

Quarterly Supplement To  
**Business, Legal,  
And Tax Planning  
for the Dental Practice**

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The purpose of the Quarterly Supplement is to continually update the material contained in **Business, Legal, And Tax Planning for the Dental Practice**, Second Edition, as "free-standing" articles relative to both current business, legal, tax and pending legislative matters that affect your practice and my ongoing experiences as an attorney representing dental and dental specialty practices. The articles contained in the Quarterly Supplements are categorized by the chapters contained in my book, which I hope you will purchase after reading this Supplement if you haven't already.



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**WINTER, 2003  
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This Quarterly Supplement is not intended to provide the reader with specific legal or tax advice. For specific solutions to legal and tax matters, please consult with your legal counsel and CPA.

## **PLANNING FOR ASSOCIATE BUY-INS AND OWNER BUY-OUTS**

### **Significant Tax Case!**

An important tax case has heightened concerns over both "unreasonable compensation" and compensation based owner buy-ins and buy-outs for shareholders of professional C-corporations.

In Pediatric Surgical Associates, P.C. v. Commissioner, April 2, 2001, two shareholder-surgeons were found to have unreasonable compensation based on pay in excess of the receipts for professional services rendered, less applicable overhead. The unreasonable compensation was primarily due to the professional corporation's net income produced by other associate physicians. The theory here was that net profits of a professional C-corporation that are attributable to non-shareholder productivity cannot be paid to shareholder-employees as compensation, as such amounts are not solely for services rendered by the shareholder-employees.<sup>1,2</sup>

In this case, the Tax Court used a methodology that will allow the IRS to find significant dividends in professional C-corporations that derive profit from sources other than the shareholder-doctors. In a dental or dental specialty practice, this would be either the associate dentist(s), specialist(s) or hygienist(s). Unfortunately, the fact that the operation of a professional practice involves significant administrative, management, mentorship, training, compliance and marketing activities for which the shareholder-doctor should be paid, was ignored.

### **Unreasonable Compensation**

The protective measures that a professional C-corporation should consider implementing to avoid the unreasonable compensation problem may be as follows. First, the C-corporation could convert to S-corporation status. However, there is a risk of double taxation on "built-in gains" of C-corporation assets that have not yet been taxed. This includes not only accounts receivable, but arguably, practice goodwill. Second, the professional C-corporation should pay a meaningful dividend each year. Third, the professional C-corporation could enter into a contract with its shareholder-doctor(s) to perform any administrative and management services that are unrelated to the professional services rendered to patients. This may be accomplished by either documenting the administrative and management services to be performed through a provision contained in an existing employment agreement or in a separate administrative and management services agreement. This assumes that the services are actually provided and equate to the additional compensation paid. Finally, the professional C-corporation should document in its

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<sup>1</sup> American Bar Association – Section of Taxation, 2002 Mid-Year Meeting - New Orleans, Louisiana  
Authors: Alson R. Martin, Shook Hardy & Bacon LP; Morton A. Harris, Hatcher, Stubbs, Land, Hollis & Rothchild LLP

<sup>2</sup> Tax Court Decision Threatens Personal Service Corporations, Michael P. Coyne, Esq., Waldheger-Coyne, A Legal Professional Association, January, 2002.

corporate minutes the time and effort made by the shareholder-doctor(s) in performing any administrative and management services that are unrelated to professional patient services. This means keeping a log or diary of the time spent for the specific administrative and management activity performed.

A sample of an employment agreement provision and Directors' Minutes for administrative and management services is attached.

### **Compensation Based Owner Buy-Ins and Buy-Outs**

Where a new doctor buys an interest in a professional C-corporation at "fair market value" there is no tax problem. The same holds true where a departing doctor is bought out by either the practice or the other owner(s) at fair market value. Assuming that the practice is valued on a tax-neutral basis, the purchase price for the stock could be reduced to account for the favorable capital gains treatment to the seller(s) and the tax detriment to the purchaser who pays for stock in after-tax dollars. Here, the purchase price is "balanced".

