Quarterly Supplement To

Business, Legal, And Tax Planning for the Dental Practice

Second Edition,
ISBN 0-87814-800-0, © 2001 PennWell Corp.

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 you may download at www.wickenslaw.com at no charge.

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SPRING, 2006
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Revised April 3, 2006

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CAN CO-OWNERSHIP WORK?

Co-ownership or group practice can work and be more rewarding than other forms of practice for purposes of coverage, efficiency and another doctor to work with. To the extent that dental and dental specialty practices now have and will continue to have higher demand for services than ever before, co-ownership arrangements will increase. However, it is more complex than practicing as a sole practitioner. Co-ownership works best for growing and specialty practices. Growing practices will become large practices and large practices are difficult to sell in their entirety because no one or two doctors can complete all of the production. These practices are generally sold in increments by elevating worthy associates to owners. Specialty practices generally have substantial demand for professional services and new owners can often be admitted with a minimal risk of the existing owner(s) incurring any reduction in compensation.

Why Do Co-Ownership Arrangements Succeed or 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 flourished or failed and continue to do so today for the same reasons. Notwithstanding personality issues and demand for professional services, I believe that the most important reason for co-ownership success or failure is the necessity for the development and preparation of thorough agreements that deal with joining the practice, operational considerations and leaving the practice. The considerations of joining the practice are associate employment, the practice valuation and the tax and business structure of the associate buy-in. The operational considerations consist of allocation of compensation and benefits, decision making control and employment of family members. Finally, leaving the practice consists of developing the buy-sell agreement, possibly the agreement for purchase and sale of personal goodwill and possibly deferred compensation agreements. If these agreements are developed, prepared and signed, the co-ownership relationship should work. If it does not, however, the buy-out agreements should provide for an efficient and effective exit of any owner without the emotion, time and expense of litigation.

Notwithstanding the development and preparation of thorough agreements, I have listed Common Criteria for Successful Co-Ownership in Exhibit A and Common Reasons Why Co-Ownership Relationships Fail in Exhibit B. The development and preparation of thorough agreements that address joining the practice, operational considerations and leaving the practice, prepared at the earliest time possible, encompass all of these items.

Like the design of a dental practice facility, few succession plans and co-ownership arrangements are identical, although they may be very similar. This is because there exist several variables or decision points that must be decided upon by the respective owners that are described herein.

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Succession and Entry Options

Before entering into co-ownership, consider all practice exit and entry options. The exit options are a complete sale, hire the associate with a complete sale in one to two years, enter into a solo group arrangement, enter into co-ownership or work for an additional one to two years and close the practice. The incoming doctor can purchase a practice, become an associate with the obligation to purchase the practice in one to two years, enter into a solo group arrangement, enter into co-ownership or establish a practice. Prior to entering into a co-ownership relationship, each party should examine all options in light of what the doctor wants in life and how long and how many days per week that the doctor 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 you out upon the earlier of death, permanent disability or election to retire on or after a specified future date. A significant succession problem here is that the incoming owner has no need to buy-out the senior owner once the incoming owner has reached full revenue capacity. 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, the co-owners can split into a solo group arrangement, whereby each practice owner can hire an associate and sell such doctor's respective practice at retirement. Thereafter, each new practice owner would be a party to the solo group arrangement, which would include the facility lease or building ownership.

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 work schedule 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 – An Alternative to Co-Ownership!

In the late 1970's, Dr. Jim Pride, founder of Pride Institute, recognized the failures of co-ownership and group practice, particularly where the remaining doctor(s) was left in the costly facility that the departing doctor(s) 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.

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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.[1]

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. In co-ownership or group practice, the associate typically will not agree to pay for goodwill related to his or her

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[1] Business, Legal, And Tax Planning for the Dental Practice, Second Edition, PennWell Corp., 2001, William B. Prescott, M.B.A., J.D., page 98.

