TOP 10 ISSUES FOR DENTISTS CONTEMPLATING RETIREMENT IN 10 YEARS OR LESS

TIMOTHY G. GIROUX, DDS

WESTERN PRACTICE SALES
Western Practice Sales/John M. Cahill Associates is a dental brokerage team committed to excellence. Our outstanding credentials, decades of experience, professionalism and reputation are superior to any in the industry. We are the only brokerage firm that represents sellers and locates buyers in all of Nevada, California and Arizona. Meet our Team of Brokers and Professionals:

**Timothy G. Giroux, DDS**

Hailing from the greater Chicago area, Dr. Tim Giroux established his own dental practice in Scottsdale, Arizona, upon graduation from Creighton University, School of Dentistry in 1983. Relocating to Northern California with his wife, Mona Chang, DDS (LLUSD ’84) upon selling his highly successful practice after 15 years, Dr. Giroux brings a unique perspective and personal experience in dental associateships, practice start-up, sales, and work-back situations to serve and assist you during your exciting transition! Dr Giroux writes the widely-read monthly “Ask the Broker” feature, is a regular contributor to Dental Economics, has been a Featured Speaker for CDA, as well as providing numerous dental transition presentations.

**Jon Noble, MBA**

One of the original Founders of Western Practice Sales, Jon Noble received his M.B.A. from California State University, Chico. He adds not only a wealth of knowledge and professional expertise but also more than 25 years of experience and involvement in over 600 transitions! Jon, his wife and 2 sons are avid Kings’ and Giants’ fans and partake in the perennial recreational activities of fishing, snow and water skiing. Jon especially enjoys the opportunity to facilitate the smooth and successful transition of dental practices by consulting or brokering.

**John Cahill, MBA**

Mr. John Cahill, MBA, has more than 45 years of experience in the dental industry, including all aspects of appraisals, sales, purchases, and buy-ins in connection with dental transitions. John is nationally known as one of the country’s premier transition specialist. He is an emeritus member of American Dental Sales, Inc., a regular contributor to Dental Economics and has been a frequent featured speaker for many dental groups over the years. He brings knowledge, experience and integrity to the transition process.

**Ed Cahill, JD**

Mr. Ed Cahill received both his accounting and law degrees from the University of San Francisco. His strong background in banking and accounting complements his prior experience as a mediator. Ed’s wide range of knowledge, hands-on experience and outstanding people skills allow him to connect with both the Seller and Buyer, helping to create a smooth transition environment.
Western Practice Sales/John M. Cahill Associates is a proud member of ADS Transitions, a national consortium of dental brokers which provides quality service to healthcare professionals.

Our brokerage firm provides much more than practice transitions:

- Seller Representation
- Document Preparation: Letters of Intent, Contracts of Sale and related documents
- Practice Appraisal/Valuation
- Practice Consultation
- Equipment Only Sales
- Facility Only Sales
- Chart Only Sales
- Partnership Agreements
- Real Estate Sales (California Only)
- Financing Procurement Assistance

As part of our unsurpassed transition services, we offer our Sellers an effective marketing strategy during the selling process. To achieve this, we prepare a comprehensive Prospectus and Proforma which is posted on our website and sent to prospective Buyers for consideration. In addition, we advertise in the following:

- CDA Journal
- AzDA Journal
- Dental Economics
- The Dental Shopper
- Specialty Journals
- Our Web Site: www.westernpracticesales.com
- ADS www.adstransitions.com
- Dentaltown.com

We are committed to excellence and look forward to working with you.

Sincerely,

Timothy G. Giroux, DDS
Broker/Owner
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ABOUT THE AUTHOR

Timothy G. Giroux, DDS attended Creighton University undergraduate school and dental school. He entered dental school after two years of science and one year of business school. He graduated from Creighton Dental School in 1983 and immediately moved to Phoenix, Arizona where he was an associate in one of the first successful corporate dental settings. He opened his own practice from scratch in Scottsdale in January of 1986.

He later brought his future wife into his practice, Dr. Mona Chang, a Loma Linda School of Dentistry graduate in 1984. Dr. Giroux and Dr. Chang relocated to Northern California for family reasons in 1999.

Dr. Giroux “fell into” practice transitions when he contacted Dr. Bob Gartrell, a past associate dean of the University of the Pacific Dental School in San Francisco, to help him locate patients to take the California board at UOP. At the time, Dr. Gartrell owned Western Practice Sales, a dental brokerage company for Northern California. Eventually, Dr. Giroux asked Dr. Gartrell if he could buy Western Practice Sales from him as he was not intrigued with the idea of having to take the California board. That transaction occurred the first quarter of 2001, and Dr. Giroux has not looked back since. He later acquired his well respected competitive firm, John M. Cahill and Associates, in July of 2006.

Western Practice Sales now does business in three states and completes approximately 60 to 80 practice transitions every year. Western Practice Sales is a member of ADS Transitions, a conglomerate of respected independent dental practice brokers across the country.
INTRODUCTION

While I will treat “The Top Ten Issues for Dentists Contemplating Retirement in Ten Years or Less” as separate chapters, some of the issues will need very little explanation and others might fill pages that should be broken down into several chapters. Since general dentistry practices represent the majority of dental practices, the discussion will be geared towards general dentistry practices. However, these issues affect all specialties in one way or another.

In full disclosure, I believe in the “KISS” rule. Keep it simple stupid. We will discuss many of the alternate exit strategies that one can consider themselves an expert after a weekend class, but most dentists that are retiring in the next ten years are private practitioners in solo practices. Partnerships, partial sales, long associate buy-ins are sometimes feasible and sound good in that weekend seminar, but I have also seen lives utterly destroyed by a bad business divorce. Most of us that got into this profession enjoy being our own bosses. That sentiment is changing and we will discuss this as a reason why there will be more partnerships and multi-doctor practices in the future.

When I practiced dentistry, I did not even know how to turn on my own computer. I viewed dental brokers as the devil, and attorneys were even lower life forms than brokers. Every dentist I knew could be classified as cheap. Sometimes that was true in a bad way, but mostly I believe that dentists are simply wired to be as efficient as possible. (I also think that we came from a generation that had to be responsible at a much earlier age than the young dentists I see entering the workplace today.) Most of us are computer savvy now, but I blame that, combined with those other traits, for the reasons I believe dentists “go it alone” when making important business decisions. Instead of asking professionals in accounting, investing, partnerships or retiring, we ask our fellow colleagues what they did and then go do it. Guess what, your fellow colleagues may not have had the best advice either, or they flew solo because they took a course or read a lot on the internet!

Obviously I had to change my attitude towards brokers and attorneys to do what I do now. As in any profession, there are good ones and not so good ones. However, it is probably easier to research and discern who you should trust in those professions than it is for patients to know if they had a good filling placed!

Below is a list of “take-aways” that I hope all readers reap after understanding the issues presented:

- Dentistry is a great profession and will continue to be.
- One can never start too early to plan for the future.
- Happily engage the qualified specific dental professionals regarding leases, accounting, legal issues and practice management.

No matter what your age or plan is right now, speak with a financial advisor about what you should do for retirement. As you read about the issues, you might want to speak with your attorney about your long term lease or your accountant about your depreciation schedule, depending on where you are in your journey.

Of course, your local friendly dental broker can also give you an idea on just how valuable your dental practice is!
CHAPTER 1
THE TIMELINE
Most dentists do not plan for their retirement soon enough. Young adults in general do not think of making a plan in their twenties or thirties as they believe retirement is so far away and that the notion is not something that needs to be addressed for quite some time. The reality is that retirement planning should truly begin within a few years of graduation from dental school.

