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Merging Two Worlds?:
Reston Dental Arts and American Dental Partners
Part A

For decades, dentists chose to practice as individuals or in small groups. By and large, they operated on a fee----for----service basis. Dental insurance was rare and relatively few participated in government programs. If patients required specialized care, the general dentist referred them to specialists. This situation created an opportunity. What if general dentists and specialists could work on the same premises, offering patients and one another a seamless process for dental care? Combining forces made sense.

By the 1980s, a few dentists were trying a new approach—house all dental specialties under one roof. An early adopter of the new one----stop shopping model was Reston Dental Arts Center (RDAC), a group of 10 dentists in Reston, Virginia, who banded together to offer patients oral health care services including hygiene, general dentistry, endontics, periodontics, oral surgery, and orthodontics. The group formed in 1987 and quickly found itself in demand.

Over the next decade, the dentists within the practice prospered, both professionally and financially. Patients seemed satisfied as well. But dental profits were attracting another group: dental practice management companies. These firms promised to streamline processes, save purchasing dollars through volume discounts, centralize human resources functions and generally consolidate back----office services to achieve economies of scale. This arrangement could free dentists to focus on clinical procedures, dental practices could become even more profitable—and both the firms and dentists would benefit.

American Dental Partners (ADP) was one of the first companies to enter into such arrangements with individual dental practices. In September 1997, ADP approached Reston Dental with a proposal. The deal was: we will purchase your assets, including your trade name and your existing dental equipment. We will enter into a contract that allows us to run the business side of the practice. You will be free to leave work after your shift and not worry about administrative aspects such as payroll and insurance reimbursements.

This case was written by Kirsten Lundberg, Director, for the Case Consortium @ Columbia and the College of Dental Medicine. The faculty sponsor was Prof. Tamar Schiller of the College of Dental Medicine. (09/2014)

For eight months, the 10 Reston Dental doctors wrestled with the decision of whether to accept the ADP offer. On the one hand, it was financially attractive, especially to the older dentists, who likely would be able to access the capital they had invested over the years in their practice ahead of retirement. It also made sense: leave administration to those who knew best business practices. But the dentists had never before partnered with non----dentists. Such an arrangement would change not only the processes, but the culture of the group. The dentists would sacrifice some of their independence; the "family" feel of the practice would change, especially for staff.

On Thursday, May 21, 1998, the group met to debate the proposal. They would have to make a choice: accept the deal, or walk away.

Trailblazers: Reston Dental Arts

The solo practitioner dentistry model of many decades was tried and true. Before the 1980s, almost all dentists were solo practitioners. But the model required that dentists be proficient not only in dental medicine but also personnel management, procurement, insurance and billing. Being your own boss came at the price of long hours and worries over issues unrelated to dentistry. Operating independently as a specialist, one also had to maintain and refresh a vibrant referral network of general dentists.

Then in 1979, the Federal Trade Commission lifted its ban on advertising by dentists. With advertising came the idea not only of practices with more than one dentist, but with multiple locations that would reach more patients.[1] Groups allowed for economies of scale across the board, from marketing to rent. "By bringing general practitioners in with specialists, it wasn't necessary to refer work out of the practice, but rather keep it in the practice if a specialist was part of the group already," said Robert A. Hankin of the American Academy of Dental Group Practice.[2]

In 1986, Dr. David Porter Sutton, a dentist from Idaho, called on Dr. Thomas Eichler's office manager promoting the concept of a multi----disciplinary practice. Eichler worked in the Washington, DC suburb of Reston, Virginia, in partnership with a dental school classmate from Georgetown University, Timothy Kirkpatrick. Dr. Sutton proposed a model under which workload and revenue were shared among dentists, patients could access the full range of services in one place, quality could benefit from regular patient----care communication among dental specialists and dentists, and administrative responsibilities were managed by a core group of employees.

Dr. Sutton was advancing the idea that general dentists, who played a crucial role in referring patients to specialists, could team up with those very specialists to capture the benefits of referrals in one practice, in----house. Joining a group practice could offer

[1] Aegis Communications, "Flying Solo? Understanding the Trends Driving Large Group Practice," *Inside Dentistry*, Vol. 7, Iss. 8, September 2011. See: www.thedgpa.org website.