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collections. 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. The development of the succession plan means that an associate needs analysis has been completed in light of the size of the current patient and/or referral base, amount of pent-up demand for professional services and the facility design. If the succession plan is properly prepared 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.

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

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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, over a measured time period. 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.

Sometimes the best associate/candidate will be a former patient of the practice owner's practice who grew up in the same community where the practice is located. If the working relationship is unsuccessful, I recommend that a buy-out of the restrictive covenant be in place that would allow the departing associate to retain charts of patients that he or she has treated as an associate, should such former associate desire to continue to practice within the restricted area. While there may be some minimum dollar amount, the restrictive covenant provisions for the associate may not be effective for the first 90 to 180 days of employment with the practice. However, under no circumstances would the associate be permitted to solicit other patients of the practice or solicit the employment of any staff member(s) unless otherwise agreed to in advance.

Practice Valuations

Of roughly thirty factors that determine the value of any general or specialty practice, the two that are most important are revenues and a given calendar or fiscal year and profitability. All other factors, such as location, management systems in place, quality of staff, etc. will ultimately affect revenues and profitability. If I had to choose between revenues and profitability, I would pick profitability because I can increase revenues if deficient, but would have difficulty improving substandard profitability. This presents a good case for the inclusion of practice management as part of the strategic practice or ongoing business plan.

Appraisers and their appraisal findings vary widely. Select an appraiser that has prepared many dental and dental specialty practice valuation reports. Just because an appraiser has certain credentials, such as CPA certification, does not mean that the appraiser understands dental and/or dental specialty practice values.

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In my view, there are four basic methods for valuing a dental or dental specialty practice. They are asset summation, capitalization of earnings or a variation thereof, multiple of gross revenues and comparable sales. Whichever method or combination of methods is used, the four criteria for verification of value that your CPA should confirm are as follows. First, the incoming doctor must earn a "reasonable" living. In other words, the associate does not want to incur a drop in compensation which is why associate profit to the practice owner is important. Second, the incoming doctor must pay the operating expenses that he or she will have in the practice. For example, the senior owner may make significant retirement plan contributions and the incoming doctor may not have the ability to do so, particularly with a young family. Third, the practice owner must be paid the purchase price. Finally, the purchase price must be repaid within a measured time period, inclusive of interest, e.g., five to seven years. It surprises me that the dental lenders are granting loans for complete purchases and sales for ten year periods. Stay away from this in co-ownership, as the incoming doctor would be paying for the ownership to owner practice over twenty years. In co-ownership, my observation is that 99+% of the associate buy-ins are internally financed. This is why I say "seller beware" because if the incoming doctor gets discouraged and leaves, the practice owner is not paid and has to start over. This is why proper valuation is so important. Unfortunately, some advisors attempt to provide a "windfall" to the selling practice owner. Remember, a windfall to the practice owner will be at the incoming owner's expense. If this occurs and when the incoming doctor and his or her advisors figure this out, the incoming doctor will leave and the practice owner will not be paid. Here, the practice owner loses both the incoming owner and precious time. Even though the appraiser will probably be paid by the practice owner, the appraiser has to be unbiased or the co-ownership will not be successful.

On departure, the buy-out documents should use a formula based upon today's value, based upon the twelve months' revenues immediately preceding the date of departure. Additionally, I recommend that the valuation for each practice and co-ownership be updated each year to insure that the formula for the owner's buy-out is correct. However, the documents should provide that the failure to update in any given year would not negate the agreement provisions.

In the event that the personal goodwill and any covenant not to compete of the practice owner is being purchased as part of any form of practice transition, the valuation report should reflect that the goodwill, and any covenant not to compete, is personal to the owner and not part of the professional practice. This is particularly important if the practice is organized as a C-corporation. Since December 31, 1986, the sale of C-corporation assets have been double taxed and the sale of personal goodwill outside of the C-corporation can serve to minimize this problem. Therefore, if the goodwill is personal, as well as the covenant not to compete, they should be appraised as such.