Chances are if you are reading this, you are later in your career and may or may not already have some type of savings and retirement account. No matter where you are in your plan, I highly recommend that your accountant and your financial planner have met with one another to make sure you are all on the same page. Personally, I have been out of dental school for over 30 years and I started an IRA account just a few years out of dental school. However, some poor investments and no real focused plan have left me in a situation where I recently realized that I desperately needed to hire some investment folks that are now finally putting the plan together. They are responsible for quarterbacking the advisors to make sure my goals are met. I was surprised to learn that my previous financial advisor, my accountant and my pension plan person really did not communicate much with each other on the nuances of the entire plan.

Your insurance agent is also part of the plan. Life insurance, disability insurance, umbrella liability insurance are all part of a portfolio for someone who is financially set to retire. Again, make sure your advisors agree on the types of insurance you need to meet your goals.

The local dental broker can sometimes be an incredible plethora of information. Many brokers understand the tax and legal consequences of a practice transition. At the minimum, they should be able to give you a “ballpark” value of your practice in the current local market. This “ballpark” number should be reasonably close enough to help your financial team determine when the proper goal of retirement can be obtained. We will discuss much more on dental brokers in a later chapter.

Tax structures, the economy and life’s various surprises will continually change the plan. Take the time to form a goal and check with your advisors on the goal. Make sure when you decide to retire, it is not just because it took you seven impressions to get that crown margin correct!
WHEN IS THE BEST TIME TO SELL?

Many times I hear people in my profession advising doctors to sell at the peak of their careers. I do not necessarily agree with this advice. Your career is not like selling a stock, where it absolutely makes sense to sell at the top. Your practice is a long term income stream. It is also something that gives you value in your life.

After you have consulted with your financial planner and accountant, you can then decide when the best time to sell is. Most of us have too many “what ifs” to say with certainty that we are completely set financially. If you still enjoy practicing dentistry for at least 20 hours a week, it might make more sense to continue to practice even though your practice is starting to slow down. Since a practice sale only averages about two times what you make as income for a year, it is simple math to see that it does not take too long to make up for the difference you might have lost by selling your practice once the numbers started to decline. Think about it, you could work your practice just an extra two years after you hit your “high mark” and pocket what you would have by selling your practice.

However, there is a point of diminishing returns on a practice that is winding down. Once a doctor starts to take home less than their hygienist or front office person, they have probably stayed in the practice too long. Some dentists enjoy practicing more than they enjoy golf. Some dentists or their spouses know it is better if they don’t spend every waking hour of the day together. There are a myriad of reasons to answer the question “when is the best time to sell”!

What steps should I take if I am __ years from retirement?

0 – 2 YEARS OUT

At this stage, there is really nothing to do. You should NOT be making any capital expenditures of any kind at this point. Even if your chairs and some equipment is 30 years old, I do not believe you will recoup any of the costs to replace the equipment that probably should have been replaced years ago. The dental market is constantly changing and we will be addressing some of the market forces in later chapters, but contacting your local dental broker is most advised at this point. The local broker should be able to give you an idea of how marketable your practice truly is. For instance, if your practice is a better merger candidate due to its size, it would be foolish to spend any money to replace old carpet or paint the space. If your practice has a good chance to sell in the market, the broker can advise you what steps might be cost effective to improve the desirability of your practice. Sometimes just a little spring house cleaning and some paint can greatly improve the desirability of a practice when the doctor wants to sell in less than 2 years.

3 – 5 YEARS OUT

Three to five years out is not too different than zero to two years out except that it now makes sense to change the carpet, paint the walls and do the spring house cleaning anyway. You, your staff and your patients will appreciate the effort and the improved office. Large capital expenditures at this point should also be avoided. Cerec units should have a definite return on investment. Unless you are doing a great deal of single unit crowns
and the amortized payments over the remaining time you plan on practicing show a large return on investment, I would advise against the purchase.

The only expenditure I believe is worthwhile less than 5 years from retirement is digital x-rays. Offices that already have a fairly hefty computer system for their management software won’t take a gigantic expenditure to get the office into the digital x-ray environment. Other offices might need a complete computer overall, and the return on investment is not worth the expenditure.

So why consider digital x-rays with 3 to 5 years out? If your practice is definitely a candidate for a traditional transition, the new dentist buying your practice probably has never used film before! It has been almost 10 years since a new graduate used anything except a digital x-ray system. I suggest considering leasing the system and then marketing the practice with a price and disclose that the new buyer will also be assuming the lease in place. The dental supply companies will be happy to show you that a ten year lease on a digital x-ray system might actually save a little money if the cost of lead in the film and processing chemicals keeps increasing.

I recommend all of the suggestions from zero to five years left to retirement, especially carpet, paint and digital x-rays. Large capital expenditures like a Cerec or a Laser might actually have a positive return on investment, but crunch the numbers to make sure. Some ergonomic expenditures or even classes on new techniques where there might be a subsequent investment might energize your attitude towards your profession and that positive attitude sometimes translates into a positive ROI. If you enjoy dentistry, you may choose to practice longer than you need to economically, but your physical and mental health needs to be attended to.

Again, all of the previous suggestions are recommended. New ergonomic chairs for the patient and you might just make your work environment healthier both physically and mentally. Again, it does depend on the size of the practice. Larger practices generate more cash flow after normal fixed expenditures to support your family, so larger practices can absorb these capital expenditures easier. Your practice is not unlike the homes in your neighborhood. A well maintained house will sell easier and for more money than a house where customary maintenance and upgrades were ignored. Most dental schools now have the latest and greatest technology. Dentistry in the technology and computer age is changing way faster than the dentistry for the 80 or so years prior. Sometimes the buyers cannot look past the old equipment to realize there is a great patient base that might appreciate some new technology. Don’t let things get too outdated. Make the expenditures early enough so that you enjoy the majority of the useful life of the equipment or improvement. Obviously there are different types of upgrades that can be more cost effective, like re-upholstering chairs or resurfacing cabinets and counters compared to total replacements. Bring a fresh set of eyes into the office to make sure you are not overlooking things of which you have become accustomed.
Various equipment and leaseholds have different lifespans, but since we spend a huge portion of our lives at work, we deserve to work in an environment which we enjoy. A good environment with ergonomic equipment can help us enjoy working more years with greater satisfaction. Update your basic equipment and leaseholds on a routine basis. Substantial investments such as a Cerec machine or a 3D cone beam unit should only be purchased if it increases your return on investment. *It should be utilized enough to offset the expense. Don’t assume that it will expand your practice. Be sure you have the patient base to support your investment. This is not like the famous line in the movie that states “if you build it, they will come!”

Practice value is typically based predominantly on your collections or net profit. Upgraded equipment and leasehold improvements may only increase the practice sales price nominally and generally will not return dollar for dollar the cost to upgrade compared to nominal increase in the purchase price. However, in a competitive market, you might need an updated office with newer equipment in order for it to be competitive with the other practices on the market. Your local dental broker should be able to give you some guidance.

**UPGRADED EQUIPMENT AND LEASEHOLD IMPROVEMENTS MAY ONLY INCREASE THE PRACTICE SALES PRICE NOMINALLY, AND GENERALLY WILL NOT RETURN DOLLAR FOR DOLLAR THE COST TO UPGRADE COMPARED TO NOMINAL INCREASE IN THE PURCHASE PRICE**

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is keeping your practice in its current location or leaving the opportunity open for a buyer to purchase your patient charts and merge them into another practice.

In summary, capital expenditure decisions are dependent on: 1) the time remaining before you retire, 2) the possible return on investment for new technology, and 3) the size of your practice and likely model for your specific transition requirements.

