



# PRACTICE MANAGEMENT NOTES

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## Financial arrangements in an oral and maxillofacial surgery practice

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*This is the first of a two-part series on financial arrangements in an OMS practice. Part I addresses considerations and sharing arrangements during the associateship and buy-in phases of a partnership. Part II, which will publish with the May/June issue of AAOMS Today, will focus on methods of compensation, particularly in the buy-out phase.*

Over the years, the number of multi-doctor and percentage of group to solo practices in our the specialty have increased considerably. The latest data of the American Dental Association<sup>1</sup> report that 42.4% of oral and maxillofacial surgeons are in some form of associateship in private practice. Tangentially, many new practice management problems have arisen while others have significantly increased. A major problem has been determining the financial arrangements of the doctors in the group. This *Practice Management Notes* presents an overview of the myriad financial arrangements and income divisions involved in an associateship, buy-in and departure in an active oral and maxillofacial surgery practice by presenting a case that progresses through the three-stage process of associateship, ownership and departure.

Although most financial arrangements fall into general methodologies, they are unique and special to the OMSs and practices involved. The descriptions, illustrations and explanations contained herein are rather typical of the arrangements. Their applications in real life practice are, or will be, modifications of the examples. For them to be workable at any stage, financial arrangements must be fair, reasonable and equitable for all parties. In this article, the owner or owners of the practice are referred to as doctor, senior doctor and doctors and the new

OMSs as associate, junior doctor and doctor(s). Together, they are the “parties,” without feminine or masculine references. The practice entity is termed “practice,” regardless of the business form of solo practitioner, C or S corporation, limited liability company, limited partnership (also known as limited liability partnership in certain states) or general partnership.

If a solo practitioner practice takes on an associate the doctor will no longer be solo and it will become necessary for the practice to become a more formal business entity, more particularly a C or S corporation, limited liability company or limited partnership. In corporations, the doctors become shareholders and they own shares of stock. In limited liability companies or partnerships, they become members and they own units. For multiple critical reasons, primarily asset protection and the extent of the liability to which each partner subjects herself or himself, a general partnership is not recommended. The partnership is liable for any wrongful business act and each partner is fully and solely responsible for all debts and obligations of the partnership regardless of whether the partners or the partnership incurred the debt or obligation. In this type of arrangement, there is absolutely no business lawsuit protection.

### Associateship – the trial phase

The initial phase starts with recruitment. Planning the associateship phase and recruitment includes having a method of associate compensation in place and in writing. Called a “Fact Pact” or “Term” or “Dream Sheet,” this one- or two-page document lists the major terms, compensation and benefits—the “Package.” Specifics of the Fact Pact will vary depending upon the geographic location of the practice, cost of living in the

area, general and local economic conditions, employment and unemployment factors, source of patients, types of procedures done, how far in advance patients have to be scheduled, health and ages of practitioners, general objectives and goals of all doctors, how eager each OMS is to enter or to exit practice and much more.

The following provisions are normally included in the Fact Pact:

**Status:** Full-time employee of the practice. Many terms and conditions of an employee surgeon and independent contractor surgeon are similar. This article refers to the OMS who is or will be a full-time employee of the practice with anticipation of becoming an equal owner.

**Term:** Normally 12 months with automatic renewal at the end of the year in case the term is extended. Includes 30- to 60-day termination clause by either party with or without cause and without liability. Most states are "At Will" states, which means that either party to the agreement can be terminated or can leave immediately without cause.

If the parties determine that the initial or trial term should be 24 months, during the second year, the practice increases the annual salary based upon the Consumer Price Index, inflation rate or a reasonable percentage.

**Restrictive covenants:** For 24 to 36 months - no solicitation of patients, staff, or referral sources; and b) non-competitive activities within a reasonable geographic area of practice location(s).

**Compensation:** Varies considerably depending upon the above and other factors. Today, across the country, the ranges of starting annual base salaries are:

- Single degree OMS . . . . . \$135,000 to \$175,000
- Double degree OMS . . . . . \$175,000 to \$200,000
- Fellowship OMS . . . . . \$200,000 to \$250,000
- Retired military/faculty member (boarded) . . . . . \$200,000 to \$250,000

Occasionally, the parties are more comfortable in an arrangement in which an associate's compensation is a percentage of the practice's collections for services the associate provides to patients of the practice, on average around 35%, less refunds, discounts, courtesy, write-offs, etc. Another common arrangement sets an associate's compensation as the greater of a base salary or a percentage of the associate's collections.

