

Quarterly Supplement To

Business, Legal, And Tax Planning for the Dental Practice

Second Edition

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 no charge at www.PrescottDentalLaw.com.



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**Ten Questions on Associate Employment –
From the Practice Owner's Perspective**

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TEN QUESTIONS ON ASSOCIATE EMPLOYMENT – FROM THE PRACTICE OWNER'S PERSPECTIVE

I. What steps should you take to find a quality associate?

Answer: Place advertisements in local, state and national dental journals. Contact your dental school and others located in your and nearby states. Usually, there is an executive director or head of a residency program who can assist in locating a dentist or specialist for your practice, at no cost to you. Contact your dental dealer. Dental dealers know who is looking for a new dentist or specialist and can also assist you with no cost to you. While practice brokers charge for associate placement services, their fees are worth the cost to locate a dentist or specialist that you cannot otherwise find.

For specialists, begin your candidate search very early and be prepared to hire the "right" associate, even if your patient demand may not warrant the associate's cost. Then mentor the associate to build both pent-up and new demand.

One interesting situation that has been evolving for several years is clinics can generally afford to pay the associate at a higher wage than your practice. However, your private practice will provide a much better path to ownership than will a clinic. Where a young doctor does work for a clinic and later desires to change to private practice, you should be hopeful that the associate's living expenses have not risen to the level of the associate's income. Otherwise, the associate will have a difficult time making a switch from a clinic to private practice, unless you over pay the associate. If you do, it will be difficult to elevate the associate to future ownership without a reduction of pay and the relationship will fail. Yes, some clinics are now providing for ownership, but point out to the associate that he or she will have the clinic for a partner and the associate's ability to sell the associate's interest in the future will usually be limited to another clinic doctor.

II. What are the key questions that should be asked during the first, then subsequent, employment interviews?

Answer: The employment interview questions should be the same for the associate and you. Questions should relate to the categories of mutual expectations on quality and quantity of production, vision about the practice of general dentistry or your specialty, mentorship, how the production will be accomplished (e.g., use of specific treatment rooms, patient assignment and work schedule) and future ownership after the associate period. My recommendation on the second or third interview is for the associate to sign a confidentiality letter and provide the practice valuation, which you should have authorized for completion before conducting any interviews. This assumes that the relationship is not one of a permanent associateship. Beyond the appraisal, you need to specifically know how the associate will be elevated to ownership or purchase your entire practice. In other words, your succession or exit strategy should be definitive before conducting any interviews. In addition, the specific business and tax structure of any co-ownership or

solo group arrangement should be delineated with agreements in place before the associate starts work or, minimally, a detailed memorandum of understanding outlining the economic terms and business and tax structure of the co-ownership.

III. How can I determine if my practice can support an associate?

Answer: First, estimate the associate's monthly collections for the first three years of employment. Those collections will be through pent up practice demand and patients that the associate will bring to the practice through the associate's own internal and external marketing efforts. Yes, the associate really needs to build a practice within your practice. The big mistake most practice owners make is not making this an up front expectation. Most practice owners who consider adding an associate have more production than they can handle, but not enough for the associate to be fully booked. Mentor the associate to present full and comprehensive new patient exams and focus on the associate's efforts on internal patient referrals, community involvement and external marketing efforts to build a practice within your practice. Understand that to the extent that the associate resides a substantial distance from your practice, community involvement will be curtailed.

Second, determine the associate's anticipated compensation, benefits, payroll taxes, direct business expenses, cost of dental assistant, loan repayment for dental equipment purchased for the associate, lab and any other costs related to the associate's employment.

Third, determine the breakeven point of the associate's yearly cost to your practice in light of the associate's yearly collections, inclusive of hygiene exams. For example, if the associate earns \$120,000 per year and has \$50,000 of additional yearly costs attributable to his or her employment, the yearly breakeven point is \$170,000, without any contribution to fixed costs. The associate contributes to fixed costs above \$170,000 of yearly collections, except for variable laboratory and supply costs. The business rule is that if variable costs are covered and there is some contribution to fixed costs, then hire the associate. There will also be times when it is advisable for you to hire an associate even where variable costs are not completely covered for some period of time due to the difficulty of locating an associate in some geographic areas.

Get your management systems in place, fees reviewed, then hire the associate if existing and potential demand warrant the hiring. In a general practice, the rule of thumb is 2,000 active patients, those seen in the last 18 months.