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**SMALLER PRACTICES**

Practices which are collecting less than $400K to $500K might be better merger opportunities as the average debt loan of a recent graduate is approaching $400K. Those smaller practice owners may need to position themselves with shorter term leases to be able to accomplish the move or merger into another practice. Therefore, equipment and leasehold expenditures would definitely not be warranted. When you are five years out from your planned retirement, speak with your advisors to determine whether your best exit strategy
CHAPTER 2

DEMOGRAPHICS
Supply and demand is always considered the greatest of all economic forces in any market. The chart above shows the number of dental school graduates between 1970 through 2013 and projections until 2020. I had the fortune of graduating from dental school in 1983, the year of the most dental school students on record. Our instructors predicted that we were the most unfortunate class in the history of dentistry, as not only was supply and demand against us, but we graduated into 15% interest rates and an economy that was in a significant malaise. This negative attitude lead to the closing of many dental schools and the chart above shows that the lowest number of graduates occurred around 1995. The good news was that the Reagan recovery was followed by the technology boom during the Clinton years and the negative prognostications of the economy and dentists in general completely turned around. Around the year 2000, the general thought was that many of the retiring baby boomers might have to “leave the keys to the office and just walk away” when they wanted to retire as there would not be enough dentists to purchase the retiring dentists out. As the chart shows, that is no longer the concern. Dental schools opened up again and the number of graduates in 2016 is, for the first time, expected to be greater than the graduates in 1983.

But wait, the above graft shows the breakdown of the dental school classes by gender. In 1983 about 10% of the graduation class was female. In 2015 about 50% of the graduation class is female. Some women want to work part time in dentistry so that they can spend more time with their children. Dentistry is a fantastic profession for women who wish to have a professional career and raise a family as there are several avenues that a male or female dentist can take if they wish to practice less than 25 hours per week. Corporate dentistry is one of those and we will discuss their effects on dentistry in another chapter. Partnerships are on the rise with split-shift models or two doctors each working 20 to 25 hours in the same facility.

I absolutely know that the mentality of nearly 100% of my class was to go out in the world and eventually get into private practice (with the possible exception of a few military or public health scholarship recipients). However, this new generation is not “wired” like the older generation to be their own boss. Between the desire of some female dentists that want to also raise a family and the new attitude of the Millennials, this supply of new dentists may still fall short of the demand once the baby boomer generations of dentists decide to hang up the drill.
THE DILEMMA

How do the demographics affect my retirement plans? My instructors in dental school predicted our demise. Supposedly the golden age of dentistry had passed us, but they could not have been more wrong. The relative incomes of dentists actually grew steadily from the late 80’s until about 2008.

The graphs included in this chapter were provided by Eric S. Solomon, DDS of Geo Site Search. If you are interested in requesting a specific demographics report, you can reach Dr. Solomon via mail: Geo Site Search, ATTN: Eric S. Solomon, DDS, 9432 Spring Hollow Drive, Dallas, TX 75243, by phone: 214-503-9310 or via email: ESolomon@bcd.tamhsc.edu

PREDICTION

I believe the supply and demand forces of private practice sales will remain relatively constant. There will be more practices entering the market as the baby-boomers finally let go of their practices. The average practice nationwide sells in the range of 67% of last year’s collections. I do not see that changing greatly. Larger cities always seem to have a higher demand, but I see their higher multiples over 80 percent of price to gross to come closer to the national averages. However, the lower revenues we are seeing and the probable increase in interest rates will have a negative effect on practice values.
CHAPTER 3

CORPORATE DENTISTRY

SAD TO SAY CORPORATE DENTISTRY IS HERE TO STAY!
I was part of a panel of experts discussing The New Economics of Dentistry. Part of the discussion focused on what affects dentistry today and the growing influence of Corporate Dentistry. In full disclosure, I started my dental career in corporate dentistry (That particular company closed its doors in 1989.). It was a great experience for me as I was exposed to more dentistry in those two years than any of my classmates who worked at traditional positions. That was 1983. I believe that almost everyone in my graduating class dreamed of owning their own practice. *The attorney on the panel last week stated that a recent survey in a Southern California dental school revealed that nearly 80% of that particular class did NOT want to own their own practice!* Why and how can that be?

1. **There is a generational difference.**
   The new graduates are happy just “working for the man” and getting their paid holidays. They value their time off and do not dream of creating their “empire.”

2. **My class was less than 10% female.**
   Now the classes are over 50% female. However, there seems to a higher percentage of female dentists who desire to work part-time for family reasons as compared to their male counterparts.

3. **The debt load of the current graduates is more than $300,000 compared to only $30,000 when I graduated.**
   The new graduate is concerned about taking on additional debt with a practice start-up or a purchase.

When I graduated, the biggest problem for Corporate Dentistry was the revolving door of dentists who would come to work for a few years and then leave to pursue and establish their own practices. For the three reasons above, this is no longer an issue. Many of the corporate players are offering different financial packages and continuing education opportunities. They are finding ways to reduce the staff and doctor turnover that plagued the industry in the past.

While I do believe that Corporate Dentistry will continue to grow over the next several years, I also believe that it will also reach a lower peak point than where most of the industry professionals think it will hit. Currently Corporate Dentistry comprises approximately 20% of the industry. Many think it may double in the next few years. Below are some reasons that I believe its growth will be self-limiting:

1. While Corporate Dentistry has perfected the new forum of marketing through social media and the internet, I believe that patients will eventually sense that corporations exist to make a profit. While private practitioners obviously need to make a profit to stay in business, I still believe that most dentists realize that if patient concerns come first, the financial rewards will follow. Patients also want to know that the doctor giving them an injection with a three inch needle actually cares for them more than their own wallet. Compared to medicine, dentistry is still fairly affordable and properly educated patients are willing to pay a little extra for quality care with a practitioner they can trust. I think it is fairly safe to say that Corporate Dentistry trains their doctors to maximize their treatment plans. Eventually the general public will realize that fact. Of course there are private practitioners that are very adept at this also, but it is the rule for Corporate Dentistry.
2. Corporate Dentistry sells itself to their associate dentists by telling them that the Corporation will take away most of the management headaches which allows them to simply practice dentistry. While some of that is true, it would cost less for a high producing dentist to hire a full time Human Resource/Office Manager to take away those headaches. The full time, hard working associates who start with Corporate Dentistry will hopefully come to understand that Corporate Dentistry exists because it takes approximately 40% of the profit out of the practice that would have normally been part of the take home pay for the owner/doctor. For example: Your typical $1 Million dollar practice should cash flow about $375K. Normally $700K of that practice is from dentist production and the rest is from hygiene. With bonuses, a doctor in Corporate would take home about 28% of his production of the $700K, or about $196K. Therefore, the same production in private practice would have yielded an extra $175K that would allow the doctor to hire that additional manager to take away his headaches and retain the remainder.

3. Corporate dentistry exists because it takes 40% to 50% of the profit!! Yes, I realize that I just stated that above, but I want all sellers to resist the urge to sell to corporate dentistry for the same reason. Normally corporate dentistry insists on a two year “earn out” or “hold back”. The selling doctor is required to stay on for two years and work as an associate for 28% (or less) of production. If a doctor in that same million dollar practice scenario works the math, he generally has to work an additional two years at the same level, which equates to working just as hard for $350K less over the two years!!! Yes, he does have some cash in the bank and supposedly lesser headaches, but please be fully informed before you consider pulling this trigger!

Therefore, it makes sense that Corporate Dentistry would only be attractive for dentists who do not want to work full time. Overhead costs in dentistry are high and will probably continue to grow, but dentists who work full time in their own busy practices will normally be more successful in their own well managed practices compared to Corporate.
CHAPTER 4

DEBT
STUDENT LOAN DEBT IS ONE OF THE LARGEST PROBLEMS IN DENTISTRY TODAY FOR OLDER DOCTORS TOO!

