

Chapter 7

WHY SOLO GROUP PRACTICE MAKES SENSE

Historically, the complexities of co-ownership in group practice arrangements have resulted in a dissolution or split-up of the owners. Not every time, but often enough to make a generalization. One way of avoiding an ownership dispute is not to enter into the relationship.

Several years ago, the solo group practice model was developed and continues to work well. Why? An expensive facility is shared by two or more separate practices. While the true efficiencies of a well run co-ownership arrangement or a group practice are typically not attained in a solo group, many practice expenses are shared and such an arrangement is much more cost effective than solo practice with one doctor per practice facility.

Additional benefits are coverage availability, professional and personal camaraderie and another doctor to acquire your practice in the event of death or permanent disability.

Associate Employment Arrangement

One model for a solo group is for a busy practitioner to make the decision to hire an associate. The associate's revenues are monitored along with the patient base developed. This arrangement is evidenced through an associate employment agreement.

Associate Acquisition

Assuming that the associate and senior doctor desire to work together over the long term and once the incoming doctor's productivity reaches targeted levels on a consistent basis, the incoming doctor acquires the goodwill attributable to his or her patient base. This is calculated as a multiple of the incoming doctor's annual productivity, e.g., thirty-five percent (35%) of one year's production.

In addition to the incoming doctor's acquisition of his or her goodwill, the doctor acquires an undivided interest in the tangible assets of the senior doctor's practice. Due to the negative effects of a C corporation selling its tangible assets, it may be advisable for the senior doctor's practice to lease an undivided half, or pro rata interest, in the tangible assets. There are also situations whereby the doctors do not equally share the entire facility but work in specific treatment rooms. Here, the incoming doctor may acquire 100% of certain equipment with an undivided interest in the other dental equipment, office equipment and furniture. The acquisition documents are typically an asset purchase agreement between the senior doctor's practice and the incoming doctor's practice, as well as a bill of sale, promissory note and security agreement. It may also be necessary to prepare an equipment lease agreement between the senior doctor's practice and the incoming doctor's practice; and possibly an assignment of personal goodwill agreement between the senior doctor personally and the incoming doctor. This occurs where the senior doctor operates his or her practice through a C corporation.

Operations

The respective practices would operate pursuant to an officer sharing agreement between the respective practices. The office sharing agreement would provide for: (i) management of the facility and decision making procedures; (ii) work schedules and use of the facility; (iii) joint and individual checking accounts as the parties designated; (iv) division of expenses either based upon respective practice productivity or shared equally; (v) facility maintenance; (vi) equipment repair; (vii) sharing of certain staff members as well as payment of staff compensation, fringe benefits and retirement plan contributions; (viii) confidentiality of patient records and/or referral sources; (ix) use of telephone lines; (x) mutual indemnification or hold harmless provisions; (xi) maintenance of current license to practice the doctor's profession; (xii) responsibility for repair of the premises other than equipment; (xiii) capital contributions; (xiv) requirements to sublet or assign space as well as the process to hire or engage an associate doctor; (xv) termination provisions; (xvi) miscellaneous provisions, e.g., an integration clause whereby the document contains the entire agreement relative to the subject matter, possibly arbitration in the event of a dispute, jurisdiction and venue provisions, changes to the agreement must be in writing; (xvii) maintenance of malpractice/liability insurance with specific coverage limits; (xviii) any individual who acquires the practice of a retiring or departing practice owner may be required to become a party to the office sharing agreement as a condition to the practice sale; and (xix) the time and place of respective practice owner meetings to discuss common agenda items and business.

Buy-Out of a Practice Owner

In the event of the death or permanent disability of a respective practice owner, the surviving or remaining practice owner would typically be obligated to acquire the practice of the deceased or disabled practice owner.

In the event of retirement of a respective practice owner, the remaining practice owner is typically not obligated, but has the option, to acquire the practice of the retiring doctor. The reason for this is because the non-retiring owner does not usually have a need to acquire a second practice after building his or her own practice. In other words, the doctor who was your associate five or ten years earlier and who develops his or her own practice is not the person who will desire to buy you out upon retirement. This is one reason why groups can fail. As a result, the retiring practice owner would typically find someone to acquire his or her practice. This incoming doctor may also become a party to the office sharing agreement between or among the respective practice owners. This assumes that the purchasing doctor would keep the retiring doctor's practice located in the common facility.

In the event of a dispute, the buy-sell agreement may provide for one or the other specified practice owner to remain and the other to leave. The buy-sell agreement may also provide for multiple dispute resolution mechanisms.

A respective practice owner may elect to leave the practice facility and either leave the geographic area or practice nearby the facility. The office sharing agreement should provide for termination of the working relationship and the buy-sell agreement should provide for the remaining practice owner(s) repurchase of any jointly owned tangible assets. The death,

permanent, disability, retirement or dispute or other departure of a respective practice owner would be provided for under a buy-sell agreement. The mandatory buy-out events of death or permanent disability can and should be covered by insurance, subject to availability, coverage limits and cost.

The buy-sell agreement in a solo group arrangement can be tricky to draft in that the doctors may operate their respective practices in different entity forms which have varying tax effects relative to the sale and purchase of stock, assets or personal goodwill. The terms of payment would also be part of any buy-sell agreement as well as a provision that if a third doctor acquired the practice of a departing doctor, such incoming doctor's acquisition of the practice would be contingent upon becoming a party to the buy-sell agreement. This assumes that the incoming doctor will remain in the practice facility and will also become a party to the office sharing arrangement.