**Incentive compensation:** When base salaries are in the high range, incentive compensation is not usually a factor. Otherwise, it is usually based on one of three factors:

1. Pre-determined fixed amount - \$5,000 to \$10,000
2. 15-20% of practice collections less refunds, write-offs, etc. for services that the associate has performed for patients of the practice over the break-even point
3. 15-20% of practice collections less refunds, write-offs, etc. over the previous 12 months' collections

**Benefits:**

1. Malpractice insurance
2. Health care – family
3. Continuing education, Board preparation, vacation, sick and personal days
4. Dues, licenses, applications, DEA registration
5. Cell phone -- pager
6. Social security, Medicare
7. Federal and state unemployment – worker's compensation

The arrangement may also consider the following, which, of course, will increase package costs and the break-even point, and may not commence until the ownership phase:

8. Relocation expense
9. Signing bonus
10. Entertainment, promotion
11. Vehicle expense, especially in a multi-office practice
12. Life and disability insurance
13. Increased personnel
14. Additional equipment
15. Office refurbishing
16. Office expansion
17. Eventual profit sharing and retirement benefits
18. Practice provides facility(s), staff, equipment, supplies

The agreement should stipulate that the associate is entitled to her/his incentive compensation and certain benefits provided that she/he remains an active employee of the practice at the end of each year.

The parties must consider the *break-even point*. It will cost between \$10,000 and \$15,000 to bring a new associate on board, and the compensation package includes the base salary and/or incentive compensation plus benefits, which can easily run 20% or more of the base salary. A simple determination of the break-even point is:

$$\frac{\text{THE PACKAGE}}{\text{OVERHEAD EXPENSE}} = \frac{\$190,910}{.53} = \$360,208 = \text{BREAK-EVEN POINT}$$

If you wish to fine-tune this method to determine the break-even point, you, your accountant or advisor can calculate and use the more detailed:

$$\frac{\text{TOTAL FIXED COSTS}}{1.0 - \text{VARIABLE COSTS \%}} = \frac{\$180,000}{1-.50} = \$360,000 = \text{BREAK-EVEN POINT}$$

Determining the break-even point clearly indicates that the associate or practice must generate around \$360,000 in *additional* revenues to pay for the increased costs of paying the associate his initial, basic compensation package.

It is wise that the practice clearly indicates and introduces the associate to the hefty costs of running an oral and maxillofacial surgery practice and how such costs affect the bottom-line profit and compensation of all doctors.

**Equity Ownership:** Operating under the assumption that the employment arrangement will progress to equity ownership, a comprehensive practice valuation and proforma projections should be prepared. (Table 1).

The valuation becomes an important part of the practice. Not only does the appraiser determine and provide a written (hopefully certified) report of the current value of the practice, but the appraisal also acts as a feasibility study. Values are not static and the practice should be valued annually and updated appropriately. A wise

Table 1

COMPENSATION PRO-FORMA							
CORPORATION DR. JUNIOR	Year	1	2	3	4	5	6
REVENUES*	\$1,200,000	\$1,272,000	\$1,348,320	\$1,429,219	\$1,514,972	\$1,605,871	
(LESS) EXPENSES @ 50%	-600,000	-636,000	-674,160	-714,610	-757,486	-802,935	
NET DISTRIBUTABLE INCOME	600,000	636,000	674,160	714,610	757,486	802,935	
COLLECTIONS @ 35,40,45,50,50%	210,000	254,400	303,372	357,305	378,743	401,468	
(LESS) INCOME ADJUSTMENT	-25,000	-35,000	-45,000	-55,000	-58,750		
COMPENSATION	<u>185,000</u>	<u>219,400</u>	<u>258,372</u>	<u>302,305</u>	<u>319,993</u>	<u>401,468</u>	
* Annual increase - 6%							

investment, the valuation carries forward from year to year and forms the basis for certain insurance coverage, buy-ins and buy-outs and other financial activities. The documents that the parties require at this stage are the comprehensive practice valuation, general plan for buy-in and the associate's employment agreement.

**Advisors:** Advisors are required from the beginning and throughout the three phases of a professional practice. Each OMS must have a team and work with qualified, competent experienced advisors. Simply, there are too many facets throughout their careers in which the parties shall become involved. The facets are personal, professional, legal, accounting, financial and risk managing in nature. Today, more than ever, a career and practicing in an oral and maxillofacial surgery environment is not a do-it-yourself proposition.