[2] Ibid.

increased flexibility and economies of scale, not to mention substantial income and, ironically, independence.

Park Dental in Minnesota had been one of the first to try it and Porter Sutton was marketing the concept as a product in itself.[3] Park Dental started in 1969 when two dentists who had met at a dental conference decided to form a business together. They had the idea that business best practices and dentistry professionalism could be leveraged and extended into a larger group setting. Over the years, the Park Dental practice expanded to 36 locations staffed by 100 dentists and included the full range of dental specialties as well as general dentists. The doctors believed that by gaining accreditation from professional bodies, lengthening operating hours to accommodate patients' schedules and standardizing records, purchasing and processes, both dentists and their patients would benefit.

New venture. Eichler and Kirkpatrick were intrigued. Over the next year, they solicited feedback from other dental colleagues in the Reston area. The reaction was favorable. Within 12 months, they had a group of nine ready to commit. Reston Dental Arts, Professional Corporation (PC) incorporated in 1987. Each of the participating dentists was a shareholder. It brought together 10 doctors from a variety of backgrounds. The group included general dentists Thomas Eichler, Timothy Kirkpatrick, David Dodrill, Eric Forsbergh, Emilio Canal and Michael Messina. They teamed up with Dr. Robert Averne, a pediatric dentist, and periodontist Dr. Nicholas Ilchyshyn.[4] Endodontics and oral surgery were covered by associates.

Some of the shareholders knew each other from dental school. Drs. Eichler and Kirkpatrick, for example, had been classmates at Georgetown University and set up practice together. Canal and Messina also met at Georgetown. But mostly they were dentists already operating smaller practices in Reston who were acquainted as competitors and colleagues. Averne summarizes why he joined:

> My reason for joining the group was the real estate factor. We were tired of renting. We were tired of increases in the leases. And secondarily, [it] was the belief that we'd be better prepared for the future, the consolidation that we all expected… was going to be imminent.[5]

Orthodontics was the only specialty missing from their lineup. Dr. Vincent Mascia had practiced for years in New York City until family affairs brought him to northern Virginia. Although it was a high growth and potentially lucrative area in which to practice, Mascia did not have the existing patient base or referral network to sustain a new practice. Joining an established group made sense for him, and he accepted the group's offer.

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[3] "Park Dental History." See: http://www.parkdental.com/about/park-dental-history (accessed 20 January 2014).

[4] A second periodontist, Dr. Charles Fields, joined in March 1991.

[5] Researcher's interview with Dr. Robert Averne on January 13, 2014 in Reston, Virginia. All further quotes from Averne, unless otherwise attributed, are from this interview.

Life Is Good, Mostly

For patients and dentists, the Reston Dental Arts Center model proved robust. Patients received comprehensive care from qualified dentists right in their neighborhood. The hours were convenient; the practice was open Monday through Saturday from 7am to 9pm. Some 70 dedicated staff, including billing and insurance personnel, receptionists, dental hygienists and dental assistants, took care of patients.

As they had done as individual practitioners, Reston Dental accepted no insurance. The administrative and time costs of doing so did not seem worth it. The group practice also offered no discounts. Nonetheless, patients flocked to it. While there were some leaner years, the practice flourished. It needed 35 clinical chairs to keep up with demand. After a while, the group expanded into space next door for a laboratory, so it could control and retain benefits from lab work. Recalls Averne:

> This was revolutionary. It was a clinic… Ninety----nine percent of the patients who were already in the practices were pleased with the convenience. The quality of the practice didn't change. The quality of the doctors was unchanged. All in all, I would have to consider it a success.