Sole groups have proved to be a positive alternative to the complexities and difficulties of co-ownership which has not yet been entirely successful in dentistry. Co-ownership as an alternative to separate practices works best in specialty practices where one practice owner has the obligation, as opposed to the option, to buy out any departing owner.

Compensation and Retirement Plan Contributions

The method of paying employees in a solo group arrangement will impact how retirement plans are funded for each practice, delineate management complexities among the practices and dictate accounting costs by the necessity of preparing a third tax return in the event that a separate management entity is formed. Let's assume three scenarios as an explanation:

- (i) Two practices in a solo group form and operate a third entity to allocate revenues and expenses, as well as pay employees' compensation and benefits;
- (ii) Each practice shares its employees and pays the employees' compensation to the extent that an employee works for each practice; and
- (iii) One practice pays all employees under an employee leasing arrangement and the second practice treats the leasing arrangement as an expense allocation.

Form and Operate a Third Entity

Notwithstanding the additional step of allocating revenues to each practice as well as expenses, the patient may think that the practices are the same as the patient receives one statement for professional services. This can be confusing to any practice owner who chooses to sell his or her practice or hire an incoming associate. In addition, the practice which did not hire the associate is now partially responsible for the retirement and other benefit plan coverage of the associate.

Under IRC Section 414(m), the management company would be considered to be a member of an affiliated service group with each of the doctors' practices. As such, the employees of the management company would be deemed to be employees of each doctor's practice for

purposes of retirement plan coverage and benefits. As a result, the employees of the management company would be entitled to receive retirement plan benefits as good as the best retirement plan benefits offered by either of the two practices.

Under IRC Section 414(m), the affiliated service group rules were based on two cases, the Kidde case and Garland case, both of which involved dentists. Prior to enactment of IRC Section 414(m), each practice would have been required to have 80% ownership in the management entity for a "controlled group" which would require coverage for staff employees. It was anticipated that if each practice owned a 50% interest in the management entity, there was no controlled group and that staff employees in the management entity would be excluded from coverage. IRC Section 414(m) was put into effect so that any ownership in the management entity would require coverage of the eligible employees working for the management entity, e.g., 21 years of age, over 1,000 hours of work per year and three years of service.

Therefore, formation and operation of a management company requires the practice owners to pick up eligible management employees in the retirement plan which can limit the contributions of a respective practice owner in a retirement plan or make owner contributions more costly due to coverage of additional employees.

Finally, there are accounting costs associated with the management entity in that it must file a tax return and account for its operations on an on-going basis.

A management entity works best where there are several solo practices in the group with common employees and where the practice owners are attempting to attain centralization of management.

Shared Employees

With shared employees, those employees working for both or all practices receive paychecks and W-2's from each practice comprising the solo group. Those employees who work more than 1,000 hours per year between the two practices are covered for retirement plan purposes, but only to the extent that a practice pays the employees' compensation. For example, two practices comprise the solo group and the recipient works 15 hours per week for the first practice and 15 hours per week for the second practice. Even though the employee works less than 1,000 hours for each practice, he is covered by the plan of each practice since he works more than 1,000 hours between the two groups. The employee is covered under the retirement plan for each practice/employer to the extent that such practice/employer: (i) pays the employee's compensation; and (ii) maintains a retirement plan.

While the shared employee format is efficient for retirement plan coverage purposes, it may not be advantageous from an employment or public relations perspective, particularly if each practice pays the employee differently.

Leased Employees

Assume that employees common to each of the two practices in the solo group are paid by the first employer. This employer pays all compensation of the common employee(s) and issues

the W-2(s). Further, assume that both practices/employers maintain retirement plans and that one common employee works 20 hours per week for each practice. Here, the first practice/employer is the lessor and the second practice/employer is the lessee under IRC Section 414(n).

The lessee employer picks up the employee in any retirement plan which the practice maintains, but gets a credit under Section 414(n)(1)(B) on behalf of those contributions made for the employee in the leasing employer's plan.

The lessor/employer does not receive a credit, however, for contributions made for the employee on behalf of the lessee/employer's plan. This could produce an unfair result for the practice which pays the employee's compensation and benefits. Therefore, to the extent that the lessor offers retirement benefits equal or greater than the lessee, the employees will be covered for their full compensation under the lessor plan and a portion of such costs will be charged back to the lessee. The lessee will receive credit with respect to its retirement plan contributions for the contributions made on behalf of the leased employees to the lessor plan.

Health Insurance

Health insurance coverage is probably more important than retirement plan coverage for all practice employees to the extent that an employee is not covered through a spouse. Coverage can be provided through the either practice which shares a common employee, provided that the employee works enough hours for either employer to be covered under one of the group health plans, but not both plans. Typically, insurers do not prohibit an employer from covering employees who work less than a minimum number of hours. For example, if a practice pays the full cost of individual health insurance premiums for employees who work at least 25 hours per week provided that the employee is not covered by the plan of their spouse, the employer would not be prohibited from covering an employee who works 20 hours per week for such employer and 20 hours per week for the other employer. The employer which does not cover the common employee would be allocated its proportionate share of the premium cost as a practice expense. The point is, practice employees need health insurance availability, irrespective of how the cost is allocated.

Solo groups have proven to be a positive alternative to the complexities and difficulties of co-ownership, which has not yet been successful in dentistry. Co-ownership as an alternative to separate practices works best where one practice owner must buy out the departing practice owner for any reason, particularly in specialty practices.