The facility is important in your situation. A small facility with limited space will not allow the associate to be sufficiently productive. If you have not recently relocated or expanded, what is your strategic plan for doing so? If your practice has just relocated or expanded, you probably have already made the conscious or unconscious choice to hire a new dentist or specialist, depending upon facility size and number of treatment rooms.

Be cautious if your practice can hire the associate for only one or two days per week, the associate will need to practice elsewhere and the relationship may ably fail. This is almost

like an associate establishing a practice within a practice from scratch, but without the cost of the facility or equipment. If you do this, you and the associate need to know up front what the associate will be asked to pay later to be admitted to ownership or what the date of valuation will be. Also, be aware of limitations of any restrictive covenants that the associate is bound by where an associate will be working or works for another practice. Note that the other practice will also require the associate to sign a restrictive covenant. In essence, a double restrictive covenant. In this case, the associate may not want to sign a restrictive covenant with your practice, which is essential.

IV. Is the young doctor an employee or independent contractor and why?

Answer: The associate is an employee and not an independent contractor, except in rare circumstances. The same holds true for you rendering services post-retirement on behalf of the purchaser of your practice. Where the practice schedules the patients, pays the associate or you (as the retired doctor), employs the staff, pays the operating expenses, where the work is full-time and exclusive, where the associate (or you post-retirement) is subject to a restrictive covenant and where the associate has an expectation and/or option to purchase an interest in or your practice in the future, the relationship provides sufficient behavioral and financial control for classification as an employee. While working part-time, forming the associate's own entity and working at other practices is helpful in a finding of independent contractor status, these factors are not determinative.

On the other hand, if the associate rents space from you, bills the patients that the associate treats, controls his or her work schedule, his or her own scheduling and pays your practice for use of the space, the associate could be properly classified as an independent contractor. This is almost never the case. It would also be helpful if the associate treats his or her own patients and is free to retain those charts should the relationship terminate.

Practice owners prefer independent contractors because payroll taxes and fringe benefits are avoided. It costs your practice less to treat the associate as an independent contractor versus an employee. In addition, the associate (or you, post-retirement) would want to be classified as an independent contractor so that benefits, insurances and direct business expenses can be offset against income.

Consultants often ask, "if the employer and independent contractor pay all applicable taxes, no harm no fowl, right?" The IRS has said "no". Where misclassification is found, the practice is assessed all federal income taxes, fines and interest with limited ability to get the funds back from the worker. The associate (or you, post-retirement) would effectively be denied the benefits, insurances and direct business expenses. In short, this is a disaster and the IRS is significantly increasing its audit efforts on worker classification and sharing information with most states and vice-versa.

What does work, however, is that your practice can pay the associate (or you, post-retirement) fairly, then reduce the associate's compensation by the full or partial cost of benefits, insurances and direct business expenses not part of the employment package.

V. Should an employment agreement be prepared or is a letter stating the employment terms sufficient to start work and who prepares the document?

Answer: Some advisors believe that an employment agreement is unnecessary for the first six months of employment, that just a letter of employment terms is sufficient. Almost every time we attempt to have an employment agreement signed after the employment has commenced, we have disagreements over the terms of the restrictive covenant provisions. I just do not see sufficient detail in an employment terms letter to eliminate negotiations on this and other issues. For example, there may be a two-year, five-mile restrictive covenant, with non-solicitation provisions contained in the letter. However, the associate's counsel may attempt to negotiate that the restrictive covenant should be null and void if you terminate the associate's employment without cause. The associate's counsel may also attempt to negotiate a buy-out of the covenant to allow the associate to practice within the restricted area. These and other points should have been agreed to from the beginning. Your lawyer should prepare the employment agreement prior to you conducting any employment interview.

VI. Why are the restrictive covenant provisions so important to the associate employment agreement and what do they include?

Answer: Restrictive covenant provisions are crucial in the event that the working relationship fails. The key terms of any restrictive covenant are confidential information (patient and/or referral sources), time, geography, non-solicitation of patients and referral sources (if applicable) and non-solicitation of employees. For associate employment, the duration of the restrictive covenant is one to three years, typically two years. On the other hand, if the associate buys you out in co-ownership or buys the entire practice, the restrictive covenant for you would be typically three to five years. The geographic limitation may be a specified radius or may include a map which may be a freeway on one side and a community on another or two miles in one direction, eight miles in another and so forth. Be very careful of overly broad restrictive covenants because they may not be enforceable, depending upon the state. Are restrictive covenants enforceable? Generally they are, although each state has different criteria. However, be careful of liquidated damage provisions as they are not usually reflective of the damage caused to the practice.