Associate Buy-In

The valuation of the practice in co-ownership or in 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

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incoming doctor may acquire a 50% interest in the practice. Alternatively, if the incoming doctor produces 25% or 33-1/3% of the practice revenues, such incoming doctor may purchase a 25% or 33-1/3% 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, there are three basic methods to accomplish the associate buy-in. Generally, the method utilized for the buy-in will be the same method, with certain exceptions, used for the buy-out. The primary exception is that the buy-out should be for cash, as compared to an internally financed buy-in.

The first is for the incoming doctor to purchase a proportionate percentage of the assets of the practice or a membership interest in a limited liability company, with the owners as co-members. 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 or, the sole proprietor may contribute all practice assets to the newly formed limited liability company and the incoming doctor would purchase a membership interest in the new entity. The incoming doctor would make an Internal Revenue Code ("IRC") Section 754 Election that would provide such owner with favorable tax treatment, substantially equivalent to asset purchase.

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. It should be note that in California and Hawaii, the limited liability company format for dentists and dental specialists is not yet permitted and a partnership would be used in place of this entity form. 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.

The second is for the incoming doctor to purchase stock in a professional corporation at its fair market value, reduced by the tax detriment in purchasing stock in after-tax dollars. 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 because those 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, tax neutral, practice valuation should indicate what the incoming owner can afford to pay, within a measured

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time period, without reducing compensation and benefits. However, the valuation must be reviewed by the incoming owner's CPA to ensure that the economics of the transaction are realistic.

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 some 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.

The third, which has a degree of risk, is to purchase stock as its "lowest reasonable value" and incrementally increase the new doctor's ownership by utilizing compensation adjustments over five or seven years. A mechanism that has long 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.[2,3] 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).[4]

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[2] Muskogee Radiological Group, Inc. v. Commissioner, T.C. Memo, 1987-490.

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

[4] Technical Advice Memorandum 944003.

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Let's assume that 50% of the stock is valued at $50,000.00. Further assume that the compensation adjustments are $350,000.00, payable over seven years as a "guaranteed" bonus to the senior owner, reduced each year from the compensation that the incoming owner would have otherwise been entitled to. This results in a significant pre-tax component of the buy-in to the incoming owner. Because the senior owner receives ordinary income rather than favor capital gains on this amount, it is typically "grossed up" to reflect this tax differential. Also, because the guaranteed bonus is being paid over time as compensation, it is often grossed up again to reflect an interest component.

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.[5] 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.

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[6] highlights the necessity that compensation to shareholder/employees of a professional C-corporations 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 pay a meaningful dividend each year, document any and all non-professional services rendered by the professional C-corporation's shareholder/employee(s) and value the professional corporation's stock at its fair market value and adjust the purchase price down to reflect the tax benefit to the senior doctor receiving favorable capital gains treatment and the tax determent to the incoming doctor in paying for stock in 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).

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[5] Contemporary Obstetrics & Gynecology, Inc. (1996), 113 Oh. App. 3d 75.

[6] Pediatric Surgical Associates, P.C. v. Commissioner, T.C. Memo 2011-81 (April 2, 2001)

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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 and risks, as I see them, are listed in Exhibit C.

The accounts receivable pose an interesting dilemma in co-ownership or group practice arrangements. I believe that all parties recognize that the accounts receivable are owned by the practice prior to the associate being elevated to ownership. The problem with paying out accounts receivable to the existing or senior owner, is that it has a tendency to make the buy-in economically difficult for the incoming owner. There is a finite amount of profit earned above the new owner's compensation and benefits to pay for the practice, over a measured time period, which will be taken up by the payment for stock or management fees/guaranteed bonus or both. A co-ownership relationship or group practice as an ongoing business should be distinguished from a complete purchase and sale where specified assets, both tangible and intangible or goodwill, are sold to a new practice owner. If the accounts receivable are being considered, take the "clean" accounts receivable that are not considered bad debt and determine the percentage of collectability, e.g., any percentage over 95% would be "healthy". Thereafter, let's assume that owner profit is 40%. This means that 60% of every dollar is used to pay ongoing operating expenses. Therefore, one accounts receivable formula in co-ownership or group practice is to determine the sum of the clean and collectable accounts receivable and multiply this sum by the percentage of owner profit in all forms. The product would be the sum that the existing owner would have received as compensation based on those accounts receivable, but for the associate being elevated to ownership. Where a component of accounts receivable is included in the associated buy-in, I typically include it as a bonus provision in the existing owner's employment agreement and it is payable as the practice entity's cash and financial position permits, but no later than the date that the buy-in is completed, e.g., five or seven years.