My daughter is a second-year dental student at a private dental school in Southern California. Her class will graduate with an estimated $400,000 debt assuming they also borrowed money for living expenses along with their dental education. This is a massive amount of debt to cover before one even discusses normal living expenses after graduation, such as a home, car, children and undergraduate school debt! The monthly payment on a 10-yr loan for $400,000 at 5.5% interest rate is more than $4,300 per month. Since that is basically an after-tax amount, one would need to generate an income of almost $5,400 per month just to pay off the dental school loans!

First, let’s discuss how this affects selling or aging doctors. For those of you who have practices that generate less than $400,000 in yearly revenues, your practice which has provided such a great lifestyle for you all these years, might not provide enough cash flow to a young dentist, especially if you are in an area where real estate values are higher than the national average. Some of your practices are the best values in the market as you might be “coasting along” in your practice by referring out many specialty procedures that could be routinely performed in your office. No matter how large or small your patient base is, there is value in your patient base! The young doctors with debt may need to buy two smaller practices and merge them into one location to ensure the cash flow is adequate to meet their needs.

Therefore, the selling doctors of the small practices should get creative with their leases and place themselves in a position to facilitate a possible merger of their patient base in the future. Since mergers yield the best Return on Investment in practice transitions, there should be no discount in price for a merger opportunity.

Doctors with medium to large practices that have the notion that they would like to work part time as an associate need to realize that there might not be enough income to support the young dentists cash flow needs in that situation.

Doctors with larger practices are candidates for alternate strategies and are advised to read the chapter on those options.

What is the best path for a young dentist to pay off their student debt?

OWN YOUR OWN SUCCESSFUL PRACTICE AND USE THE “PROFIT” TO PAY OFF DEBT

This message needs to be instilled into the current young dentist environment beginning in their dental schools!
CHAPTER 5

THE LEASE
The lease is becoming one of the most critical issues on a transition. Most doctors believe they have a lease or the landlord will easily come to some agreement to facilitate bringing a new tenant into their space. It would seem to be common sense that the landlord would be appreciative that a dentist would bring the tenant, and the landlord would not even have to pay a commission to an outside leasing agent. Well, business is business and if the landlord sees a way to extract money or extra protection on the new lease, he will certainly take advantage of that. Landlords fully understand the lender will insist the lease is at least as long as the term of the buyer’s loan.

In the “old days,” it was understood that the dentist would simply make sure their current lease had an option or two that a buyer could exercise and that would be enough. The assumed understanding is that these options would go with the current lease to the new buyer, and if and when the buyer exercised that option years after the sale, the seller had no concerns as it made no difference to him.

The reality of today’s leasing world is that none of this is addressed in the standard lease language. What now happens is that when the seller gets the assignment language from the landlord, usually just before the close of the sale, the language clearly states that not only is the seller still on the hook for the remaining term of the lease (which is a standard understanding), but the seller will also be on the hook for the remaining option periods of the lease, no matter how long that might be, because these options were transferable only because they really belong to the original tenant. The seller is now over a barrel, and sometimes the landlord will “let the seller off the hook,” for a small price… like $5000 to ten times that amount, depending on the size of the transaction.

All of these issues can generally and easily be negotiated at the onset of the lease. As stated, it is not normal to get that specific on these issues at the beginning of a lease, but obviously all negotiation strength is gone once the lease is in place and the landlord knows that you are making money on the sale of your practice. Specifically, the options cannot be considered “personal” which is code for non-transferable. The options need to be specifically assignable and there should be language in the lease that states that the original tenant is not responsible for these assignable options if they are exercised by a future buyer of your practice. The original lease should specifically be assignable and that the assignment “cannot be unreasonably withheld” by the landlord. This means that the landlord has the right to approve the future tenant by looking over their financials. In most cases, if the buyer can get a loan to buy your practice, they should have adequate financial strength to be approved by the landlord. If the buyer does have some credit issues, it would be understandable that the landlord would need some assurance that he has recourse if the buyer does default. We advise a larger security deposit from the buyer as compared to the seller having to stay on the lease for a longer period of time.

**LANDLORDS FULLY UNDERSTAND THE LENDER WILL INSIST THE LEASE IS AT LEAST AS LONG AS THE TERM OF THE BUYER’S LOAN**
The seller does need to understand that there is generally “nothing in it” for the landlord when you decide to sell your practice. It costs time and money with his attorney and leasing agents to assign a lease. Also, in 99% of the cases, the landlord is trading an established client that is financially stronger for a new client that might have negative net worth due to student loans. This is why it is so important to address this issue years ahead of the process!!

For those doctors that have a practice producing less than $500K per year, we advised in the debt chapter that you need to consider a series of short term leases to make your practice available for a possible merger. A two-year lease with 5 two-year options and all the protection language we mentioned allows for a sale or a possible merger.

CALL YOUR ATTORNEY BEFORE YOUR NEXT RENEWAL TO MAKE SURE YOU HAVE PROTECTIONAL LANGUAGE IN YOUR LEASE, EVEN IF YOU ARE DECADES AWAY FROM RETIREMENT
CHAPTER 6
ATTORNEYS, ACCOUNTANTS AND CONSULTANTS
If you are reading this book, I assume you already have an accountant. If your accountant is a known “dental accountant,” then they are already versed in the nuances of the tax ramifications of a dental practice sale. While many of you may have used an attorney for different reasons, if he is not a “dental attorney,” then I would highly recommend that when you need an attorney in your practice transition, that you hire a known and respected “dental” attorney. There is no such thing as a “dental” accountant or attorney, but there are some in these professions that limit their practice to mainly dental issues. Many dental brokers are also invaluable vessels of useful information that they have gleaned over the years by negotiating between the buyer’s and the seller’s professional advisors. If your accountant is not a “dental” accountant, you made need them to speak with the attorney or broker that has had experience in dental transitions. Ultimately your accountant needs to be comfortable filing your tax return.

Consultants might be a great idea to help grow a practice prior to retirement. They can also be a valuable asset if you are one of the few owners that really do have a large enough practice to consider a partial sale, extended sale to an associate or a sale and work back situation. Generally they are not needed by the seller in a simple transaction, but they can be very valuable to the buyer in a simple transaction.

ACCOUNTANT

Hopefully your accountant has been there during the lifetime of your business and pointing out areas on your profit and loss statement that might need evaluation in an effort to make your business more profitable. One step that gets overlooked too late is your depreciation schedule. Many old doctors end up carrying tens of thousands of dollars of already disposed of equipment on their depreciation schedule.

If you have a larger practice, look over your own depreciation schedule at least 10 years prior to retirement of a sale and eliminate equipment from the schedule that no longer is in the practice. The allocation of equipment on a practice sale is normally a percentage of the purchase price, so a large practice price tag may result in an allocation to the equipment that is greater that the current value of the equipment in the practice. Without going into the details, there might be a tax benefit to those who can realize some of this equipment allocation as goodwill as compared to recaptured income.

YOUR LAST YEAR’S TAX RETURN IS NEARLY EVERYTHING!