For the dentists, the benefits of combining skills and resources were many. Staggered shifts allowed them to work less and yet enjoy an annual income ranging from $422,000 to $856,000. The group shared expenses for equipment, supplies, staff and other administrative functions. Each dentist contributed monies in proportion to his use of the common goods and services. On the revenue side, each dentist maintained his own practice and his compensation came exclusively from his own production; no revenue was shared. However, any expense contributions remaining at the end of the fiscal year were returned proportionately to the partners. Eichler comments on the impact of seeing the income distribution within the practice:

> I was the one that put together the graphs, and it was amazing when you saw your performance against [that of] the guy sitting next to you. That motivated. I was never the top performer, Vinnie [Mascia] was never the top performer, but I think it motivated both of us to work on it. Even though we worked a six----hour shift, seven----hour shift, four days a week, we still produced a heck of a lot of money.[6]

To sustain such a large and growing practice, Reston Dental engaged a variety of associates as required. The goal was to bring ambitious, highly----skilled dentists into the practice and eventually make them partners. Under this model, new dentists could join and eventually buy their way into the partnership. The capital they contributed would be paid to older partners to allow them to exit. The price of admission was typically several hundred

[6] Researcher's interview with Dr. Thomas Eichler on January 10, 2014 in Reston, Virginia. All further quotes from Dr. Eichler, unless otherwise attributed, are from this interview.

thousand dollars, and it could be paid over time. Over the years, this sometimes worked, especially with younger dentists. But those who joined further along in their careers often declined to become partners, as the return on the capital required to buy in was not seen as compelling.

Real estate. In addition to the joint practice, some of the doctors also belonged to a real estate partnership that owned the building where the practice was located. The extended operating hours meant maximum utilization of this asset. But the building was a sore spot in the doctors' relationship. Some felt the building was like a fortress: the price to buy in was set so high that it precluded new entrants. In addition, non----owners saw the rent the practice paid to the building's owners as excessive.

The non----owner dentists perceived that *all* doctors were paying *some* doctors rent above market rate, and that there was no way to break into that rarified world. Whether true or not, this idea persisted and contributed to ill feelings among some of the dentists. Mascia, for example, was not an owner, and in fact turned down a chance to buy in because it was too expensive. He recalls:

> [It] actually was a contentious issue with me. There were tax advantages for billing out the office rent per square foot to the practice, at a set value, which may or may not have reflected true market value… But on the back end, if you didn't own the building, you didn't necessarily reap the benefits of that approach. Ultimately, I did seek to become part of the building [arrangement]. And because I was one of the first potential new partners, they made a suggestion at the time of the cost to buy in… But the price that they offered was way beyond the assessed value of the building.[7]

Other cracks appeared over the first 10 years of the partnership. Cliques began to surface among the doctors according to the physical proximity of their dental chairs, their age and their specialties. Averne remembers:

> I guess little cliques formed out of the 10 partners, and Vinnie and I were empathetic. Physically we were 10 feet apart… It was a small corridor between the pediatric suite and the orthodontic suite. And we just got very friendly.

As Mascia recalls it, the general dentists shared a "group think" distinct from the specialists. He says:

> The general dentists tended to have more of their way because of the dynamics of both their strong personalities, and they were somewhat more seasoned. And they were the original developers of the project. In

[7] Researcher's interview with Dr. Vincent Mascia on January 5, 2014, in Charlottesville, Virginia. All further quotes from Mascia, unless otherwise attributed, are from this interview.

> theory, we all had a similar say and one vote. But in essence, it tended to be much more driven by the general dental perspective.

The practice was home to strong performers and strong personalities. In general, whoever spoke loudest or with most authority at the monthly partner meetings got the equipment purchases and other preferences he sought. But despite the stresses and strains, it was hard to argue with results. As of 1997, the practice generated $9.5 million in revenues and employed over 100 people.

Overture from ADP

During the annual American Academy of Dental Group Practices conference in early 1997, Dr. Dodrill met representatives from the newly----formed ADP. ADP was the brainchild of CEO Greg Serrao, formerly an investment banker in the health care sector, and later manager at the Dublin, Ohio----based Cardinal Health.[8] ADP was based in Massachusetts. Serrao had launched ADP in 1995 at age 32 with the belief that he could bring his management experience to bear on improving the business of dentistry. For example, dental practices rarely accepted government reimbursements or even insurance payments. He aimed to team up with dental practices around the country and apply best practices management principles, consistency and specialization to improve both the patient and doctor experience. He saw group practices gaining market share from one----man outfits.

