain tax requirements are met, payments for deferred compensation are tax-deductible to a professional corporation where utilized in the buy-out of an owner/shareholder in conjunction with the remaining shareholder(s) or professional corporation's purchase or redemption of stock.<sup>9</sup> Because a professional corporation is subject to the highest corporate tax rate, 35%, such payments would generate a 35% tax benefit to the corporation. However, the deferred compensation payments to a departing shareholder for services previously performed are ordinary income and are not taxed at the lower capital gains rates.

The triggering events under a deferred compensation arrangement would typically track the terms of the buy-sell agreement.

It should be noted that IRC Section 1060(e) may impose certain informational reporting requirements where deferred compensation and similar arrangements are utilized in connection with the sale of stock. Additionally, the Treasury Regulations provide that a "Top Hat Exemption Form" be filed with the Department of Labor within 120 days after any deferred compensation agreement is signed.<sup>10</sup> Although the Department of Labor has not typically audited deferred compensation plans, failure to file the Top Hat Exemption Form will result in penalties similar to the failure to file a Form 5500 for a tax-qualified retirement plan.

## **Buy-Out Obligation Problem or Opportunity?**

The associate becomes an owner and buys into the practice. In time, the new owner becomes very productive. When the senior doctor retires or otherwise departs from practice, the new owner probably has no desire to buy-out his partner, the senior shareholder. Assuming that the new owner does buy-out the senior doctor(s), the new owner must hire additional doctor(s) to "stand in his or her shoes", when he or she then stands in the "shoes of the senior doctor(s)". This is one significant reason why co-ownership arrangements can fail, as the buy-out of the senior doctor may be a tremendous burden. On the other hand, buying out the senior doctor can be a significant opportunity, as the new doctor replaces the retiring doctor with an associate who is paid less than was the departing owner.

## **Timing the Associate Buy-In**

The practice owner hires an associate in the practice who meets the practice owner's performance expectations. The practice owner wishes to retain that associate and recognizes that he or she may leave the employ of the practice if no opportunity for ownership is available. As a result, the associate acquires one-half of the practice.

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<sup>9</sup> Revenue Ruling 60-31; Internal Revenue Code Section 409A.

<sup>10</sup> Labor Reg. 2520.104-23.

The structure of this sale may be through a solo group arrangement, with each of you owning your respective practices, which is recommended. As an alternative, the structure may be through common ownership of the same practice, e.g., co-shareholders of a professional corporation or co-members of a limited liability company.

Five to ten years after the buy-in, the senior doctor elects to retire in accordance with prior plans. At such time, the associate has either the option or, hopefully, obligation, to buy out the senior doctor, as defined in the buy-sell agreement.

Now, the senior doctor has 50% of the practice to sell upon retirement rather than 100%. In addition, the profit that the practice owner hopefully made on the associate changed in character for payment of the first 50% of the practice.

In light of this situation, when should the associate be hired and when should the associate become an owner?

The answer depends upon the level of owner and associate production, "pent-up" demand, the availability of candidates at the senior owner's retirement and the degree of need for someone to continue the practice in the event of the practice owner's permanent disability or death.

As long as the practice owner's personal productivity does not decrease significantly with an additional owner, notwithstanding that the senior owner may take more time off, the senior owner is still selling a full practice rather than half of a practice upon retirement.

A key consideration in the decision to hire an associate is the ability to meet a continually increasing demand for patient services. This demand should allow the associate to earn an "appropriate" living, while maintaining the current level of compensation to the owner. The owner should also earn a profit from the associate's efforts. Assuming these criteria are satisfied, the decision to hire the associate is probably sound.

Because the practice owner(s) has limitations on personal productivity, sometimes patient demand is not serviced and therefore dissipates. By not hiring an associate, the practice owner has made the decision that growth will be curtailed. That's fine as long as this decision is not made unconsciously. This continual and ongoing decision making process should be part of strategic and long term business plan for the practice.

### **Availability of Acquisition Candidates**

There is not an overabundance of candidates at this time, particularly good ones. This is an especially sensitive area for specialty practices, which typically conduct a national search for candidates and often early in the specialty training. This means that unless the practice owner hires a new doctor when he or she can, the new doctor may not be available when needed.

However, a merger with a nearby practice may effectively resolve the problem of candidate availability.

Assuming that the practice owner remains healthy, there may exist little concern about permanent disability or death. However, should either triggering event take place, the practice owner would desire anyone who practices in the common facility or as a co-owner of the same practice have the obligation, as opposed to the option, to be bought out. The buy-out would be in accordance with predetermined terms and conditions and possibly through an insurance component, e.g., term life and/or disability buy-out insurance.