Sometimes, however, the parties attempt to keep the price of the professional C-corporation's stock as low as possible and reflect the increasing worth of the new doctor, or the decreasing worth of the older doctor, through compensation adjustments rather than through the payment for stock.<sup>3</sup> Often, the value of the stock is equal to the fair market value of the professional corporation's tangible assets. For an incoming doctor, compensation will be disproportionately lower than the higher compensation that the existing doctor(s) is paid for the first several years of "junior" ownership. The rationale behind this is that the younger doctor's overall contribution to the practice is less than the overall contribution of the existing doctor(s). In fact, even long after the associate period, the existing doctor(s) will typically still be mentoring the incoming doctor, as well as running the practice and rendering a high level professional services. In the case of a departing doctor, the interest in the accounts receivable and, arguably, "personal goodwill" is reflected as "deferred compensation" and not payment for stock. If properly characterized and structured, the deferred compensation may be ordinary income to the departing doctor and tax-deductible to the professional corporation.<sup>4, 5</sup>

There could be a significant problem if it is determined that the incoming doctor or practice pays a bargain price for the stock; either through the associate buy-in or the owner buy-out process. The difference between the price paid and the fair market value could be "recharacterized" to constitute ordinary income to the incoming doctor, not to mention other unpleasant difficulties, such as the compensation being recharacterized as non-deductible dividends to the professional C-corporation. One way to avoid this problem would be to ensure

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<sup>3</sup> Ohio corporation while with Federal tax analysis, Matthew P. Cavitch, Matthew Bender, Volume 2, 18-23

<sup>4</sup> Ibid. 18-24

<sup>5</sup> Muskogee Radiological Group, Inc., 37 T.C.M. 1851-6 (1978)

that any compensation paid to any shareholder-employee is reflective of the services actually rendered.<sup>6</sup> The Pediatric Surgical Associates case highlights the necessity that compensation to shareholder-employees of professional C-corporations equates to the value of both professional and non-professional services actually rendered.

The Pediatric Surgical Associates case is not only relevant to the payment of dividends versus compensation through the efforts of non-shareholder employees, but also directly impacts any compensatory arrangements reflecting a younger doctor's increasing or older doctor's decreasing worth to the professional C-corporation. The safe approach in light of the Pediatric Surgical Associates case is to: (a) pay a meaningful dividend each year and document any and all non-professional services rendered by the professional C-corporation's shareholder-employee(s); and (b) value the professional corporation's stock at its fair market value and adjust the purchase price to reflect the tax benefit to the senior doctor receiving favorable capital gains treatment and the tax detriment to the incoming doctor in paying for stock in after-tax dollars. Forget valuing the stock at its lowest reasonable value and the use of compensation arrangements, other than for the actual value of services rendered by the shareholder-doctor(s).

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<sup>6</sup> Internal Revenue Code Section 162

## Sample Employment Agreement Provision

**Duty to Perform Practice Management Services.** In addition to Dr. Employee's duties and responsibilities to render professional services to Corporation's patients hereunder, Dr. Employee shall undertake the following practice management services (herein collectively called the "Practice Management Services") for and on behalf of Corporation: the hiring, training and supervision of clinical and staff employees; the marketing and promotion of Corporation's practice with existing and potential patients and referral sources; the monitoring and collection of accounts receivable of Corporation; serving as the contact person for accounting, legal, banking and insurance advisors; the development of a long-range and short-term strategic plan for Corporation and its practice, including (but not limited to) the planning and development of new facilities; the development of educational, entertainment and public relations programs to foster and sustain existing and future sources of patient referrals; the evaluation of new products and techniques; the development of uniform quality of care standards, patient records information and patient records maintenance; the development of annual revenue projections and operating expense budget; the development of professional/employees and shareholder compensation and incentive and fringe benefit plans; the recruitment, development, training and motivation of Corporation's professional/employees and administrative/clerical staff; and planning, directing and monitoring of other business activities of Corporation which are integral to its success.