At the conference, Dodrill heard a presentation from ADP about its business approach. Intrigued, he approached Serrao to ask for more information. ADP was looking for new markets in large metropolitan areas like Minneapolis, Minnesota or Phoenix, Arizona. "We weren't looking at a market like a Reston; it never even came up on our radar screen," recalls Serrao.[9] However, "I was impressed with [Dodrill] and certainly his view of the opportunity that we would present to Reston," adds Serrao.

Dodrill promptly reported the encounter to his partners, and RDA invited the management firm to make a presentation. In April, Serrao flew to Reston to explain how ADP operated and how a partnership with RDA might work. In turn, he learned more about the group. Reston Dental had a strong reputation in the community. It was a comprehensive practice. It could form the basis for future growth in the rapidly----expanding region. Serrao could envision using the practice as a platform to extend its footprint into other locations in northern Virginia. He was surprised that all 10 RDA dentists were owners. That was common in medical practices, but not in dentistry. "To make decisions, they had to get everybody around the table," he recalls. "In theory, everyone was an equal partner."

Over the next few months during some four visits, Serrao also met the other members of the practice. As he recalls, Eichler "was a really nice, sweet person." Serrao found co----founder Kirkpatrick to have a "loud voice. And he was a bully. I mean, at one meeting he

[8] Cardinal Health sought to improve the cost-effectiveness of health care.

[9] Author's telephone interview with Greg Serrao on April 23, 2014. All further quotes from Serrao, unless otherwise attributed, are from this interview.

told Dr. Averne to just shut up… I don't know why, but the group thought of him as a financial wizard." In group meetings, Serrao also noticed that the younger doctors tended to remain quiet. Still, the opportunity seemed worth pursuing. For their part, the RDA dentists were intrigued, and agreed to consider an offer.

A proposal

Gradually, the outlines of a deal emerged. ADP knew it could not purchase the group outright because Virginia law stipulated, as did most jurisdictions, that only a dental professional could own a dental practice. American Dental Partners of Virginia could, however, purchase the physical assets like dental chairs and equipment, and employ all the support staff. As RDA owned its building, ADP would also rent the premises.

Affiliation. It called such an arrangement an affiliation. "It's an acquisition," says Serrao, "and then we enter into a long----term management agreement… So everybody that used to work for them, now works for us. And their corporation has the dentists in it." Since physical assets, once used, had relatively little value, ADP essentially purchased the goodwill of the practices with which it affiliated, and allowed the dentists to realize the equity value they built up in the practice over the years.

During their meetings, ADP got a glimpse of the internal dynamics of the practice. "There was dysfunction in the group," notes Serrao. In one unusual exchange, the younger doctors "Canal, Messina and Fields pulled me aside to basically tell me, don't trust these guys; we don't trust them. They charge an exorbitant rent. Don't let them do that to you," he recalls. The young dentists were talking about their senior colleagues. Nonetheless, negotiations continued.

The parameters were fairly straightforward. The dentists agreed among themselves that they would continue to divide future earnings according to the percentage each generated. The dentists would retain their Professional Corporation, which would provide professional services to the practice.[10] For its part, ADP would fund future expansion into other parts of Virginia and pay all future expenses. As Mascia recalls:

> They felt that we were the most productive group they'd ever seen in terms of per hourly billing and such. Because our location was somewhat of an upper middle class location, they felt that our group's business model and clinical practice model could be easily duplicated regionally. Their goal was to develop our particular organizational structure over several offices within the Washington, DC area. I think they threw around [a suggestion of] about 30 or 40 offices. That was the original strategic plan.

By summer 1997, ADP had an idea of the value of the practice. Serrao floated an informal offer to the dentists of $6.1 million. He calculated that ADP's annual share of RDA's

[10] For a summary of the proposal, see Appendix 1.

profit would come to $1.6 million. The first offer was about four times that—an approach ADP had used for previous purchases.

