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- Attorney and President of Collier & Associates, Inc., a national law firm for the dental profession
- Publisher of the C&A Doctors’ Newsletter, which for 45 years, has been providing doctors with unbiased and cutting edge advice on tax saving strategies, saving and investing, practice transitions, practice management and how to live a good life
- Collier & Associates continuing education seminars at top destinations throughout the United States, Canada, Mexico and the Caribbean
- Collier & Associates retirement plan division which designs and prepares profit sharing, 401(k) and defined benefit plans for hundreds of dental practices throughout the country

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Lecture overview

- We represent orthodontists in all 50 states in all phases of transitions, from negotiating associate employment agreements, to practice appraisals, partnership buy-ins and practice sales.
- Since we work with employers and employees and buyers and sellers, we know the issues and how to address them fairly
- I’ll do my best to be as impartial as possible. Depending on your situation as “Dr. Senior” or “Dr. Junior”, there will be times when you like what I have to say, and other times when you don’t . . . but just be patient because you’ll soon hear something that will make you happy!

The most important rule — “More Important Than the Deal is the Person in the Deal”

- Everywhere and at all times, in business and in life!
- If you associate with good people, good things will happen. And vice versa.
- If you want to know why someone has a bad reputation, become his or her partner, and in short order, you’ll find out.

This is a lecture on group practices, but . . .

- Before that often comes an associateship and employment agreement
- If a buy-in is to be contemplated, both Dr. Senior and Dr. Junior should get some things out on the table
- First, the basic terms of employment
  - Schedule, job duties, compensation and benefits, restrictive covenants, etc.
- These things are important, of course, but if Dr. Junior is interested in a buy-in or buy-out, then the employment agreement should address this towards the end of the agreement in a “Future arrangements” section
Future Arrangements

• No guarantees, but if (1) employee is still employed after, say, two years, and (2) practice collections have reached a new plateau, then the parties will proceed to a buy-in.
• Partnership documents will be prepared at the two-year mark which will build on the following major terms that are outlined in the initial employment agreement:
  • How much of an interest will be purchased. 50%? 49%? 33-1/3%?
  • As of when the practice is to be appraised
  • Structuring the buy-in for tax purposes
  • The parties' rights and responsibilities concerning the future buy-out of a doctor from the group practice (i.e., Dr. Senior’s retirement)

Future Arrangements – Good for Dr. Sr. and Dr. Jr.

• No need to prepare the final documents up front when we don’t know if relationship will work out
• Both sides agree on major terms up front which makes final contract drafting smoother
• Both sides can refer back to what was agreed upon which avoids future confrontation. People acting in good faith often remember things differently.
• More important for Dr. Junior who has to live with a restrictive covenant
• What if Dr. Senior refuses to include this in the employment contract?

Restrictive covenants in employment contracts

• Assume they’re enforceable
• What is reasonable as to time and scope?
• Apply regardless of reason employment ends
• Ways to compromise
  • Honeymoon period – can make sense
  • Dr. Jr. can buy his/her way out of them – doesn’t make much sense

How much to sell to Dr. Junior

• Generally, it’s an equal interest (e.g., 50%)
• What about 49% so that Dr. Senior can remain in control?
  • Dr. Senior can remain in control even with a 50% partner. The doctors’ partnership agreement will define voting rights and Dr. Senior is usually given more voting rights – until the buy-in payments are completed and sometimes until Dr. Senior retires
  • Not fair to make Dr. Junior feel like a second class citizen with 49%
• What about 33-1/3%?
  • if at the time of the buy-in, Dr. Junior is substantially less productive than Dr. Senior, the buy-in may be for 33-1/3%, with the right to buy another 16-2/3% if and when relative doctor production gets close to even

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The buy-in... The Appraisal

• Dr. Senior pays for it. Dr. Junior pays an advisor to review it
• As of when should it be performed? Three possible answers, all of which are fair and reasonable
  • As of Dr. Junior’s arrival date in practice (but updated for tangible assets on hand as of buy-in date)
  • As of the buy-in date
  • The average of the arrival date and the buy-in date
• How are practices appraised? A couple recognized techniques
  • Asset summation method – e.g. 150% of total profitability for goodwill value, plus tangible assets
  • Capitalization of excess earnings – more subjective