Operational Considerations[7]

Allocation of Compensation and Benefits

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 collections or productivity of one owner as a percentage of the collections or productivity of all owners; (b) by respective collections or productivity with certain expenses, e.g., rent, allocated on

[7] Reprinted, in part, from Business, Legal, And Tax Planning for the General Practice, Second Edition, PennWell Corp., William P. Prescott, M.B.A., J.D., Chapter 6.

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the basis of ownership percentage; (c) by ownership percentage; (d) equally; (e) by management and administrative responsibilities; and/or (f) by the number of days, half-days or time spent working in the practice, e.g., pediatric and orthodontic practices. 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, although I often include a provision that permits the senior owner(s) to terminate the employment of the incoming owner(s), provided that protections are in place for the new owner(s).

The discretionary termination provision is sometimes, but not always, included because the co-ownership is offered very early in dentistry and its specialties as compared to legal, accounting or veterinary practices. The protections for the incoming owner may be as follows. Assume that the stock is valued at its lowest reasonable value and compensation adjustments are utilized. If the new owner practices outside of the restricted area, he or she is paid the value of the stock that he or she had paid to the senior owner, plus 150% of the management fees/guaranteed bonus as deferred compensation (notwithstanding any IRC Section 409A considerations) that the professional corporation previously paid to the senior owner(s). This sum is payable over the same time period that the senior owner was paid the management fees/guaranteed bonus. If, however, the new owner elects to treat those patients of record that he or she customarily treats, such new owner would be permitted to retain those patient charts, provided that the new owner would have fully paid for his or her proportionate interest in the practice. In this example, the unpaid 50% of the stock would be paid by the new owner to the senior owner and the unpaid balance of the management fees/guaranteed bonus and any unpaid balance of the accounts receivable, if applicable, would be purchased by the departing new doctor by way of the purchase of personal goodwill of the senior owner. An underlying assumption in a general practice is that each owner maintains a separate and distinct patient base from the other. What is sometimes difficult to sort out is where one doctor treats children, performs certain procedures, e.g., orthodontics, or treats only certain family members.

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

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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 very 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 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

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it does not. Employment of family member(s) should always be discussed prior to entering into the co-ownership arrangement.

In family practices with two or more owners, treat the ownership like entering into co-ownership with a third party. Rely upon thoroughly prepared documents and not on an unwritten understanding that may lead to dispute.

Leaving The Practice[8]

The buy-out of a departing owner(s) presents the single biggest challenge in co-ownership for continuance of future practice operations. In the past, the structure and terms of an owner'(s) buy-out(s) would track the structure and terms of the associate'(s) buy-in, often through the use of deferred compensation payments. This is not necessarily the case now because in a two owner practice, the remaining owner can provide the practice as security and buy-out the senior owner for cash at closing.

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 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 should, but has not yet, reduced 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. However, the failure to do so should not negate or make void the buy-sell agreement provisions.