Dodrill let Serrao know that the number was insufficient. "But it was certainly enough for them to be willing to receive a [formal] proposal," recalls Serrao. So on September 17, 1997, ADP brought an offer to the table. Serrao met with all the partners at Kirkpatrick's house. The offer was $8.1 million in cash. That included $4 million for the goodwill which the dentists calculated the group had generated. As for governance, ADP suggested a board of three representatives from ADP and three from Reston Dental. Although ADP would own, if the deal went through, what amounted to a de facto majority stake in the operating business, Serrao believed that a 3----3 split would facilitate cooperation between the parties. Issues would be decided by majority vote.

Industry Changes

As the RDAC dentists considered the ADP offer, they paid attention to what was going on in the wider dentistry industry. By 1998, group practices like Reston Dental Arts had become more common; the dental industry was moving toward greater consolidation. According to the American Dental Association, by 1995 12 percent of dentists worked in group practices, up from 4 percent in 1991.[11] Although general dentistry continued to represent the bulk of dental care services at 79 percent in 1996, specialty dentistry was on the rise at 21 percent.[12]

The move toward larger group practices offered numerous benefits over solo practitioners. For example, it allowed recent graduates to enter the profession without significant debt or capital outlay. With partners to pick up the slack, those nearing retirement could enjoy greater flexibility in their schedules, as could dentists with young children or others who needed reduced working hours. The apparent preference of younger dentists for workplace flexibility, and emerging changes in the volume and type of dental services the public wanted seemed to reinforce the move toward larger practices.[13]

Corporate dentistry. At the same time, the concept of corporate dentistry was starting to take hold. Dental management professionals at companies like ADP ran corporations that operated across large geographic areas. One of the major selling points was the opportunity for dentists to focus solely on patient care and leave administration, including human resources, billing and insurance, to others who specialized in those fields. Dental practice management was becoming more complex as the industry shifted toward accepting insurance. Managing reimbursements and the multiple systems involved was a major headache for many dentists.

Companies like ADP could offer economies of scale as well, purchasing equipment and supplies in bulk. They also offered veteran dentists a way to realize, prior to retirement,

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[11] American Dental Association (ADA). From ADP's NASDAQ listing background information. See: http://www.nasdaq.com/markets/ipos/company/american-dental-partners-inc-2517-4492?

[12] National Association of Dental Plans. Ibid. [??]

[13] ADA Health Policy Resources Center, *A Profession in Transition: Key Forces Reshaping the Dental Landscape*, American Dental Association, 2013.

the capital investment they had been building in their practice for years. As a sign of the times, ADP itself went public in April 1998, and was listed on the NASDAQ exchange.[14]

Finally, dental patients were starting to have more choices. Fee----for----service remained the standard. But increasingly, employers provided dental insurance as an option. The number of Americans with dental insurance rose from 41 percent in 1990 to 46 percent in 1995 and 55 percent in 1997.[15] The industry could anticipate that demand for dental services would rise. Then there was public funding: Medicare and Medicaid were considering adding dental coverage for children and adults already on their rolls for general health insurance. If that happened, dental services could be expected to skyrocket.

Due diligence

As the RDA partners weighed the pros and cons of the ADP offer, the looming industry changes were much on their minds and led them to favor a partnership. The mechanics of a deal moved forward after the September 1997 with a letter of intent. But both sides still had to conduct due diligence, engage lawyers and accountants to vet drafts of the evolving contract, and assemble the necessary documentation.

Typically, a group like Reston Dental entertaining an offer from a management firm would consider what the control of operations and profit would mean for the practice, both in fact and in appearance. It might examine details of the organizational structure going forward, whether the culture would change, how much the management firm would earn from the deal, and the legality or enforceability of non----compete agreements for any dentists who might choose to leave.[16]

Drs. Eichler, Kirkpatrick and Dodrill took the lead on due diligence for RDA. Constituting themselves as a finance committee, they asked the practice's accountant, John E. Smithers, to research the business side and report back to them. Among other questions, the dentists went back and forth on the proposed formula for their future earnings.