The buy-in... Structuring for Tax Purposes

• First, understand the basic premise
  • BUYERS WANT TAX DEDUCTIONS, AND THE SOONER THE BETTER
  • SELLERS WANT TO PAY TAX AT THE LOWER CAPITAL GAINS RATE, NOT THE HIGHER ORDINARY INCOME RATE
• Inherent tension. What’s good for one is bad for the other
• What is being bought? (buyer/seller)
  • Shares of stock? (non-deductible/capital gain)
  • Tangible assets? (depreciable quickly/ordinary income)
  • Intangible asset value, i.e., goodwill or income shift? (see next page)
• When Dr. Junior buys in, does he/she do so with an income shift or the purchase of Dr. Senior’s goodwill?
• It depends on a couple factors
  • The size of the practice
  • The doctors willingness to take on some added complexity
• The traditional buy-in method, done in 2 parts
  • (1) Sale of stock from Dr. Senior to Dr. Junior at “adjusted book value” of tangible assets minus liabilities. Payable with a promissory note over, say, 5 years. This is the small part of the practice value, roughly 20%.
  • (2) Income shift from Dr. Junior to Dr. Senior over a period of, say, 5 years. This is the large “goodwill” part of the buy-in, roughly 80% of the total

The newer goodwill buy-in method. Also called the “Three Entity Approach”

• Rather than allocating a small piece to stock and a large piece to an income shift,
• The three entity approach allocates the buy-in price primarily to goodwill (capital gain to seller and deductible over 15 years to buyer) and a relatively small portion to tangible practice assets (ordinary income to seller/immediately deductible to buyer)
• More complex structure, but worth doing for large buy-ins because here the goodwill is actually treated as the sale of goodwill (capital gain) rather than compensation (ordinary income).

Financing the buy-in

• Bank financing or seller financing
• With the traditional method, it’s always seller financed
• With the three-entity approach, it doesn’t make much of a difference. In fact, a preference for seller financing. Don’t have the complication of a bank, and if Dr. Buyer defaults, the results are the same
• (Buy-outs, on the other hand, should be bank financed. It’s readily available, Dr. Seller doesn’t want to become a lender in retirement, and any bank lien is on Dr. Buyer only)

The “big issues” in group practices

• Compensation
• Management
• Transition out of the practice
Compensation

• One of the primary reasons for practice break-ups is money - the partners' compensation arrangement is no longer fair based on the circumstances

• Key Concept – He or she who is doing the work must feel that he or she is being fairly paid

• Three ways to allocate compensation
  • by percentage ownership
  • by production
  • by a hybrid of the two

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• Percentage ownership
  • Rare, but appropriate in some cases
  • Changing circumstances mean changing the formula

• Production
  • In orthodontics, it’s often based on relative days worked (assuming a day worked by one partner is roughly as productive as a day worked by the other(s))
  • If not, then days worked is inappropriate. It should be used in conjunction with number of patient appointments during the year and/or number of new patient starts during the year

• Hybrid
  • Majority of profits (e.g., 80%) based on production and minority (e.g., 20%) based on ownership. May be the fairest.

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• Management stipend
  • If one partner is doing more than his/her fair share, he/she should be paid something off the top (i.e., before the profits are split)
  • Depending on how much time is being spent, this could range from $40,000 to $100,000/yr
  • Ideally, there isn’t a need for this, and if the partners ending splitting management fairly, the stipend will go away

Practice Management

• Different possibilities
  • Every decision, no matter how small, has to be unanimous (“50-50 means 50-50”). This can become a management nightmare
  • Dr. Senior is in charge of all management until he/she retires. Fair?
  • Most common – Distinguish between “mundane” and “major” decisions
    • Major decisions like do we open a new office, hire another doctor, buy expensive new equipment, take on debt, etc. are unanimous regardless of how much of an interest Dr. Senior owns, and regardless of whether or not the buy-in payments are complete
    • Mundane decisions like which bank do we use, which CPA do we use, which dental supply company, etc. remain vested with Dr. Senior at least until buy-in payments are completed. Dr. Senior has been doing this and knows how to do this, and no great need to interfere with this.