**Sample Directors' Minutes Documenting Additional Compensation**

[CORPORATE NAME]

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ACTION BY DIRECTORS  
IN WRITING  
WITHOUT A MEETING

The undersigned, being all of the Directors of [CORPORATE NAME] (herein called "Corporation") do hereby take and adopt the following action, unanimously in writing and without a meeting, pursuant to the authority of Section \_\_\_\_\_ of the **[State Code or Statute]**:

RESOLVED that Corporation hereby ratifies, approves and confirms the payment of additional compensation in the amount of \$ \_\_\_\_\_ to Dr. \_\_\_\_\_ for performing the following responsibilities: hiring, training and supervision of clinical and staff employees; collection of accounts receivable of Corporation; communicating and development of relationship with accounting firm, law firm, bank and insurance advisors; long-range/strategic planning for Corporation, including the planning and development of new facility expansion; development of educational and public relations programs to maintain and build new patient relationships and new patient referrals to Corporation; evaluation of new products and techniques; development of uniform quality of care standards, patient records' information and patient records' maintenance; development of yearly revenue projections and operating expense budget; recruitment of general dentist/employee(s) and development of doctor **[specialists – add referral source language]** compensation and incentive plans; and recruitment, development, training and motivation of employees and shareholders; and that the appropriate Officers of Corporation are authorized and directed to take such actions necessary to effect the purposes and intentions of this Resolution.

\_\_\_\_\_  
\_\_\_\_\_, D.D.S.

\_\_\_\_\_  
\_\_\_\_\_, D.D.S.

\_\_\_\_\_  
\_\_\_\_\_, D.D.S.

\_\_\_\_\_, 20\_\_

## **REVIEWING FRINGE BENEFITS AND BUSINESS DEDUCTIONS**

### **Providing Health Care For Your Employees**

On July 15, 2002, IRS Notice 2002-45 and Revenue Ruling 2002-41 were issued and attempt to provide a unique method of assisting employers to obtain and pay for health care on behalf of their employees.

The method allows employer only contributions for medical expenses on behalf of employees, their dependents, retirees and former employees to be "carried-over" from year to year under a health reimbursement arrangement ("HRA") or a form of what is now termed a "defined contribution" health plan.

Some practices do not provide health coverage for employees thinking that coverage can be obtained through a spouse, and that's fine. But what about you and your family and your other staff members and their families that need medical care? Health insurance premiums are consistently skyrocketing and employees want both the health care coverage and raises. The federal and state regulation for employers providing health care is also significant. The employer is required to adopt a written plan and issue summary plan descriptions to employee-participants. Because the insurance carrier does not want to take on your fiduciary liability, the insurance booklet almost never qualifies as a summary plan description for Department of Labor purposes.

Well, here's some good news. First, your legal counsel should be able to prepare your written health plan and issue the summary plan descriptions in a manner very similar to a tax-qualified retirement plan; a 401(k) or profit-sharing plan.

As to health insurance premium costs, expect continuous increases. One way to reduce the cost of health care is to purchase high deductible group health insurance and also have employees share in both the current premium costs and any future increases. Studies have found that the higher deductible insurances, coupled with employer paid medical reimbursements up to the level where coverage begins, can save the employer significant sums.

Cafeteria plans have been the useful tool in allowing employees to pay for their portion of health insurance premiums in pre-tax dollars under Internal Revenue Code ("IRC") Section 125. For example, the practice may pay 100% or 50% of individual health insurance premiums for eligible employees who have completed 90 days of service, who typically work at least 25 hours per week and who do not have the ability to obtain health insurance from another source other than the practice, e.g., a spouse. The remaining cost of the insurance premiums, e.g., 50% of the individual premium, plus spousal or family coverages, are paid pre-tax by the employee through a salary reduction. The premium only cafeteria plan under IRC Section 125 works fairly well for a dental practice and is relatively simple to draft, implement and operate, even when other permissible benefits are mixed in with the health insurance coverage, e.g., group-term life insurance, dependent care, group disability insurance, vision, etc. Where several benefits are in place, the employee can elect a dollar amount of salary reduction in a given year and spend the collective amount on the benefits elected. This is a "flexible spending arrangement" under a

cafeteria plan. The problem with cafeteria plans, however, is that there is a "use it or lose it" rule. This salary reduction cannot be carried over into a later year.