Right or wrong, the market forces in dental practice transitions have decided that the last tax return is the basis of value for a dental practice. Dental lenders have a big say in dental practice sales as they typically provide 100% financing to buyers that have a negative net worth due to their school debt. They have been most gracious compared to conventional business lending and have routinely loaned 100% of a purchase price up to 85% of the gross receipts on practices that grew every year based on their last year’s return, normally their best return. Since the economy has been fluctuating since 2008, the banks have not changed their policy and are still lending on the last tax return. The problem here is that many of our practices have declined for various reasons since 2008. Not only do the lenders base their loan amount on the past year, but they may reject a practice that has declining revenues over about 7% or so. They will not “average” or do a “weighted average of the last three years” to come to their “value” on a practice. There are some markets in hot areas where buyers with additional funds and no debt can break the lender’s value, but since the majority of the buyers are new dental graduates with debt, the lenders have a say in most markets.
THEREFORE, IF YOU HAVE A PLAN TO RETIRE, TRY TO FINISH UP YOUR LAST TAX YEAR STRONG. PERHAPS WORK THAT LAST WEEK OF THE YEAR AND MAKE ALL YOUR DEPOSITS TO BE POSTED BEFORE YEAR END. IT IS BETTER TO PRE-PAY SOME BILLS THAT YEAR TO OFFSET THE ADDITIONAL INCOME AS THE MARKET FOR PRACTICE SALES IS ALSO WEIGHTED TOWARDS THE GROSS RECEIPT NUMBER.

IT IS A CRIME NOT TO REPORT ALL YOUR INCOME!

This should be self evident, but I cannot tell you how many times I have doctors that will admit to not reporting all their income, but WANT THEIR PRACTICE VALUED INCLUDING INCOME NOT REPORTED!

Most small business owners enjoy tax benefits that are not available to simple employees. Some accountants and/or dentists are definitely more aggressive on what they categorize as a business expense. If the government does not agree with our deductions, you might get a penalty with interest, but normally only if they audit you. If you falsify your income, they don’t just slap you on the wrist with a penalty, they may throw you in jail!

I can definitively say that selling a practice with a clean tax return is easier than selling a practice where the doctor or the accountant are aggressively trying to show a low taxable income. Some adjustments are considered normal, while others might seem so aggressive that a buyer might begin to distrust the seller. Sometimes there is a fine line to be drawn for reasonable deductions and blatant disregard for the tax law.

APPRAISAL FOR THE PRACTICE

I might step on a few toes with my colleagues on this one, but I feel it is more beneficial developing a relationship with your dental broker than it is to have an appraisal done. Unless you need an appraisal for legal matter, such as a divorce, a buy in or perhaps financing of some sort, your local broker can give you an idea of your practice value for curiosity or planning purposes. Your particular local market can change and it is a good idea to keep up with the changing value. It is also a good idea to have your spouse know your broker and know who to contact in case something happens to you. It is probably a good idea to sign a codicil that gives directions on how the sale of the practice is supposed to occur in the unfortunate situation of the death of the practice owner. I will address why it is important to consider a broker in every transaction in a later chapter. Suffice it to say, it is imperative in my opinion to hire the broker immediately after an untimely death, and yet, I think I see more spouses trying to sell their deceased partner’s business than the percentage of dentists that attempt this on their own while they are alive!
Essentially an appraisal is done upon the listing of any practice that is going to be taken to the market. Ultimately the final say of an appraisal is what the market bears as the definition of an appraisal in real estate which is “the estimated amount for which an asset or liability should exchange on the valuation date between a willing buyer and a willing seller in an arm’s length transaction after proper marketing and where the parties had each acted knowledgeably, prudently and without compulsion.”

Your dental broker is probably the best person to ask as to what the local market will truly bear at that given time. This can certainly be a range of value, because as stated, the market is constantly changing.

**Conclusion:** If you and your spouse set up your future proposed practice sale with your broker in advance, you have my permission to take your spouse to vacation to Maui instead of spending that money on an appraisal!
CHAPTER 7

SELLER EXIT STRATEGIES
Let’s first talk about what the most important part of any practice is. Goodwill has a few different definitions in practice sales. It is the largest allocation of the purchase price in a typical practice sale. It is referred to as “blue sky” because it is considered “intangible”. Your patient base and whatever helped to contribute to your patient base is your practice’s “secret sauce”. Your location, your staff, your personality, your business systems and everything that keeps those patients coming to the practice represents your greatest asset of the practice, the goodwill. Many people get wrapped up in the tangible items such as the equipment and leasehold improvements. Anybody can purchase those at any time, and unfortunately the equipment needs to be replaced every 10 to 15 years, computers every 7 to 10 years, carpet every 5 years, and so on.

So when you sell your practice, you are selling your goodwill and you have an obligation to facilitate that goodwill to your buyer. By the same token, when you bring in an associate into the practice, you are showing that associate your “secret sauce”. Different states have different laws on “covenants not to compete” or “protection of trade secrets” when hiring associates. In California, covenants not to compete for associates are unenforceable. Essentially a long term associate can set up next door as long as they do not take patient lists, but they probably could take the staff with them as it is a right to work state also. These issues should be well thought out before a practice owner brings in an associate dentist as part of their exit strategy.

The following discussions are true for the majority of solo practices.

**Mentoring:** Unfortunately mentoring a young dentist in your practice with the idea that they can slowly take over your practice might be a thing of the past. The current economic climate, as discussed in another chapter, makes this age old process unworkable. It is financially unfeasible for a young doctor to be able to pay off their debt load in a traditional “mentoring” relationship. The young dentists basically need to come out of school and hit the road running as fast as possible to build up their speed and efficiency. It is very rare that a retiring dentist is totally financially secure and wants to cut back enough in his office and spend the time and effort mentoring a young dentist, essentially giving most of the production to the young dentist.

**Sell and work back:** This also sounds attractive, but may not work for the same economic reasons mentioned previously. The typical buyer in today’s market has built up their speed working for a corporate type office for a couple of years and is now ready to work at full bore. In most situations, they are fully capable of producing at the same level as the selling dentist, and in many cases they will take the practice to another higher level. As mentioned, they need to do this to pay off their debt load and support their families. Essentially, if the practice is a one doctor practice, it does not become a two doctor practice just because it is being sold! The buying doctor usually needs ALL of the revenue of the practice from the day it is purchased.

Practices that already have a part time or full time associate are able to reverse the tables where the seller can then become the associate. In these situations, the staffing and the facility are supporting the situation for selling and working back. If this is an exit strategy that is appealing and you are a solo dentist, then planning in advance to grow a practice to that size would be the key.
Partial sale leading to eventual full sale: This is definitely a possibility where a practice has grown larger than a one doctor practice. Usually these practitioners have acquired a legal, accounting and consultant team along the way that has had experience with larger practices. Partnerships present a great deal of accounting and legal issues that must be discussed fully. Exit strategies can be particularly difficult. If you have a practice that is going that direction and you are still “winging it”, I strongly suggest that you seek help to properly structure your partnership arrangements. ADS Transitions does have some nationwide consultants that would be excellent advisors for those types of large practices.

Many times I receive calls after the dental conventions are in my area from doctors that want to sell “part” of their practices. After a few questions, they reveal to me that their practice collects $500K or so. For a doctor that has no more debt, this is a nice practice providing a nice living, but as mentioned, this practice might not even be big enough for a new graduate to pay his bills, not to mention selling just “part” of his practice. Most of us believe that one should not even consider this strategy until you have at least 2000 active patients and are collecting over one million dollars.

Outright sale: I would estimate that this is 95% of all practice transitions. Even practices that had the metrics to bring in an associate or do a partial sale wind up in a gigantic mess if the long term associate and the original owner have a change of goals or change of heart.

There are buyers out there for every size of practice. Extremely small practices might be better to sell into another practice (merger), and there are buyers that understand the cash flow in large group practices and the financing is available. I am always amazed at the number of dentists from these two extremes that approach me with the assumption that there is nobody out there to buy their practice!