For those situations where you hire an associate who grew up in your community and maybe who is/was your patient, the associate should request the ability to buy-out the covenant. The price should equal the goodwill value of patients that the associate customarily treats. This would to apply only if the associate leaves and practices inside of the restricted area. In the first year, there may be a minimum cost to the buy-out of the covenant and in subsequent years, it would be based upon the calculation of the goodwill

of those patients that the associate customarily treats, e.g., 45% of the associate's collections over the last 12 months of employment.

VII. How should the associate be paid compensation and benefits and how do specialists differ from general dentists?

Answer: Associate compensation should be determined in advance of the hiring process through an analysis by you and your advisors of what the practice can afford to pay with your practice earning a 5% to 15% administrative profit. This analysis should also consider your geographic area and the difficulty of locating candidates in your geographic area. Ask the associate to determine his or her compensation requirements based upon living expenses, debt and relocation costs.

As an example, assume that your practice agrees to pay the associate the greater of \$7,000 per month or 30% of adjusted production. Adjusted production means associate production, less write-offs, reduced fees, refunds, uncollectible accounts and/or laboratory remakes. The associate receives credit for hygiene examinations, but not hygiene services or x-rays performed by the hygienist(s). Assume further that your practice pays the associate's liability insurance, one-half of individual health insurance premiums, \$1,000 per year toward the cost of continuing education and professional dues. This seems like a fair compensation package, right? But how does the associate become an owner?

There needs to be a sufficient difference between associate compensation in all forms and owner compensation to allow for future ownership. This difference, inclusive of hygiene collections attributable to the associate, must allow for ownership without a reduction in the new owner's pay, over a specified period of time, e.g., seven years. This can be quantified based upon anticipated yearly collections, practice overhead percentage and the practice appraisal. If this analysis doesn't work, the appraisal is flawed.

What is an appropriate rate of compensation? The greater of a monthly base salary for full-time employment (or a daily or hourly rate for part-time employment) or 28-32% of adjusted production or collections for a general dentist (with the practice paying the laboratory costs) or 35% to 45% for a specialist. Another way of paying your associate would be 25% of adjusted production, inclusive of all hygiene services. The base salary should not be a draw to be repaid in the future, but the percentage should be paid or "trued up" on a quarterly basis to eliminate peaks and valleys in compensation. Once predetermined production levels are consistently reached, the monthly compensation based upon a percentage will exceed the base salary. Or, the base salary may only be in effect for a limited period of time, e.g., 90 to 180 days. I like adjusted production rather than collections because the associate does not control the collection policy of your practice, you do.

If you and the associate do agree to a draw to be repaid from the associate's future compensation percentage, in all fairness, the associate should not be required to repay any draw above the compensation paid should he or she leave the practice. If the associate is

paid on collections, the employment agreement should contain the provision whereby the associate's collections would continue to be paid for some period of time after the employment ends, along with the requirement of a monthly accounting by your practice. You do not need some litigator on a contingency fee coming after your practice for unpaid associate compensation as a result of a dispute and failed relationship.

In a general practice, the methodology for any payment of laboratory expenses should be delineated. For example, 35% of collections, less 35% of laboratory costs, is different from collections, less 35% of laboratory costs, multiplied by 35%. It may be helpful to include any laboratory expense calculation as an example in a schedule to the employment agreement.

Bonuses are designed to economically reward work over and above the standards expected by you. In dental practices, bonuses usually take the form of a reward for exceeding a predetermined level of productivity or collections. Designing a bonus formula only based upon productivity or collections is one dimensional. Associate bonuses should be designed to measure and reward quality of work, effort, attitude, overall performance, yet consider the cash and financial position of your practice. In short, bonuses should be discretionary for associates. The associate should benefit from a discretionary bonus in that important criteria in addition to productivity, e.g., quality of services, are evaluated. Because the associate period is a time of mutual evaluation for both parties, you can and should assess each other. You should have an evaluation form in place, and should evaluate the associate's performance in writing and discuss it at least on a quarterly basis or immediately as necessary. The employment agreement may provide that the associate must be employed on the last day of any calendar or fiscal year to be eligible for any bonus. Other bonuses may include a one-time signing, relocation or bonus to pay the associate's advisors where co-ownership is contemplated.