With the favorable guidance now issued for the first time, any amounts in an HRA that are not used in one year may be carried over and used to reimburse qualified medical expenses in subsequent years. The broad array of medical expenses are described under IRC Section 213.

With an HRA, an employee may not make contributions through a pre-tax salary reduction. The HRA must be funded solely by employer contributions. Perhaps in the future, employees will be permitted to use the "carry over" feature through salary reduction amounts in cafeteria plans or flexible spending arrangements, but not yet.

IRS Notice 2002-45 and Revenue Ruling 2002-41 discuss in detail both the continuation coverage requirements in the event that an employee leaves the practice, as well as utilizing the HRA in conjunction with a separate flexible spending account in a cafeteria plan. Although most dental or dental specialty practices do not fall under the realm of COBRA (20 or more employees), state continuation coverage rules would apply for employers with fewer than 20 employees.

Basically, an HRA is a type of flexible spending arrangement that functions separate from an IRC Section 125 cafeteria plan. In reality, an HRA is an employer pay all self-insurance health plan that allows any unused portion of the maximum dollar amount at the end of a coverage period to increase the maximum reimbursement amount in the subsequent coverage period. The bottom line is that a HRA is a tool that may be useful to use in your practice in conjunction with high deductible health coverage provided by an insurance carrier. I look forward to the day when salary reduction amounts in a cafeteria plan can also be carried over on a year-to-year basis like an HRA.

## **DESIGNING THE "RIGHT" RETIREMENT PLAN FOR YOUR PRACTICE**

### **Good News For Safe Harbor 401(k) Plans\***

Good news for retirement plans, particularly safe harbor 401(k) plans, through the Economic Growth and Tax Relief Reconciliation Act of 2001 ("EGTRRA"), enacted June 7, 2001. Many key provisions became effective on January 1, 2002. Attached is a chart listing some of the significant EGTRRA retirement plan changes to review with your advisor(s). In light of EGTRRA, a comparison of safe harbor 401(k) plans is compared with other defined contribution plans; non-integrated profit-sharing plans, integrated profit-sharing plans and cross tested profit-sharing plans.

A 401(k) plan is a type of profit-sharing plan where employees may elect to defer a portion of their compensation to the plan. In the past, 401(k) plans were not advantageous for dental practices because of the complex "ACP" and "ADP" testing rules. Further, if the employees did not significantly contribute to the plan, neither could the doctor(s).

Prior to January 1, 2002, it took two retirement plans to contribute the maximum of the lesser of 25% of compensation or \$35,000.00. Therefore, in the past, an employer may have adopted: (a) a profit-sharing plan or, more recently, a safe harbor 401(k) plan; plus (b) a money purchase pension plan with mandatory contributions. Effective January 1, 2002, an employer may sponsor one plan with contributions equal to the lesser of 100% of compensation or \$40,000.00. The contributions are elective, except for the 401(k) safe harbor contribution, e.g., a 4% employer matching contribution. This means that the money purchase pension plan with mandatory contributions is no longer necessary. Assuming that the safe harbor contribution is made, the practice owner may defer up to \$11,000.00 in 2002, \$12,000.00 in 2003, \$13,000.00 in 2004, \$14,000.00 in 2005 and \$15,000.00 in 2006. Therefore, for a 4% employee match, the practice owner can attain a significant contribution with relatively low administrative costs. Plus, for those doctors over age 50, additional "catch up" contributions may be available as indicated on the attached EGTRRA chart.

While the SIMPLE IRA can work well for certain practices with "tight" cash flow, you may desire to contribute a greater level of contributions than allowable in a SIMPLE plan. SIMPLE plan contributions, if previously made, could be "rolled over" to a new plan. However, under two recent 6th Circuit cases in 2002, it is questionable whether contributions to a SIMPLE plan provide creditor protection. As a result, now may be an appropriate time to adopt a tax-qualified retirement plan, e.g., safe harbor 401(k) plan with profit-sharing plan provisions.