Mergers: As I have mentioned already, sellers with practices that collect only about $400K to $500K might need to consider setting their practice up for a merger. Below is an article I wrote to explain why your practice is still valuable in that situation.

“Mergers are unquestionably the best return on investment you can make. The success of EVERY transition or merger is based on the assumption that the vast majority of patients will stay with the practice and transfer to the new practice. This is generally true when the transition is handled properly and both parties understand that the “goodwill” portion of the transaction is the most important aspect. The hard assets, such as equipment, supplies and leasehold improvements have a limited life and will always need to be replaced. However, the patient base is what generates the revenue stream.
To clarify, chart sales are not the same as a merger.

Chart sales refer to a simple purchase of the physical charts, but not necessarily receiving any additional help in the transfer of the goodwill. A chart sale might not even include the transfer of the phone number from the previous dentist. In addition, true “chart sales” are done at extreme discounts compared to what the price might be in a traditional practice sale. Mergers, on the other hand, assume that the transfer of the goodwill and patient base will be as successful as in a normal practice transition. With a successful merger, the return on investment is normally double the return on investment from a traditional practice transition because the overlapping expenses such as rent, phone, electricity and roughly half of the staff salaries will be eliminated. Therefore, if a normal dental practice profit is approximately 35% of collections, the profit from a merger can be as much as 70% of the collections. Think about it….if you can add 1000 patients to your existing practice, the only real overhead will come in supplies, lab costs and some staff.

If the return on investment for a merger is twice that of a typical practice transition, shouldn’t the price for a merger be twice as much? That would make sense from a business perspective, but the reality is that most buyers feel that they should get a large discount on a merger verses an outright practice purchase. The argument is that they don’t need the equipment or the space.

My advice to young buyers or doctors that want to expand their practices is to absolutely pay the market price or more if you have an opportunity for a merger. This is about return on investment, not equipment. Again, there needs to be cooperation to ensure that the vast majority of patients make the transfer to your location, and when they do, it will be the best return on investment you can make!
As I mentioned in the introduction, I did not like dental brokers or attorneys when I practiced dentistry full time. I obviously changed my attitude prior to becoming a broker myself. The best way I can relate this is to compare it to dentistry. It is the cumulative experience that eventually allows a dentist to turn what might be a difficult procedure in some hands to a seemingly easy procedure. The irony is that often the patient that was the beneficiary of that well performed procedure questions why his bill is so high for so little effort. Dr. Eric Stavoe, a dental broker in Arizona, who recently retired from full time dentistry said it best in the following article.

THAT WAS EASY, DOCTOR

Debra was my last patient of the morning. We just finished prepping a couple of crowns, taking impressions, and making temporaries. She was right, it was easy. At this point in my career it should be easy. Like most of the procedures I do daily, I have repeated them thousands of times. Debra wasn’t there for all of the previous procedures, nor was she there for the hundreds of hours of Continuing Education that made it easy for her today.

We hone our skills through the years, making even the most difficult procedure appear easy. We also assess the patient and procedure to minimize the possibility of exceeding our professional limitations. The most successful practitioners realize it is better for both the patient and doctor to refer out some procedures to others with more expertise. Throughout our careers, we seek the advice of mentors with skill and experience (Pankey, Spear, Kois, Pride...).

I’ve met with doctors that have started down the road to transitioning their practices on their own. While some are successful, I have assisted many doctors in the eleventh hour of a chaotic sale and even more who hit road blocks resulting in failed transitions. After interviewing the doctors, I realize many of these transitions would have been much easier and transitions could have been saved with sound advice from an experienced broker.

I recently met with a very successful doctor who “sold” his practice. Everything seemed to be ready: there was agreement on price and conditions, date of sale was set, the contract was signed, and the doctor had his retirement party! However, the sale fell apart for reasons that an experienced broker probably could have mitigated, and the buyer has since moved on and purchased another practice. This sale could have been saved by a few seemingly easy steps that an experienced broker had learned from performing similar procedures on many previous occasions.

The best way to minimize the chance of a tumultuous sale is to start by listing with a seasoned broker who has a great team backing them up. There is no substitute for experience, someone who has been down the road dozens of times and knows where potential potholes lie and how to avoid them before the sale gets derailed. The process may appear easy, but the seller and buyer generally remain unaware of many backroom issues that are resolved before they impede the transition of the practice. Every sale is different, with its own unique set of pitfalls, just like every treatment plan has its own unique set of issues.

Similar preparation is necessary as you plan for retirement and the transition of your practice. Now that your professional and financial goals are met, which experts will you turn to assist in transitioning you into retirement? Who will make it easy on you?
YOU’VE WORKED A LIFETIME BUILDING YOUR DENTAL PRACTICE

Your dental practice is one of your most valuable assets and it deserves the personal attention of experts. Most of us will not consider selling our houses without a broker, and as a licensed real-estate broker in California, I honestly feel that it is easier to sell a house than a dental practice. A house is an inanimate object that can be easily compared to the other houses in the neighborhood.

A practice has multiple aspects which makes it more difficult. To make a good decision, you should consider: tax ramifications which depends on what type of entity your practice is; how the purchase price is allocated; the type of dentistry that is performed to achieve the value of the practice price; what premium or discount to apply based on the quality and age of equipment and leaseholds; the location of your practice; how to deal with re-treatment issues, etc.

A broker should have an inventory of buyers interested in a particular area and theoretically, the broker with the most exposure should have access to the most possible buyers. Most brokers already know of doctors/buyers who are interested in a particular area. This should help get the best price and hopefully also the best fit for the practice. Finding the right buyer will significantly lessen the chance of legal issues after the sale. In our office, I would estimate we might screen five candidates before a particular buyer meets the seller.

Even if you have a current associate or a dentist already in mind, I would still advise you to hire a broker. We generally will decrease our commission in this situation. This keeps the buyer honest in the negotiations and ensures their performance. Every year I end up listing several practices where the doctor was strung out for months or years waiting for the associate who expressed their desire to buy the practice but never did.

All practices need to be appraised or analyzed for any lender. We provide a rough draft of the contract of sale and navigate the arrangements between the attorneys and accountants. Most of our time and efforts occur AFTER we have designated a buyer! There is a reason we say we “practice” dentistry, and there is a good reason to hire an experienced broker! In short, hiring a broker allows you to do what you do best….caring for patients!!

WHY DO BROKERS ONLY REPRESENT SELLERS?

This is a question I asked when I decided to become a “dental broker”. The basic answer is that this business is a very finite market as compared to real estate, and therefore there is no “multiple listing service”.

While it is true that the pricing of practices might be similar to finding “comparable” practices in a specific market; the values of practices in the same market depend on the types of dentistry being performed on a particular patient base. For instance, the typical price of a practice in a specific location might be 70% of the year’s collections. Most of the dental practices in that neighborhood will probably sell within 5 to 10% variance (at most) of that multiple. However, the percentage of cash flow that hits the bottom line will be different for practices that accept all PPOs and HMOs as compared to a strict fee-for-service practice.
FROM A LEGAL ASPECT, BUYERS MUST REALIZE THAT IT IS THE BROKER’S JOB TO REPRESENT THE SELLER’S BEST INTERESTS. HOWEVER, A GOOD DENTAL BROKER SPENDS A GREAT DEAL OF TIME COMPILING IMPORTANT DOCUMENTS WHICH HELP THE BUYER DECIDE IF THE PARTICULAR PRACTICE IS A GOOD VALUE IN THAT BUYER’S HANDS. ONLY THE BUYER CAN DETERMINE IF HIS/HER OWN SKILL SETS WILL BE SUCCESSFUL IN A PARTICULAR TYPE OF PRACTICE.