### Ownership – the buy-in phase

Congratulations. The associateship went very well. The arrangement has progressed from associateship to ownership and the associate becomes doctor junior. In this phase of practice, all doctors commence the process in which doctor junior becomes an equity owner in the practice, that is, doctor junior buys-in. At the same time and in most cases, the doctors understand that doctor junior must prepare, take and pass the examinations of the American Board of Oral and Maxillofacial Surgery in order to progress to equal ownership in the practice and to obtain hospital appointments and advancements. This is something else that makes equal ownership more challenging and requires all parties' consideration and cooperation.

Prior to doctor junior's entry into the practice, doctor senior had the practice realistically and professionally valued by a qualified appraiser who understands the dynamics of an oral and maxillofacial surgery practice. If not, they should at the very least have had a method in place and in writing that determines the value of the practice. An example of this method could be: "The value of the practice for the purpose of associate's buy-in shall be: The fair market value of the tangible assets (major and minor equipment, furniture, furnishings and instruments), clinical and clerical supplies, accounts receivable and payable, liabilities, etc.) plus intangible asset value (goodwill, going concern, records, etc.) at 45% of the practice's 12 month's gross revenues less refunds at the time of associate's entry into the practice. Excluded are cash, real estate or real property and vehicles." They should also have a general plan including

pro-formas in place for implementation of the overall buy-in process. The doctors do not want to be surprised.

By way of example: the determined fair market value of 100% of the practice is \$500,000 which is a reasonable fair market value of a mature oral and maxillofacial surgery practice today. Doctor senior holds the pre-associateship value for the year. In cases of extended terms, the doctors may want to have the value up-dated. In our two-doctor practice, 50% of the value, then, is \$250,000. The term of this and most buy-ins shall be five years, although increasing the term to six, eight or 10 years in larger practice situations may be required. The parties, therefore, break out the value of the stock or units (normally tied into the value of the tangible assets) and intangible assets as follows:

Tangible assets (stock or units)	\$ 75,000
Intangible assets (goodwill, etc.)	175,000
Fair market value of 50% of practice	<u>\$250,000</u>

Today, oral and maxillofacial surgery practices are no longer small businesses. Rather, they are large private, multi-doctor enterprises that generate millions of dollars annually. They have qualified managers and administrators and dozens of trained personnel. Their budgets, expenses, cash flows and problems are large and, in many instances, staggering. The latest statistics (2007 data) of the National Society of Certified Healthcare Consultants present the following revealing information relative to average, mature oral and maxillofacial surgery practices:

Gross revenues	\$1,107,028	
Overhead	- 586,725	53%
PROFIT	<u>\$ 520,303</u>	47%

**Stock or Unit Sale and Purchase:** The Internal Revenue Service requires that doctor junior actually purchase and pay for her/his stock or units for a realistic price. Accordingly, doctor junior shall purchase and pay for his stock or unit interest directly from doctor senior at \$15,000 annually or \$1,250 per month for 60 months. When doctor junior completes his annual payments, doctor senior either separately holds the number of shares of stock or units or places them in an escrow account at the end of each 12 months for five years. Since doctor junior purchases the stock or units monthly and annually, in most cases, she/he may not be required to pay

interest on the annual purchases. Nevertheless, certain accountants and senior doctors still insist upon adding an interest charge. As a distressing matter of fact, certain accountants and senior doctors require their doctors junior to pay the entire buy-in price as a stock or unit purchase with after-tax dollars and interest. As a result, many favorable associateships and buy-ins break down at this point. This is a major reason for pre-associateship and employment practice valuation and planning. As stated, most doctors do not like surprises.

Major points during the entire buy-in process are the price allocations of the tangible and intangible assets and the pre- and post-tax payments for the purchases and sales. Normally, doctor junior should pay for the entire purchase on a post-tax basis, which, today, is around 40% combined federal and state. At this 40% rate, the purchase becomes very expensive. In this case the entire buy-in purchase price would be \$350,000 after-tax ( $\$250,000 \times 40\% = \$100,000 \rightarrow \$350,000$ ). Doctor senior should pay taxes on the sale at her/his long-term capital gain rate, which today is 15% on the “gain over basis,” or the increase in value over her/his original cost of the stock or units. In our example case, doctor junior pays an additional after tax total amount of \$30,000 or \$6,000 per year, which is affordable ( $\$75,000 \times 40\% = \$30,000$ ). The doctors shall have a stock purchase agreement in place that outlines the terms of the stock transaction.