In the event that your practice already has a profit-sharing and/or money purchase pension plan, these plans need to be updated for compliance with several recent tax acts, collectively called "GUST" in the immediate future. Consider merging your money purchase pension plan

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\* I would like to thank my partner, Dick Naegele, for his help and assistance in preparing the material for this article.

with mandatory contributions into the profit-sharing plan which would be restated as a safe harbor 401(k) plan with integrated profit-sharing plan provisions. There are three reasons for this. First, there is greater funding for the doctor at a reduced cost for staff than in other plans. Second, there is an opportunity for staff members to contribute to the plan on their own. Finally, contributions are not mandatory as in a money purchase pension plan.

There are other plans in addition to the safe harbor 401(k) plan with integrated profit-sharing plan provisions, such as cross-tested (new comparability) profit-sharing plans, defined benefit plans and cash balance plans. These plans consider age as component of the contribution mix and can require expensive yearly actuarial calculations. In the event that the doctor(s) are under age 50, due to the high administrative costs and significant costs of drafting these complex plans, we do not generally recommend them. However, if each doctor is approximately 50+ years old, each doctor desires to contribute tremendously large sums into a plan and the non-doctor staff is relatively young as compared to the doctors, one of these plans may be recommended.

The limit on compensation from which contributions can be made is \$200,000.00 for plan years commencing in 2002. Compensation above this limit is not counted for purposes of contributions. It should also be noted that the family member aggregation rule for purposes of the compensation limitation has been repealed. Therefore, a husband and wife employed by the same employer/practice are not subject to a joint compensation limit. So, if the non-doctor spouse is a bona-fide employee of the practice, additional contributions can be made.

The profit-sharing provisions of the safe harbor 401(k) plan can be integrated with the Social Security. Here, each employee of the Corporation, including doctors, would receive a contribution equal to the specified percentage of contribution allowed under current law, e.g., 5.4% of compensation. However, each doctor would receive an additional percentage of compensation above the integration level, e.g., 5.4% above 80% of the taxable wage base, plus one dollar. The result is that the doctor(s) receive a disproportionately higher percentage of the contribution than do the non-doctor staff members. Nevertheless, non-doctor staff members still receive a significant and meaningful contribution. Additional contributions above this level (e.g., 5.4%) are permissible and all employees would receive contributions as an equal percentage of their compensation. However, such additional contributions may be unnecessary as each doctor would approach the \$40,000.00 maximum contribution.

As illustrated in the two following examples, the safe harbor 401(k) plan with integrated profit-sharing plan provisions is clearly less costly to the practice than the other defined contribution plan options. However, with optimal demographics, the cross-tested profit-sharing plan will provide the practice owner/doctor with the greatest contribution percentage at the lowest employee cost. This assumes that the practice owner/doctor will be older than the non-doctor staff and that the compensation to the non-doctor staff falls within acceptable actuarial limits. Where this works, it works well, but the safe harbor 401(k) plan with integrated profit-sharing plan provisions will be appropriate for the vast majority of practices that do not fit the optimal demographics for cross-testing or the appropriate age and ability to fund the significant contributions allowable in a defined benefit plan.