The simplest practice succession option for the practice owner is to work as a solo practitioner until retirement and sell 100% of the practice. However, to the extent that the practice owner's productivity does not drop when an associate becomes an owner, selling a portion of the practice, e.g., one-half, to the associate, should not be a monetary problem.

### **Can Co-Ownership Work?**

Can co-ownership work? It can, provided that the complexities can be effectively resolved. These complexities can be seen through a list of ten questions that I am commonly asked about co-ownership as described in Exhibit E. However, provided that the owners are truly compatible, the practice is economically healthy, compensation and benefits are allocated fairly, the economic terms of the associate buy-in(s) and owner buy-out(s) are fair to all parties, decision making control of the practice is agreed upon, spousal involvement in the practice is agreed upon and the incoming doctor(s) agrees to buy-out the senior doctor(s), then co-ownership can work very well. Again, the difficulty is complexity, which is why practicing solo or in a solo group arrangement is, in my view, a better alternative than co-ownership.

## EXHIBIT A

1. The owners are compatible with each other;
2. The practice is economically healthy;
3. The economics of the associate buy-in are "fair" to both or all parties;
4. Compensation and benefits are allocated fairly;
5. Decision making control of the practice is agreed upon by both or all parties, with dispute resolution devices in place;
6. Spousal involvement in the practice is agreed upon by both or all parties in advance; and
7. The younger dentist(s) or specialist(s) agrees to a mandatory buy-out of the senior owner(s) upon retirement in accordance with a predetermined and agreed upon formula to account for future practice growth.

## **EXHIBIT B**

1. The economics of the associate buy-in(s) and owner buy-out(s) are incorrect and unrealistic;
2. Insufficient patients and/or referral sources;
3. Disproportionate quality of clinical treatment;
4. Disproportionate productivity;
5. Disproportionate effort;
6. Varying long-range or strategic goals;
7. Failure to discuss practice business through regularly scheduled board or owner meetings;
8. Practicing in the wrong location;
9. Inefficient facility design;
10. Inability to compromise;
11. Personality conflicts and other problems;
12. Ineffective management and/or delegation of management duties and responsibilities, including staff training;
13. Ineffective leadership; and/or
14. Inadequate, unrealistic, outdated or the absence of buy-in, operational and buy-out documents.

## EXHIBIT C

### **Potential Issues in Funding Retirement Plan Contributions with Associate Profits and Pretax Buy-Ins.**

1. This mechanism assumes that associate buy-ins can be made on a pretax basis.
2. The economics of the associate buy-ins are based upon future projections of growth that may or may not occur. The associate/new owner may leave the practice if the future projections of growth are incorrect.
3. What is the facility relocation cost to accommodate the new doctor? Will the existing facility allow for significant increases in revenues and profits?
4. If the retirement plan adopted is a defined benefit plan, significant contributions are mandatory, not optional.
5. Any defined benefit plan will need to be in effect for minimally three years, usually five years. What happens if contributions cannot be made?
6. Human behavior and theoretical outcomes greatly differ. Behavioral change is mandatory to change economic outcomes.
7. Profitability will affect income allocation.
8. Practice owners are being told that they can fund their retirement plan from the efforts of the associate/new owner. The associate/new owner and this individual's advisors may not share the same view.
9. Tax-qualified retirement plans are not for everyone. What about real estate and other investments outside of the retirement plan? This assumes that the doctor has the discipline to save outside of the tax-qualified retirement plan.
10. Practice management is crucial to the success of this mechanism to increase revenues and profitability on a consistent basis. Given the quality, quantity and economic cost of management training, will the doctor(s) change the practice for the better?

**EXHIBIT D**

**BUY-SELL AGREEMENT MATRIX**

		Contract Terms						
		Nature of Parties' Obligations						
		Purchase Price (a)	Payment Terms (b)	Purchase of Insurance (c)	Practice/ Remaining Owner(s) Must Buy	Practice/ Remaining Owner(s) have Option to Buy	Departing Owner Must Sell	Departing Owner has Option to Sell
T R I G G E R I N G E V E N T S	Death							
	Permanent Disability							
	Election to Transfer by Owner							
	Termination of Owner's Employment							
	Retirement							
	Dispute							

**(a) Purchase Price Options:**

1. Book value, plus adjustments
2. FMV per appraisal
3. Fixed price + annual increase
4. Bona fide offer by third party to purchase
5. Practice's earnings times multiplier
6. Combination of above options

**(b) Payment Term Options:**

1. Cash
2. Promissory note
3. Cash down payment and promissory note

**(c) Purchase of Insurance to Fund Obligation:**

1. Life insurance
2. Disability buy-out insurance

## EXHIBIT E

### **Ten Questions on Co-Ownership**

#### **Question 1.**

Is the associate who acquires a 49% or 50% practice interest, the candidate who will purchase the remaining 51% or 50%?