The buy-out agreements and provisions are crucial to successful group practice or co-ownership. Group practice or co-ownership will generally not work if the incoming doctor(s)

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[8] *Ibid.*

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will not buy-out the retiring or departing doctor(s). The buy-sell agreements, like the associate buy-in agreements, provide for the buy-out of an owner in one of three ways. First, 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 IRC Section 754 election in place for favorable tax treatment. Second, the buy-sell agreement may provide for the stock to be purchased at its fair market value, inclusive of goodwill, and reduced by roughly 22% to account for the tax detriment to the remaining owner purchasing in after-tax dollars in light of the favorable capital gains to the retiring, disabled or deceased owner. Finally, the pro rata fair market value of the tangible assets could equal the value of the stock, which would be relatively low. This would either be coupled with an agreement for the professional corporation to acquire the personal goodwill of the departing doctor(s) or with deferred compensation agreements. Either way, the buy-out agreements should contain a formula to account for the future growth of the retiring or departing doctor's interest in the practice. However, if part of the buy-out is based upon the payment of deferred compensation, it would be payable, typically over five or seven years, and not a cash buy-out. This presents a risk of nonpayment to the departing doctor.

If the newly admitted owner departs without his or her employment being terminated by the senior owner and other than by death or permanent disability, the departing owner would receive less in the buy-out than would a retired, deceased or disabled shareholder. Assume again that the stock is valued at its lowest reasonable value and compensation adjustments are utilized for the buy-in. Upon departure, the incoming owner would receive the value of the stock that he or she had previously paid to the senior owner, plus 50% of the management fees/guaranteed bonus (notwithstanding IRC Section 409A considerations) that the professional corporation previously paid to the senior owner. This sum would be payable over the same time period that the senior was paid the management fees/guaranteed bonus.

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, not to exceed the purchase price, constitute the down payment and the remaining purchase price is paid in installments, over some defined period of time, e.g., five or sever years. This resolves the issue of one owner having the ability to obtain insurance versus an owner who is uninsurable.

Sale of Personal Goodwill

Where the stock is valued relatively low, e.g., the fair market value of the tangible assets of the professional corporation, the personal goodwill of the departing owner may be purchased by the professional corporation in conjunction with the redemption or purchase of stock. If the goodwill is truly personal to the departing owner, its purchase by the professional corporation could be amortized over 15 years. The departing owner would receive favorable capital gains treatment. However, the redemption or purchase of stock is non-deductible to the purchaser, which would either be the professional corporation or the remaining owner(s). The purchase of personal goodwill is helpful in achieving a cash buy-out to the departing owner, versus payments of deferred compensation that are made over time with little security for payment.

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The complete purchase of personal goodwill became popular in the complete purchase and sale of assets involving professional C-corporations as a result of two 1998 tax cases[9, 10] and a 2002 Technical Advice Memorandum.[11] Since 1986, the sale of C-corporation assets are double-taxed at 35% and again at 15%. To the extent that the goodwill to the departing owner is personal, its sale outside of the professional corporation can, arguably, eliminate the 35% tax. Any covenant not to compete between the professional corporation and the departing owner at the time of departure would also eliminate the 35% tax, but would result in ordinary income to the departing owner.

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.[12] 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. Deferred compensation arrangements are not as popular as in the past due to the remaining owner(s) having the ability to offer the practice as security to buy-out the departing owner(s) in cash. Additionally, IRC Section 409A has imposed certain regulations on deferred compensation agreements that, I believe, will reduce the use of these arrangements.

It should be noted that in the future, the existing 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.[13] 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.

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[9] *Martin Ice Cream Company v. Commissioner*, 110 T.C. No. 18 (1998).

[10] *Norwalk v. Commissioner*, T.C. Memo 1998-279.

[11] Technical Advice Memorandum 200244009.

[12] Revenue Ruling 60-31; Internal Revenue Code Section 409A.

[13] Labor Reg. 2520.104-23.

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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 or her 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. An example of an associate buy-in and owner buy-out is described in Exhibit E.

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.

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 or 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(s).

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 size of the patient and/or referral source base, level of owner and associate production, "pent-up" demand, the availability of candidates at the senior owner's retirement, the facility design 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.

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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 for 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 buy him or her 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 sole practitioner until retirement and then 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 are listed in Ten Questions on Co-Ownership in Exhibit F. Nevertheless, provided that thorough agreements are developed and prepared as early in the working relationship as possible, co-ownership can work very well. However, practicing solo or in a solo group arrangement is, in my view, a better alternative than co-ownership.