**RETIREMENT PLAN DOLLAR AND PERCENTAGE LIMITS (EGTRRA 2001 through 2006)**

	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
<b>Annual compensation for plan purposes</b> (for plan years beginning in calendar year)	\$170,000 indexed in \$10,000 increments	\$200,000 indexed in \$5,000 increments	\$200,000			
<b>Defined benefit plan, basic limit</b> (for limitation years ending in calendar year)	\$140,000 indexed in \$5,000 increments	\$160,000 indexed in \$5,000 increments	\$160,000			
<b>Defined contribution plan, basic limit</b> (for limitation years beginning in calendar year)	\$35,000 indexed in \$5,000 increments	\$40,000 indexed in \$1,000 increments	\$40,000			
<b>401(k) / 403(b) plan, elective deferrals</b> (for taxable years beginning in calendar year)	\$10,500 indexed in \$500 increments	\$11,000	\$12,000	\$13,000	\$14,000	\$15,000 indexed in \$500 increments
<b>457 plan, elective deferrals</b> (for taxable years beginning in calendar year)	\$8,500 indexed in \$500 increments	\$11,000	\$12,000	\$13,000	\$14,000	\$15,000 indexed in \$500 increments
<b>401(k) / 403(b) / 457, catch-up deferrals</b> (for taxable years beginning in calendar year) (Age 50+)	Not Available	\$1,000	\$2,000	\$3,000	\$4,000	\$5,000 indexed in \$500 increments
<b>SIMPLE plan, elective deferrals</b> (for calendar years)	\$6,500 indexed in \$500 increments	\$7,000	\$8,000	\$9,000	\$10,000 indexed in \$500 increments	
<b>SIMPLE plan, catch-up deferrals</b> (for taxable years beginning in calendar year) (Age 50+)	Not Available	\$500	\$1,000	\$1,500	\$2,000	\$2,500 indexed in \$500 increments
<b>Defined contribution plan</b> §415 percentage of compensation contribution limit	25% of compensation	100% of compensation				
<b>Profit sharing plan</b> §404 percentage of compensation deduction limit	15% of compensation	25% of compensation				
<b>Elective deferrals</b>	Count against §404 deduction limits	Do not count against §404 deduction limits				
<b>SEP contribution / deduction limit</b>	15% of compensation	25% of compensation				
<b>IRA contribution limit</b>	\$2,000	\$3,000	\$3,000	\$3,000	\$4,000	\$4,000 2007: \$4,000 2008: \$5,000
<b>IRA catch-up contribution</b> (Age 50+)	Not Available	\$500	\$500	\$500	\$500	\$1,000

**EXAMPLE 1**

**STAFF BENEFIT COSTS UNDER  
RETIREMENT PLAN OPTIONS FOR MAXIMUM  
DOCTOR CONTRIBUTION**

**A. Highly Compensated Employee (HCE)**

Compensation:..... \$ 200,000  
Contribution: ..... \$ 40,000  
Percentage:..... 20%

**B. Non-Highly Compensated Employees (NHCEs)**

<u>Retirement Plan Option</u>	<u>Approximate Employer Contribution Percentage for Staff</u>
1. Safe Harbor 401(k) (2003: \$12,000) with Integrated Profit-Sharing	10.4%
2. Profit-Sharing (Non-Integrated)	20.0%
3. Profit-Sharing (Integrated)*	16.3%
4. Cross-Tested Profit-Sharing (with optimal demographics)	5.0%

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\* Integrated at 5.4% of compensation > 80% of social security taxable wage base + \$1.00.

**EXAMPLE 2**

**THE FOUR DEFINED CONTRIBUTION PLAN OPTIONS**

Gross Revenues .....	\$ 500,000
Non-Highly Compensated Employee ("NHCE") Compensation.....	\$ 135,000
Highly Compensated Employee ("HCE") Doctor Compensation.....	\$ 200,000

**I. Safe Harbor 401(k) Plan with Integrated Profit-Sharing Plan Provisions**

**A. Safe Harbor 401(k)**

<u>HCE</u>		<u>NHCE</u>	
\$ 200,000	Compensation	\$ 135,000	Compensation
<u>  x 4%</u>	Safe Harbor Match	<u>  x 4%</u>	Safe Harbor Match
8,000	Safe Harbor Contribution	\$ 5,400	Safe Harbor Contribution
<u>\$ 12,000</u>	Elective Contribution		
\$ 20,000	401(k)Contribution		

**B. Integration at 80% of Taxable Wage Base ("TWB"), Plus \$1.00**

<u>HCE</u>		<u>NHCE</u>	
\$ 200,000	Compensation	\$ 135,000	Compensation
<u>  x 5.4%</u>	Contribution Percentage	<u>  x 5.4%</u>	Contribution Percentage
\$ 10,800	Contribution	\$ 7,290	Contribution
\$ 200,000	Compensation		
<u>\$ &lt;64,721&gt;</u>	80% of * TWB, Plus \$1.00		
\$ 135,279			
<u>    5.4%</u>	Integration Percentage		
\$ 7,305	Integration Contribution		
\$ 10,800	Contribution		
<u>    7,305</u>	Integration Contribution		
\$ 18,105	Profit-Sharing Contribution		