A good broker will also provide the accurate cash flow before taxes, computer reports that show the percentages of procedures being performed in the practice, schedules of employee pay and benefits, tax returns, office lease, and any other documents that are pertinent to the practice. A good broker often helps his own client, the Seller, navigate through what is considered normal and customary for the local market and sometimes needs to “re-educate” the Seller on what is expected in a normal transition of a dental practice.

Brokers have every good intention on producing a smooth and successful transition of a practice. A successful transition is the best protection a seller can have, post-sale. Only the attorneys win if a transition does not go well and litigation becomes necessary. Brokers cannot prevent a buyer from making a poor decision, but hopefully they’ve provided the information necessary to help the buyer make an educated decision.
CHAPTER 9
DELTA DENTAL
WHY IS AN ENTIRE CHAPTER DEVOTED TO AN INSURANCE COMPANY?

Delta dental was originally started by dentists in the 1950’s. Its mission was to provide quality dentistry with a reasonable fee schedule. Many dentists warned back then that you should not get in bed with the devil. They were wrong for 50 years, but now Delta is probably the straw that will break the camel’s back. Once they jumped into the HMO game and the reduced fee PPO, we should have known what is now coming. They have not sold a “Premier” policy for almost 10 years. I predict that once my daughter gets out of dental school in two years, there will be no “Premier” fee schedule and if a dentist wants to get more than $795 a crown, he will have to go “out of network”. The problem is that Delta not only refuses to pay an out of network provider direct, but they have been educating their patients that nobody should ever go out of their network.

WILL THE NEW DELTA DENTAL POLICY AFFECT THE VALUE OF MY PRACTICE?

If you have already agreed to take the lower fee Delta plan, you have nothing to worry about on your practice transition. You have taken the hit already and are probably wondering what happened to all the “Premier” patients you thought you had.

THE PROBLEM

If you are currently a Premier provider for Delta, your new buyer will be forced to accept the lower PPO fees. These fees are 25% to 30% lower than your current fees. You may not know it, but probably 95% of your patients are not really “Premier” patients and the new buyer will take a cut on 95% of your Delta patients. Delta has silently “grandfathered” older dentists so that these dentists usually do not know that this might be an issue. Buyers are rightfully pointing out that they will take a 25% cut on the Delta patients when they take over and this should be factored into the price of the practice.

While I still believe that this issue should not decrease the value of the practice, the local market has always dictated the sales price. On the positive side for Buyers, they will be placed on the regular PPO provider list and this might help generate new patients for the practice to help offset the decrease in revenues. Of course, this offset only works if the practice is capable of accepting additional patients at the lower fee schedule. It is imperative that Buyers have an understanding and a business plan to maximize their practice potential.

THE SOLUTION

I hope the ADA and all the state and local groups find a way to support solo practitioners. I understand that some large corporate groups are able to negotiate with Delta for only a 5% to 10% reduction in fees. We have some dentists in the US congress that are trying to force Delta to pay the providers direct. As a group and an organized society, dentists have always been concerned about “anti-trust” suits while addressing these types of issues with insurance providers. If we attack this problem from a patient’s rights and patient’s freedom perspective, we will not need to worry about this “anti-trust” threat any longer. My proposed “Patient’s Freedom of Choice Dental Insurance Act” should demand the following:
1. Patients are free to take their dental insurance plan or fee schedule to any provider they wish and the insurance company WILL pay the provider directly (This currently does not happen with Delta or Blue Cross.). The patient has the choice to make up the difference with the provider if the provider’s fee schedule is higher.

2. Dentists and patients are free to negotiate any fee schedule or payment arrangement directly with the provider. Dentists are no longer forced to collect pre-arranged payments under threat of “insurance fraud” if they choose not to collect the entire “co-pay”. (Of course, the insurance companies can continue to have arrangements with providers who agree to the fee schedule. In this case, patients can still get a list of providers who agree to the schedule.)

3. Remove the punitive language towards dentists in the insurance contracts.

4. Providers should have the freedom to charge whatever they desire and let the patient decide on the type of care the patient desires and who should deliver that care.

Insurance companies claim that costs will increase if patients have more freedom with their insurance plans and begin utilizing them more. I say, SO BE IT!!! Whose side are we on anyway? Don’t we want patients to seek out care? I believe that under-utilization of dental insurance is still primarily due to patient’s fear of dentistry. The insurance companies limit their financial exposure two ways: (1) through the fee schedule, and (2) by imposing a maximum annual benefit per patient. They are covered on every angle. This maximum benefit has not kept up with inflation for more than 30 years, making the current coverage practically a joke! The entire annual allowance can almost be used by a single molar endo procedure! Instead insurance should

be simply viewed as a sort of “medical savings account” that will help defray some of the costs of dental care.

Delta can certainly cut its costs by eliminating its ridiculous audit process. Again, our proposed “Patient Freedom of Choice Dental Act”, designed to encourage patient’s rights will eliminate the necessity of the audits. This is not a collective threat, just common sense.
CHAPTER 10
THE TRANSITION PROCESS
Once all the pertinent information has been gathered and “packaged” for buyers and the lenders, the practice is placed on the market through print media and internet outlets. An active broker in that market should have an extensive buyer’s database in which they can send out a massive email to a broad spectrum of buyers. While it only takes one good candidate, access to multiple buyers should result in a better fit for the practice and a perhaps a better price.

Generally, the buyer should be vetted by the broker to make sure they are qualified to get the necessary financing for the practice. Depending on the broker’s relationship with the selling doctor, the broker might be able to vet some candidates that the seller feels might not be qualified from a clinical sense or a relational sense. The broker can go over many aspects of the practice, from the financial strength, quality of patients, staffing issues and the entire array of computer reports PRIOR to the potential buyer meeting the selling doctor. Having said that, every buyer will want to hear EVERY bit of information the broker relayed over again straight from the seller’s mouth! It is obviously important for the broker and the doctor to be on the same page on how the practice is presented to the potential buyer.

The first meeting of the two doctors normally will take about 45 minutes to an hour. The broker normally will coach the buyer to keep the meeting concentrated on the types of dentistry being performed in the office. The buyer is admonished to not negotiate the details of the practice on that first meeting. I believe the most important part of the due diligence process is the buyer’s understanding on the dentistry being treatment planned in the office. All of us dentists believe that we are the “Goldilocks” of treatment presentations, but it is a well known fact that if one were to put a patient in a room full of ten dentists, we would have treatment plans ranging from watching a few items to perhaps tens of thousands of dollars of cosmetic dentistry or a full mouth rehabilitation to cure potential problems with occlusion.

If there at least 5 or more interested parties, I will often host an “open house” for the selling dentist. This is usually done after hours on a weekday and the potential buyers are invited to come into the office at their leisure over a two hour window. Normally four or five buyers are all asking questions of the selling doctor and he has the opportunity to answer the questions at the same time. This reduces the need to schedule the six or more individual one hour appointments. Normally the seller can narrow down his preference of buyers to two or three and he can then elect to meet individually if he so chooses.