#### **Answer 1.**

Probably not, and the practice owner should not elevate the associate to ownership without the incoming doctor being obligated to buy-out such owner(s) upon retirement. Retirement should be a defined term in the buy-out agreements and may include a "no later than date", e.g., age 70. If the incoming doctor will not agree to buy-out the retiring doctor, it is difficult to sell the retiring doctor's interest to a third party who must work with the remaining doctor.

#### **Question 2.**

If the newly admitted owner is acquiring a 49% or 50% interest of the practice for fair market or appraised value, won't he or she want equal decision making control?

#### **Answer 2.**

First, if the incoming owner is acquiring his or her interest for fair market value, the new owner should want to purchase an interest in the practice equal to any other owner, e.g., 50% in a two-doctor practice. Otherwise, the parties are not truly "partners". And yes, the newly admitted dentist or specialist does desire to maintain equal decision making control in the practice. However, it is rare where associate buy-ins are paid in cash as the lender requires the practice as security. Where the practice owner guarantees the new doctor's loan, the practice owner is still financing the buy-in due to the guarantee. Therefore, until the incoming owner pays for his or her interest in the practice, I do not object to decision making control remaining with the existing owner(s) until such interest is fully paid, typically in five or seven years. However, certain decisions such as hiring a new dentist or specialist or relocating the practice would require the unanimous consent of both or all owners during this period. Therefore, decision making control can be equal, provided that appropriate dispute resolution mechanisms are contained in the agreements. Roughly 16 states have close corporation statutes, whereby decision making control can be determined by contract. These statutes are useful tools as multiple owners can be admitted and the "founder" of the practice can maintain decision making control so long as such individual retains one share of stock in the professional corporation.

### **Question 3.**

Will the incoming doctor be willing to pay the fair market value of the practice interest being purchased as of the date of the buy-in?

### **Answer 3.**

Probably not. The incoming doctor would prefer to have the practice value determined as of the date that the associate agreement is signed, as opposed to the completion of the associate period, e.g., after three years. Therefore, the practice owner should not interview any associate until his or her succession plan is prepared and the practice valued. Preparation of a succession plan includes delineating the tax and business structure of leaving the practice and may include admitting a new owner or selling the practice in its entirety at some point. I prefer to prepare all ownership agreements prior to the new doctor commencing employment so that significant issues are not raised at a later date. Minimally, I would want the practice valuation completed, the associate employment agreement prepared and a letter of intent outlining the future ownership, if applicable. An exception to this would be where the associate relationship is permanent and will not lead to future ownership. The succession plan will be applicable irrespective of the identity of the associate/candidate. What seems to be a workable solution to valuing the practice in co-ownership is to revalue the practice after predetermined performance and quality standards are consistently met by the associate being elevated to owner. New patients brought to the practice by the associate are measured and the goodwill value is reduced by the goodwill attributable to the associate during the associate period. Not dealing with the future working relationship in advance usually leads to disagreements and misunderstandings at the time ownership is offered.

### **Question 4.**

What steps should the new doctor take prior to commencing employment if co-ownership is contemplated?

### **Answer 4.**

The new doctor should determine, both qualitatively and quantitatively, what he or she wants in a practice, rather than entering into an associateship just to have a job. Assuming that the vision and objectives of both parties are the same or substantially similar, the new doctor should sign a confidentiality letter and commence the due diligence or purchaser "homework" investigation prior to commencing employment. Unfortunately, this significant step is often overlooked by both parties as the practice owner should complete his or her due diligence investigation of the incoming doctor/candidate.

### **Question 5.**

What recourse does a practice owner have in the event that the new owner does not perform as expected or if the parties just cannot work with each other?

### **Answer 5.**

Ownership in dental and dental specialty practices is often offered earlier than is appropriate, e.g., three years, rather than requiring the associate to attain predetermined quality and productivity standards. As a result, the parties can end up in a dispute where expectations differ. Thus, the newly admitted owner's employment agreement may include a "termination by notice" provision and the buy-out agreements would specify who stays and who leaves the premises in the event of a dispute. Obviously, if the existing practice owner terminates the ownership without cause, the newly admitted owner would be bought out for full fair market value, provided that the departing new owner complies with the restrictive covenant provisions contained in the buy-out agreements. As an alternative, the buy-out agreements may provide that the newly admitted owner can elect to be bought out for the pro rata value of the tangible assets of the practice only, less any amount(s) owed to the practice owner(s), and retain the charts of those patients customarily treated by such newly admitted owner. This assumes that the new owner has paid for the goodwill attributable to his or her patient base within the practice. And yes, each doctor's patients should remain separate. In this case, the departing doctor would be permitted to practice within the restricted area, but not solicit other patients of the practice or its employees, except perhaps for his or her assistant. While this issue is more complex in specialty practices because patients and referral sources will probably not be separate, it is solvable.