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EXHIBIT A

Criteria for Successful Co-Ownership

1. 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; incentives and disincentives in place to ensure that the parties live up to their obligations;

2. Practice valuation and transition memorandum are prepared as early as possible;

3. There is a "way out" or exit that is available for any doctor;

4. Patient base remains separate for each doctor in general practices;

5. The practice is economically healthy;

6. There are sufficient new patients and growth;

7. The existing owner(s) cannot incur a drop in compensation, unless time in practice is reduced;

8. The owners are compatible with each other;

9. The economics of the associate buy-in are "fair" to both or all parties;

10. Compensation and benefits are allocated fairly;

11. Decision making control of the practice is agreed upon by both or all parties, with dispute resolution devices in place;

12. Spousal involvement in the practice is agreed upon by both or all parties in advance.

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EXHIBIT B

Common Reasons Why Co-Ownership Relationships Fail

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 personality issues;
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.

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EXHIBIT C

Potential Issues in Funding Retirement Plan Contributions with Associate Profits and Compensation Based 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?

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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
TRIGGERING EVENT	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

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(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

An Example of Co-Ownership

1. Associate relationship.

2. Valuation — often reduced by the increased revenues of the new doctor.

3. Stock at "lowest reasonable value" — additional compensation to the founder – Tax Risk?

4. 51%/49% ownership during buy-in — some decisions require unanimous consent — use of close corporation agreements where permissible.

5. 50%/50% ownership after buy-in fully paid.

6. Founder retains discretionary termination of employment provision for incoming owner.

7. Practice retains stock of departing owner for pre-determined value per share.

8. Practice purchases the personal goodwill of founder upon retirement, death or permanent disability.

9. Entire buy-out is paid in cash, as second owner can use the practice as security to obtain financing.

10. Incoming owner has deferred compensation agreement with the practice.

11. If new doctor leaves, new doctor receives 50% of the management fee/guaranteed bonus as paid to the founder, over the same period of time that the founder was paid.

12. If founder terminates employment of new doctor, new doctor receives 150% of management fees/guaranteed bonus previously paid to founder from the practice, payable in a lump-sum as severance pay.

13. If new doctor leaves for any reason, new doctor can elect to treat his or her patients and no severance or deferred compensation is paid.

14, Election must be made prior to receiving any deferred compensation or severance benefits.

15. If management fees and accounts receivable or guaranteed bonuses have not fully been to the founder, the remaining balance must be paid by the departing new doctor as purchase of personal goodwill from founder, reduced by the tax detriment, in cash — then competition allowed for those patients previously treated by the new doctor.

16. Restrictions for soliciting patients and employees of the practice remain in effect.

Note:

In states where restrictive covenants are not or are marginally allowable, buy-outs could be made through the payment of stock and/or deferred compensation over time, and payments cease if competition takes place.

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EXHIBIT F

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. Thereafter, 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.

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<u>Question 3</u>.

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?

<u>Answer 3</u>.

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 is to revalue the practice after predetermined performance and quality standards are consistently met by the associate being elevated to ownership. New patients brought to the practice by or collections attributable to the associate are measured and the goodwill is correspondingly reduced. This should be distinguished with the solo group arrangement, whereby the associate buys the goodwill attributable to his or her developing patient base. Not dealing with the future working relationship in advance usually leads to disagreements and misunderstandings at the time ownership is offered.

<u>Question 4</u>.

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

<u>Answer 4</u>.

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.

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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 may be 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 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?

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<u>Answer 7</u>.

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.

<u>Question 8</u>.

How should the owners allocate compensation and benefits?

<u>Answer 8</u>.

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.

<u>Question 9</u>.

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

<u>Answer 9</u>.

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 <u>Martin Ice Cream</u> and <u>Norwalk vs. Commissioner</u> 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

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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.

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