A letter of intent is then executed between the buyer and the seller. I personally prefer non-binding letters of intent for a myriad of reasons, but some attorneys or brokers will enter into binding letters of intent with deposit money. There is also discussion on how detailed the letter of intent should be. I personally feel that the “meat” of the contract negotiations should come with the contract, so the letter of intent is used more to establish the price and a time table. The contract of sale or asset purchase agreement should be drawn within days of an accepted letter of intent and that will contain the “meat” of the contractual issues.
It is strongly advised that a dental attorney is used at this juncture. Like any profession, experience matters. The world’s best contractual attorney that has had little or no experience in dental transitions is not the best choice in my opinion. Both the seller and the buyer need to understand the legal implications in the transitional contract, but they also need an experienced attorney to be able to explain the probabilities of the issues so that “mountains are not made out of molehills”. Sometimes, doctors with the help of their respective attorneys get so wrapped up in the “battles,” they forget that the largest asset of any dental transition is the goodwill. Buyers need to understand that a “low-ball” offer and picking battles on the contract don’t exactly make for a smooth transition of the seller’s goodwill. By the same token, sellers need to understand that buyers are nervous, especially first time buyers, and that it is normal for a buyer to have some apprehension. Sellers need to be patient and show some understanding.

Once an offer is accepted, the seller should also inform their landlord that a pending sale is in the works. Many times there are clauses in the lease as to how quickly the landlord has to respond and how long they can take to agree to an assignment. Hopefully the seller has had his attorney look at the current lease at its last renewal and provided the necessary language for this event. In any event, the seller should also ask the landlord for the application for the new tenant and the assignment documents that he will have to sign if/when the buyer is approved. It is normal for the selling doctor to be still on the hook, although in second position, for the remaining term of the current lease. However, now is the time to make sure that any future options remaining on the lease are the sole responsibility of the new tenant. (Actually, the time to make sure that is the case was at the last renewal period.)

**WHEN TO TELL THE STAFF?**

Generally we do not advise telling the staff until the contract has been signed and we are fairly certain that the financing and lease are in place. Normally the broker for the seller has relationships with all the dental lenders and will be able to guide the buyer through the lending process. In this way, the broker can also keep the seller informed about any potential financing problems. Sometimes the broker may need to suggest that the buyer try a different lender in order to make the transition smoother. I have witnessed perfectly suited buyers and sellers go sideways due to certain lender’s inflexible rules where there would have been a totally smooth transition if the buyer had chosen a different lender.

Therefore, it is usually best to wait to tell the staff quite late in the process. However, the staff will remember and resent “white lies”. Sometimes the cat gets out of the bag for different reasons. If that happens, the best thing to do is to sit down with the staff and tell them the truth. They do need to know that in the vast majority of cases, the staff is actually more important to the new doctor than they are to the retiring doctor. You can explain that you did not tell them sooner as sometimes it can take months to sometimes years to find the right person to take over. Assure them that they will keep the same salaries and benefits with the new doctor. They need to know that nothing will change except the person doing the dentistry.

**IT IS USUALLY BEST TO WAIT TO TELL THE STAFF QUITE LATE IN THE PROCESS. HOWEVER, THE STAFF WILL REMEMBER AND RESENT “WHITE LIES”. SOMETIMES THE CAT GETS OUT OF THE BAG FOR DIFFERENT REASONS. IF THAT HAPPENS, THE BEST THING TO DO IS TO SIT DOWN WITH THE STAFF AND TELL THEM THE TRUTH**
One of the most common fears I hear from doctors is that they think their practice will disappear if the word gets out that they are retiring. Not only do I think that this is totally false, but I can make an argument that their next year of business might pick up as compared to falling off as patients might make that appointment for that crown they were watching. All of us can point to patients that might travel hundreds of miles to see us once or twice a year, but the reality is that the vast majority of the patients really are not as attached to the doctor that we think they are. Studies show that up to 95% of the patients will come back to the office after a transition. That is where their records are, and they do not want to get irradiated in another office! Many times the patients are more attached to the staff than they are the doctor. Basically, they are creatures of habit and they go to the place they get their dentistry done. I once had a conversation with a prominent dental lender that told me a story of his long time dentist selling their practice. The lender received the letter in the mail like the rest of the patients. The banker went back to the practice for three or four recall visits over almost three years before he even considered trying a new dentist.

**HOW LONG DO I HAVE TO STAY AFTER THE CLOSE OF SALE?**

This is one of the biggest misconceptions out there. We believe the transition should be INSTANT. The staff and the patients need to understand that there is a “new sheriff” in town. There are all kinds of seminars out there promoting “long transitions”. I could not disagree more with that concept for the following reasons.

**Patients:** If the old doctor is even practicing one day per month, many of the patients will request to be seen by the old doctor on his scheduled day, even if that means waiting several months for the next appointment. If the patients have any access to the old doctor, they will bring their new treatment plan from the new doctor to ask if they “really” need the prescribed work.

**Staff:** While most of the staff realizes who now writes their checks, there might be long term staff that has difficulties transferring their loyalties to the new doctor if the old doctor is around. They might undermine the new doctor in his management abilities, especially any new policies in the office. They might also question treatment planning and clinical skills that are different than the old doctor. While these issues might be inherent in any transition, it does not help to have person with past authority as a sounding board. Sellers need to be 100% supportive of the buying doctor. If they perceive they cannot be supportive, they should stay away from the office and keep their opinions to themselves.

As stated previously, most circumstances dictate that the buyer cannot financially afford to keep the seller around, unless the practice is truly too much to handle for one doctor, or the old doctor does some procedures that the new doctor cannot. The seller needs to understand this dynamic in these circumstances to avoid trouble down the road.
LAWSUITS AFTER THE SALE

Obviously this should be avoided at all costs! As the saying goes, the only people who win are the attorneys. I have been a witness in several trials and I can attest that even the “winner” of these actions loses more than they realize.

Misconception number one: Hiring the best attorney to do my contract will cover me. This is simply not true. As stated, even if you win the eventual battle, you have lost the war, especially for the seller. Sellers most likely will not be sued if the buyer is doing well in the practice. Therefore, a disgruntled buyer is probably disgruntled, because they are going bankrupt. The seller can win the lawsuit, but there is nothing to recover from the buyer even if the seller wins attorney’s fees. Let me be clear, you should always hire a good attorney and make sure the proper protection language is in the contract, but do not assume that this “covers” the concern of a lawsuit.

Misconception number two: Seller disclosed everything correctly and followed all the proper guidelines, so there should be no issues. The problem is that in our litigious society, it is always someone else’s fault for their failure. A faltering buyer is not going to blame themselves for their own failure; they will blame the doctor, the broker, the CPA or the consultant.

Misconception number three: A perfect, well run, well oiled practice that is fully up to speed should result in a better transition. See misconception number two. Lawsuits are created because the buyer does not do as well as the seller for some reason. I could argue that a poorly run PPO practice where the patients have no connection to the selling dentist has a better chance of no legal action than the best run and nicest practice available! Reason being that the poor run practice has room to grow and the well run practice does not.

WHAT ARE THE MOST IMPORTANT ASPECTS TO AVOID A LAWSUIT AFTER THE SALE?

Answer: the character and skill sets of the buyer. The buyer is absolutely responsible for their own due diligence in their practice search, but a wise seller knows that a good fit for the practice will help avoid future legal issues. I believe character and communication skills are more important than clinical skills. No two doctor’s skill sets will ever match, and both parties can easily look at the procedure codes to evaluate the clinical differences. Let’s face it; the financially successful dentists are the best communicators and not necessarily the best clinicians.

Solution: If necessary, expose the practice to the most buyers possible to find the best fit. This is where an experienced broker may fit in. More choices of candidates should translate into a better fit. Sometimes we do not have that luxury in smaller markets. In that case, being open, honest and especially helpful in the transition will alleviate many problems. Of course, always hire a competent attorney in dental transitions to make sure the necessary language is in the contract. Again, the transition process is not unlike dentistry. The best situation for all involved is that the procedure (process) was quick and easy. If the patient (buyer) perceives that the doctor (seller) did his best and cared about the patient (buyer) during the procedure (process), the patient (buyer) usually will not instigate any type of litigation where the result was not as expected.