Transition of a doctor out of the practice

• A doctor can leave for a number of different reasons
  • Retirement
  • Death
  • Disability
  • Disagreement
• The partnership agreement must address each of these and from each doctor’s perspective
• The doctors are not similarly situated

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• Basic concept – If Dr. Senior exits the practice for any reason, Dr. Junior will buy out his or her interest for the future fair value
• But, if Dr. Junior exits the practice for any reason, Dr. Senior will buy out his or her interest for tangible asset value only and nothing for Dr. Junior’s goodwill value
• Many good reasons for having a partner, but financially, you will lose money or break even by elevating an associate to partner without raising his or her pay (above what a fairly paid associate would make) so they can afford to buy in?
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- Dr. Senior earns $550,000. Dr. Junior associate earns $150,000. A total of $700,000 of profitability.
- Practice is valued at $1,000,000.
- Doctor Junior does not have $500,000 available.
- $500,000 paid over 5 years at 4.5% = $112,000 per year.
- If Dr. Sr. produces 55% and Doctor Junior produces 45%, a productivity split of the $700,000 on a 55/45 basis would mean Dr. Sr’s pay drops $115,000 to $435,000 and Doctor Junior’s pay rises $115,000 to $265,000.

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- Key issue: Use an “asymmetrical” buy-sell agreement to be sure Doctor Senior doesn’t have to buy back what he or she “gave away” in the first place (i.e., low buy-back price if Doctor Junior leaves first.)
- Dr. Junior will have his/her stock bought back, and $10,000 for a five-year restrictive covenant, but nothing for Dr. Junior’s goodwill.
- Had Dr. Sr known in advance that Dr. Jr would leave first, would Dr. Sr have made Dr. Jr a partner or kept Dr. Jr as an associate?
- “But 50-50 means 50-50” Yes, for access to practice profits, and perhaps equal management, but because of the practice give-away concept, it doesn’t apply here. Dr. Jr., you will want this protection one day when you become the senior partner.

Death and disability

- Same as retirement
- Perhaps there is life insurance bought on Dr. Senior to help with the buy-out. If Dr. Junior can find another doctor to replace Dr. Senior’s production, then insurance shouldn’t be necessary
- Disability insurance is tougher. No good analogous product to cheap term life insurance.
- Disability buy-out insurance is terribly expensive.
- Perhaps the practice buys office overhead disability insurance on both doctors and uses the proceeds to pre-fund a disability buy-out.

Disagreement

- If the partners in good faith decide they can’t practice together anymore, then Dr. Senior keeps the primary location, and Dr. Junior exits without a restrictive covenant
  - Why? This has been Dr. Senior’s long-term practice and he/she may still own the real estate
  - If multiple offices, Dr. Senior gets first choice, Dr. Junior second choice, etc.

Mandatory buy-out of Dr. Senior

- I wouldn’t bring in a partner (and do the practice give-away on the first part) unless my junior partner agrees to buy me out at my retirement
  - Dr. Junior is my exit strategy
  - Dr. Junior is obligated, not an option or right of first refusal
- Complicating factors
  - What if we’re the same age?
    - Considering we each may be retiring at the same time, neither of us are required to buy out the other for “full value.” We will each look to an outsider to be our successor, and our current partner won’t unreasonably veto the new doctor.
  - What if I’m leaving Dr. Jr. with too big a practice for one doctor to manage?
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  - What if I’m leaving Dr. Jr. with too big a practice for one doctor to manage?
    - Dr. Jr. is still on the hook, but I will give plenty of advanced notice, for example, two years, during which we’ll both look for “Dr. 3” and if we can’t find him/her during those years, I will sell my interest to Dr. Jr. and agree to stay on for an additional year as his/her fairly paid associate

Final thoughts

- Be open and honest with each other from the outset
  - If Dr. Jr wants to become a partner, Dr. Sr. needs to know this up front and should be willing to address the possibility in the initial employment contract
  - If Dr. Sr only wants associates, Dr. Jr needs to know this up front
- Spend time at the beginning addressing each of these major issues. Good contracts will anticipate the big issues and address them fairly from both sides