Included in the stock or unit sale and purchase is a “senior doctor’s option,” which states that doctor junior’s purchase of the shares of stock or units is subject to an option (the “Option”). If doctor junior disassociates from or terminates his relationship with the practice during the term in which she/he is purchasing his shares or interest, for whatever reason, doctor senior shall repurchase doctor junior’s stock or units at fifty percent (50%) of the price and terms which doctor junior had paid and doctor senior shall retain the practice, all tangible and intangible assets, supplies, telephone numbers, patient records, logo and any and everything else associated with the practice. Doctor senior’s re-purchase of the shares shall be at the same time frame which doctor junior used for her/his buy-in and should include interest.

**Intangible Asset Sale and Purchase.** The doctors agree that doctor junior shall pay for her/his intangible asset portion on an income adjustment basis. Doctor junior shall receive a certain amount LESS each month and doctor senior shall receive the same amount MORE each month. In our case, that amount would be \$35,000 ( $\$175,000 \div 5 = \$35,000$ ). The doctors, however, are concerned about the tax factors, that is, the current ordinary rate of 40% versus long-term capital gain rate of 15%. Normally, doctor senior would pay for his sale at his long-term rate of 15% over basis. Since the cost of the intangible portion shall be adjusted or shifted between the doctors, doctor senior would be required to pay taxes at her/his ordinary tax rate of around 40%. The difference between the two tax rates, of course, is 25% and the difference shall be, similarly, adjusted or added to doctor junior’s intangible asset purchase price. The annual difference is  $\$35,000 \times 25\% = \$8,750 \rightarrow \$43,750$ . Each month doctor junior shall receive \$3,646 less and doctor senior shall receive \$3,646 more in compensation. Since doctor senior shall be providing management services and helping doctor junior progress in the myriad aspects of the practice, doctor senior shall have a management agreement in addition to his employment agreement. The management agreement outlines the terms of the income shift transaction.

As stated, there are multiple methods for doctor junior to purchase the intangible portion of her/his buy-in portion. The above is considered the “Exact Method” in that the doctors have a comprehensive valuation performed and specific amounts allocated to the stock or units, which include or consider accounts receivable and payable and the intangible assets. In the “Inexact Method,” the doctors do not require a comprehensive valuation. They do require the fair market value of the tangible assets or some other method to form the basis of the stock or unit sale and purchase. In this method, in contrast to the exact method, accounts receivable and payable are not included and the doctors address and handle them as a separate transaction. Generally, the senior doctor retains the accounts receivable and payable.

Instead of allocating a specific value to the intangible assets, doctor junior, generally, a) has a two-year associateship term and, thereafter, b) receives a reduced percentage of doctor senior’s annual compensation over four years. By way of example, starting in year three, doctor junior would receive 60% of doctor senior’s annual compensation. For the following three years, doctor junior would receive 70%-80%-90% of doctor

senior's annual compensation. Thereafter, the doctors would receive equal compensation or they work out a mutually agreeable compensation plan. This method has been and is popular in the medical profession. However, few oral and maxillofacial surgeons are willing to simply allocate a certain percentage of their income until doctor junior actually produces her/his fair share of revenues. Importantly, since doctor senior receives each year's percent differential as ordinary income, she/he will pay taxes on the differential at ordinary income rates, which would be considerable over four years.

At the end of the 60 months, provided that doctor junior has paid for her/his stock or unit and intangible assets purchases in full, doctor junior shall become an equal Shareholder or Member in the practice. Doctor senior shall issue doctor junior the appropriate stock or unit certificates representing the equal number of shares or

units. In former years, most buy-ins were structured on a 51%-49% ownership relationship so that the senior doctor could maintain control. This is not so common today because doctor senior can maintain control in certain aspects by other means and agreements. For instance, if doctor senior is concerned about his being unjustly terminated or "locked out," provided that he is physically and mentally capable, he could have a "no-cut" employment agreement or other agreements to protect his position. The doctors can have other terms and agreements in place that provide equal protection and responsibility for all parties in the practice business transactions.

1. 2005 Survey of Dental Practice, American Dental Association, Chicago, IL

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