Formula. Typically, dentists in an ADP----affiliated practice earned 30 percent of revenue off the top. So taking a hypothetical $100 in earnings, the first $30 went to the PC for the dentists to pay themselves. ADP then paid all monthly expenses, such as staff salaries, maintenance, purchases and so forth. Of the hypothetical $100, that might come to $50. What remained was called a contribution margin or practice profit—in this example, $20. ADP commonly divided that with the dentists 85/15—85 percent went to ADP, and 15 percent to the dentists. To continue with the $100 example, ADP would get about $17 of the $20 profit, and the dentists would get $3. So overall, the dentists would collect $33 per $100 earned, and ADP

[14] For more information on ADP and the state of the industry at the time, see Appendix 2, ADP's NASDAQ listing background information. See: http://www.getfilings.com/o0000927016-00-000908.html

[15] National Association of Dental Plans. From ADP's NASDAQ listing background information. See: http://www.nasdaq.com/markets/ipos/company/american-dental-partners-inc-2517-4492

[16] Becker, Scott, Lauralee R. Lawley and Payal Keshvani, "Investing in Dental Practice Management: Key Issues and Notable Transactions." *McGuireWoods*.com, October 23, 2012.

$17. What's more, the dentists would be guaranteed their first 30 percent, while the absolute value of the 20 percent profit would vary depending on earnings.

Kirkpatrick, however, did not like that formula. He was disturbed that ADP would get 85 percent and the dentists only 15 percent of any part of earnings. He insisted, with his partners' backing, that expenses be taken right off the top, and profits be divided 70/30—70 percent to the dentists and 30 percent to ADP. Again looking at the $100 model, that meant that of the $50 remaining after expenses, $35 would go to the doctors, and $15 to ADP. ADP pointed out that the doctors' share would now fluctuate depending on earnings, but Kirkpatrick was adamant. After months of negotiations, ADP by spring 1998 accepted the RDA formula.

Meanwhile, the dentists looked at other possible consequences for the practice of accepting the ADP offer. They visited other practices that had elected to join ADP, including Park Dental in Minnesota. In interviews with peers in these practices, the dentists asked questions about the experience, including whether the ADP partners would do it again. Overall, the response was positive. Recalls Eichler: "[Park Dental] had a review every month where they looked at everybody's charts and made sure that everybody was doing things the right way. From a dentistry perspective, we felt like hayseeds because [Park Dental] had their act together… We were so impressed!"

The partners debated among themselves ADP's terms and, more importantly, the offer price. Employees were not included in their deliberations. While there was a significant amount of money to be realized in the short----term, there were also compelling reasons to keep things as they were. The dentists had been fortunate to have built a substantial business, earned a comfortable living and worked in an environment that felt like a family. Moreover, the move could be seen as risky. The Reston Dental doctors were placing all their bets on a company and management new to them. Could they be sure they had considered every possibility and option?

After a year of back and forth, the time had come to decide. The partners called a meeting for Thursday, May 21, 1998 to take a final vote on the ADP proposal. Accountant Smithers brought with him a statement of revenue and expenses for the practice for the first four months of 1998. The statement included a putative payment of 30 percent of margin to ADP, paid after expenses but before compensation to doctors.[17]

Deal? The partners gathered, as they so often had before, in Dr. Kirkpatrick's living room. Each was given a copy of the spreadsheet and of ADP's offer. Discussion quickly grew animated. Heated conversation at monthly partners' meetings was not uncommon but, with high stakes, the participants settled in for a long day. The younger doctors, including Canal and Messina, saw no real reason to fix what was not broken. They were working amenable hours, honing their craft and earning good salaries. The older dentists, among them Eichler and

[17] For the spreadsheet, see Appendix 3. The offer itself remains confidential.

Averne, liked the idea of cashing out early. Those practitioners who brought in the largest percentages of group revenue, such as Kirkpatrick, were enthusiastically in favor.

The partners were determined to leave the meeting with a decision. They had a few hours, and then would have to vote.