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\* Assumes 2002 TWB

<u>HCE</u>		<u>NHCE</u>	
\$ 20,000	401(k) Contribution	\$ 5,400	401(k) Contribution
<u>\$ 18,105</u>	Profit-Sharing Contribution	<u>\$ 7,290</u>	Profit-Sharing Contribution
\$ 38,105	HCE Contribution	\$ 12,690	NHCE Contribution
HCE Total Contribution..... \$38,105		75% of Contribution	
NHCE Total Contribution..... <u>\$12,690</u>		25% of Contribution	
Total Contribution..... \$50,795		100% of Contribution	

\$ 40,000 Maximum Contribution  
\$ <38,105> HCE Contribution  
\$ 1,895 Additional Contribution Permitted

\$ 1,895  
\$ 200,000 = 09.475%

\$ 200,000	\$ 135,000
<u>x .09.475%</u>	<u>x .09.475%</u>
\$ 1,895	\$ 1,279 Additional Contribution to NHCEs

\$ 40,000 Total HCE Contribution      \$ 13,969 Total NHCE Contribution

HCE Total Contribution..... \$40,000	74.1% of Contribution
NHCE Total Contribution..... \$13,969	25.9% of Contribution
Total Contribution..... \$53,969	100.0% of Contribution

\$ 13,969 NHCE Total Contribution  
\$ 135,000 NHCE Compensation = 10.4%

## II. Non-Integrated Profit-Sharing Plan

<u>HCE</u>		<u>NHCE</u>	
\$ 200,000	Compensation	\$ 135,000	Compensation
\$ 40,000	Maximum Contribution	<u>x 20%</u>	Contribution Percentage
<u>\$ 40,000</u>	Contribution	\$ 27,000	Maximum Contribution
\$ 200,000	Compensation		
\$ 40,000	HCE Contribution	58.7%	of Contribution
<u>\$ 27,000</u>	NHCE Contribution	40.3%	of Contribution
\$ 67,000	Total Contribution	100.0%	of Contribution

\$ 27,000 NHCE Total Contribution  
\$ 135,000 NHCE Compensation = 20%

20% Contribution to both HCEs and NHCEs

**III. Integrated Profit-Sharing Plan**

<u>HCE</u>	<u>NHCE</u>
\$ 200,000 Compensation	\$ 135,000 Compensation
<u>\$ 5.4%</u> Contribution Percentage	<u>x 5.4%</u> Contribution Percentage
\$ 10,800 Contribution	\$ 7,290 Contribution
\$ 200,000 Compensation	
<u>\$ &lt;64,721&gt;</u> 80% of *TWB, Plus \$1.00	
\$ 135,279	
<u>5.4%</u> Integration Percentage	
\$ 7,305 Integration Contribution	
\$ 10,800 Contribution	
<u>\$ 7,305</u> Integrated Contribution	
\$ 18,105 HCE Contribution	
\$ 40,000 Maximum Contribution	
<u>\$ &lt;18,105&gt;</u> HCE Contribution	
\$ 21,895 Additional Contribution Permitted	
<u>\$ 21,895</u> Additional Contribution Permitted	= 10.9475%
\$ 200,000 HCE Compensation	
\$ 200,000 HCE Compensation	\$ 135,000 NHCE Compensation
<u>x10.9475%</u>	<u>x10.9475%</u>
21,895 Additional Contribution	\$ 14,779 Additional Contribution
\$40,000 Total HCE Contribution	\$22,069 Total NHCE Contribution
	<u>\$ 22,069</u> Total NHCE Contribution
	\$ 135,000 NHCE Compensation =16.3%

**IV. Cross Testing**

Must be actuarially calculated. With optional demographics, the NHCE cost should be approximately 5% of NHCE compensation.

<u>HCE</u>	<u>NHCE</u>
\$200,000 HCE Compensation	\$135,000 NHCE Compensation
\$ 40,000 Maximum HCE Contribution	<u>x 5%</u> Contribution Percentage with Optional Demographics
	\$ 6,750 Total NHCE Contribution

\* Assumes 2002 TWB