### **Question 6.**

What if the newly admitted owner does not honor his or her obligation to purchase the retiring owner's interest in the practice?

### **Answer 6.**

If the newly admitted owner does not honor his or her obligation to buy-out the retiring owner, there would be a breach of contract claim by the retiring doctor against the remaining doctor. Additionally, the owner and buy-out agreements would provide that the employment of this owner would terminate and such breaching former owner would receive very little for his or her interest in the practice. The agreements would further provide that the restrictive covenants would remain in effect. Thereafter, the retiring dentist or specialist would search for a new candidate to purchase the practice in its entirety.

### **Question 7.**

Should family members and spouses be permitted to work in the practice?

### **Answer 7.**

Some of the best run practices employ non-doctor family members as administrators. These relationships should be identified and dealt with at the time that the co-ownership

relationship is structured, hopefully prior to the associate picking up a "handpiece". From my experience, some of the most difficult spouses in the practice are males who function as office administrators. However, this is only a generalization. If the spouse works in the practice, the compensation should be the fair market value of such services, as opposed to a lower value, which is often the case. A very positive reason to employ the non-doctor spouse(s) is to obtain the favorable retirement plan contributions, e.g., a safe harbor 401(k) profit-sharing plan.

### **Question 8.**

How should the owners allocate compensation and benefits?

### **Answer 8.**

Compensation and benefits are typically allocated in one of four ways by: (1) the respective collections of one owner as a percentage of the collections of all owners; (2) ownership percentage; (3) the administrative and management duties performed by one owner and not the other(s); or (4) a combination of these methods. Where compensation is allocated by respective collections or production, certain expenses, e.g., occupancy costs, may be allocated equally and this should be defined in the respective employment agreements, the limited liability company operating agreement or partnership agreement. If one owner does not desire to participate in the retirement plan, a bad idea, such owner can be written out of the plan and admitted at a later date. Those expenses and benefits that are disproportionate among the owners can be fairly allocated under the compensation formula. An example of this may be an automobile expense, continuing education and travel or dental laboratory costs. It should be noted that compensation based upon respective collections or production is relatively uncommon for a specialist, especially orthodontists and pediatric dentists.

### **Question 9.**

Are owner buy-outs paid for over time and is there a risk of default?

### **Answer 9.**

Owner buy-outs used to be paid over time and sometimes still are. Yes, if the buy-out is paid over time, there is a risk of default, particularly if the retired dentist or specialist relocates. However, because of the Martin Ice Cream and Norwalk vs. Commissioner cases in 1998, it is possible for the professional corporation to redeem or purchase, the departing owner's stock in the professional corporation at its "lowest reasonable value" and acquire the "personal goodwill" of the retiring owner. The sale and purchase of the personal goodwill, arguably, results in favorable capital gains to the retiring doctor and is amortizable over 15 years by the professional corporation. While this structure results in cash buy-out because the remaining shareholder(s) owns 100% of the professional corporation's stock, it is not as tax favorable to the professional corporation as is the redemption of stock for the lowest reasonable value, coupled with the payment of deferred compensation to the departing owner. The deferred compensation is fully and immediately deductible to the professional corporation when paid and results in ordinary

income to the retiring doctor. Thus, the economics of a buy-out through the payment for personal goodwill, versus the payment of deferred compensation, should be carefully calculated because the tax results affect affordability. Typically, the buy-out agreements contain a formula to determine the sum(s) that a departing owner receives, versus the time, cost and inconsistency of obtaining an appraisal when an owner departs. However, the formula(s) should be reviewed by the doctors and advisors each year as circumstances can change at any time. By using a formula, a retiring owner is paid the pro rata value for future practice growth.

**Question 10.**

How are buy-outs handled when two or more owners are roughly the same age?

**Answer 10.**

When two or more owners are roughly the same age, it is difficult, although this is a generalization, to continue co-ownership with two or more new doctors in place of the retiring doctors. What does work well, however, is to split the practice into two separate entities as a solo group and sell each practice separately. The respective purchasers obtain the benefit of sharing expenses in one facility, assuming they chose to do so.