Specialists are usually paid a base amount, e.g., \$150,000 - \$200,000 per year, payable over 12 months during the usual and customary pay periods of the practice. Bonuses are less common in specialty than in general practices.

VIII. What are the other important provisions that should be contained in an associate employment agreement?

Answer: In addition to compensation and restrictive covenants, there are other important provisions. First, vacations and other time-off consist of vacation time, continuing education days, personal days and illness. Second, termination of employment is important. You and the associate need to be able to disengage from each other. Certain "for cause" termination events, by either party, may include a short cure period. I suggest that termination by notice be the same number of days for you and the associate, 30 - 90 days. Finally, duties, responsibilities, licensure and mutual hold harmless provisions should also be included.

IX. How and when is practice ownership contemplated?

Answer: Dealing with practice ownership, be it a complete sale or co-ownership, a year or two after the associateship begins will not work. You and the associate will not agree on the valuation date, purchase price for the buy-in, the operations, the formula or purchase price for the buy-out or the business and tax structure of the co-ownership. This needs to be addressed prior to commencement of the associate's employment.

Co-ownership is the most complex form of practice as compared to sole ownership. This is because you and the associate need to deal with three categories; the buy-in, operations and the buy-out. The buy-in is typically internally financed, unless you grant a security interest in your practice to the lender. I do not recommend this. The buy-out should be paid in cash upon your departure from practice. Operations cover the working relationship of owners, including allocation of owner compensation, decision making control and employment of family members. Usually, you would retain certain founder's rights until the associate has paid for his or her ownership interest, although certain decisions, e.g., the hiring of another doctor, should require unanimous consent.

Adding to the complexity of the buy-in, operations and buy-out, there are three business and tax structure for co-ownership. See my article, Co-Ownership, a taxing relationship, Dental Economics, September, 2010.

Solo group arrangements provide a good alternative to co-ownership because while the associate may be willing the purchase the first half of the practice, he or she may not desire to be obligated to purchase the second half. In the solo group, the associate buys one-half of the tangible assets of the practice and an undivided half interest in your goodwill or the goodwill based upon the associate's collections plus applicable hygiene. The goodwill is attributable to the patients that the associate customarily treats, not patients that the associate brought to the practice. Because the associate will own his or her own practice, a loan for the purchase price can be obtained from a dental lender without you or your practice having to grant a security interest to the lender. After the purchase, you and the new owner operate your practices in the same facility under an office sharing agreement. While you and the new owner would have a buy-sell agreement in place, the new owner would have an option, but not the obligation, to purchase your practice (the second half) upon your retirement or other departure. Should there be a falling out, the new owner takes his or her patients (that have been paid for) and leaves, along with the associate's equipment. You would also pay the departing new owner the fair market value of any jointly owned equipment that you would retain. The buy-sell agreement would define who keeps what.

As to the value of a practice, the average is now roughly 65% of one year's collections, excluding accounts receivable and debt in a complete sale. Some specialties, such as orthodontics, are higher and some lower. The value in a fractional sale is identical, although I believe that accounts receivable and debt should not be included. While I have written that 30 factors that affect practice value, the two biggest factors are practice

collections per year and the percentage of owner profit in all forms to one year's collections. Most practices do not sell for an average value. Average value is merely a compilation of higher and lower values. In any valuation formula, there are four important verification points. They are; the new owner needs to earn a reasonable living, pay the purchase price, pay his or her operating expenses and do so within a measured period of time (not to exceed five to seven years). While dental lenders will grant loans for 10 years and longer, the practice value should be based upon full repayment of the purchase price, be it a complete or fractional sale, over five to seven years. Otherwise, the price is increased due to an increased repayment period. If you are paid cash in a complete sale, you may not care. On the other hand, if you are financing an associate buy-in, you should care very much.

As a result of this complexity, I recommend that before the associate begins employment, the associate employment agreement, appraisal and all ownership agreements should be prepared. At a minimum, we need a very detailed letter of understanding delineating the anticipated practice purchase, co-ownership or solo group arrangement.

X. What are your final thoughts on associate employment?

Answer: It's not easy locating the right associate nor is it easy for the associate to locate the right practice. Practice owners and associates should use all available resources to find each other. Do your best to locate the right candidate, confirm your long term exit strategy, authorize the practice appraisal to be prepared, as well as all agreements prior to the associate interviews. This will minimize the risk of a failed relationship.