APPENDIX 1

Summary of September 1997 offer from ADP[18]

For the doctors

- There would be either an upfront, all cash or stock offering of ADP shares (each doctor's choice) at some predetermined price per share that would go to each owner/partner of record
  - This amount would reflect a transfer of ownership of each practitioner's patients of record to the new entity
  - The amount paid to each partner of record would be determined by his most recent production numbers during the last year in practice
  - This cash/stock amount was one of the negotiated items. Consideration of what was appropriate used as one element national numbers for a traditional purchase from one dentist by another
- A quarterly bonus system would be established by which ADP would pay additional amounts to the partners as the facility hit certain mutually----agreed production figures
- ADP would assume certain debts of the facility
- The original owners retained overall control of all decisions by the new entity (majority voting rights)
- The original dentist/owners retained control of their practice, its clinical decisions, kept net revenue (minus ADP's share) and continued in all other ways as required by state law.
- The original partners would share in the production revenue of any new associates, future buy---ins of newly established practices (not previously purchased) within the facility or new satellites or future acquisitions.
- ADP would assume certain debts of future capital improvements of the office, some of which were pre----negotiated (some upgrading of equipment, facility improvements)
- ADP would offer the facility economies of scale (contracted dental software, dental supplies discount, healthcare plans to staff, 401K's, etc)
- ADP would offer its expertise and advice to RDA for both present and future acquisitions, expansion strategies, marketing, etc
- ADP would help research, expend capital, assume certain debt to develop additional facilities in the Washington, DC area
- ADP would consider a long----term lease agreement with the partner/owners of the building in Reston (not all dental practice owners also owned the building)
- The original partners would have exclusive rights (such as in a franchise) to a negotiated geographical area in the tri----state area, making any additional ADP purchases part of their exclusive domain.
- The original partners would be the managing partners, participate in the revenues and retain overarching control of any satellite offices or practice acquisitions in the area
- The original partners would have their accounts receivable at the time of purchase be a separate cash purchase.

[18] The actual offer is confidential. This is a summary by Mascia of its key points.

- The original partners would receive a bonus if they elected to stay beyond a pre---
  -determined minimum time period

For ADP

- ADP would take a minority interest in all revenues generated by the purchased practices as well as the future revenues generated by the new entity.
- The original partners' practices were transferred to the new entity, which was dentist controlled.
- ADP owned all the dental equipment and good will
- ADP would have a voice in non----clinical decisionmaking
- There was a non----compete clause for a pre----determined period of time for the original partners

APPENDIX 2

Background information provided by ADP for its NASDAQ listing, 1998

See: http://www.nasdaq.com/markets/ipos/company/american-dental-partners-inc-2517-4492

OVERVIEW

American Dental Partners, Inc. is a leading provider of dental practice management services to multi----disciplinary dental group practices in selected markets in the United States. The Company seeks to affiliate with leading dental groups that provide a comprehensive range of dental care services, have outstanding reputations for quality and have proven records of financial performance. Since its inception through February 28, 1998, the Company has successfully completed affiliations with ten dental group practices and currently operates 83 dental facilities with 617 operatories in six states.

The Company''s rapid growth has resulted primarily from these affiliations, which consisted of three dental group practice affiliations completed in 1996, six dental group practice affiliations completed in 1997 and one dental group practice affiliation completed in 1998. For the year ended December 31, 1997, the Company generated $53.3 million in net revenue and $1.1 million in net earnings.

The Company''s affiliation model is designed to create a partnership in management between the Company and the affiliated dental group practice that allows each party to maximize its strengths and retain its autonomy. When affiliating with a dental group practice, the Company acquires substantially all of its assets and enters into a long----term service agreement to manage the non---clinical aspects of the dental operations. The Company supports its affiliated dental group practices with a broad range of services designed to enhance practice revenue, improve operating efficiencies and expand operating margins. The Company shares the best practices of its network with each affiliate and provides assistance with information systems, budgeting, financial reporting, facilities management, third----party payor contracting, supplies and equipment procurement, quality assurance initiatives, billing and collecting accounts receivable, marketing and recruiting, hiring and training support staff.

The Company''s objective is to be the leading dental practice management company in the United States. The Company''s strategy for achieving this objective is to: (i) expand into carefully selected and diverse geographic markets which have favorable demographics and projected economic growth; (ii) affiliate with leading dental group practices which have reputations for quality care and proven records of financial performance; (iii) increase market penetration in each of its markets through additional affiliations, recruitment of dentists and new facility development; (iv) add value to each affiliated dental group practice by assisting the practice in improving operating performance; and (v) pursue various initiatives to ensure the highest quality of care and service.

DENTAL CARE INDUSTRY

The market for dental care is large, growing and highly fragmented. The United States Health Care Financing Administration estimates that expenditures for dental care were approximately $45.8 billion in 1995 and will reach approximately $79.1 billion by 2005, representing a

compound annual growth rate of approximately 5.6%. The Company believes that the growth in expenditures for dental care will continue to be driven by both increases in costs and increases in demand for services due to: (i) improved dental benefits offered by employers; (ii) increased availability and use of dental insurance, including preferred provider organization (""PPO"") plans and capitated managed care plans; (iii) increased demand for dental care from an aging population; and (iv) increased demand for cosmetic and preventative procedures. The Company believes that this growth will benefit not only dentists, but companies that provide services to the dental care industry, such as dental practice management companies. However, the failure of any of the foregoing factors to materialize could offset increases in demand for dental care, and any such increases may not correlate with growth in the Company''s business.

Unlike many other sectors of the health care services industry, the dental care industry is in the early stages of consolidation. Although dental care is typically offered by solo practitioners, the trend towards group practice is growing. According to the American Dental Association (""ADA""), in 1995, 11.8% of the approximately 153,300 dentists in the United States were practicing in groups of three or more, up from 4.1% in 1991. The Company believes this consolidation trend will continue.

Most dental care performed in the United States is categorized as general dentistry. Based upon a 1990 survey by the ADA, general dentistry was estimated to represent approximately 83% of all dental services performed in the United States. General dentistry includes preventative care, diagnosis and treatment planning, as well as procedures such as fillings, crowns, bridges, dentures and extractions. Specialty dentistry, which includes orthodontics, periodontics, endodontics, prosthodontics and pediatric dentistry, represented the remaining 17% of dental care services. Historically, dental care was not covered by insurers and consequently was paid for by patients on a fee----for----service basis. An increasing number of employers have responded to the desire of employees for enhanced benefits by providing coverage from third party payors for dental care. These third party payors offer indemnity insurance, PPO plans and capitated managed care plans. Under an indemnity insurance plan, the dental provider charges a fee for each service provided to the insured patient, which is typically the same as that charged to a patient not covered by any type of dental insurance. The Company categorizes indemnity insurance plans as fee----for----service plans. Under a PPO plan, the dentist charges a discounted fee for each service provided based on a schedule negotiated with the PPO. Under a capitated managed care plan, the dentist receives a fixed monthly fee from the managed care organization for each member covered under the plan who selects that dentist as his or her provider. Capitated managed care plans also typically require a co----payment by the patient.

The National Association of Dental Plans estimated that approximately 117 million individuals, or 45.7% of the population of the United States, were covered by some form of dental care plan in 1995. This compares to approximately 96 million individuals, or 40.5% of the population of the United States, in 1990. Of the 117 million individuals with coverage, 70.3% were covered by indemnity insurance, 17.7% were covered by capitated managed care plans and 12.0% were covered by PPO plans. The remaining 139 million individuals, or 54.3% of the population of the United States in 1995, did not have dental benefit coverage. The Company believes that the number of individuals with dental benefits will continue to increase and that the majority of this growth will be in PPO and capitated managed care

plans. For instance, according to the National Association of Dental Plans, the number of individuals covered by capitated managed care plans increased from 7.8 million in 1990 to 20.7 million in 1995, representing a 21.6% compound annual growth rate.

The Company believes that the increased prevalence of dental benefits and the shift of those benefits from traditional fee----for----service to non----fee----for----service plans has increased the complexity of operating a dental practice and has led dental practices to begin to affiliate or consolidate with entities, such as the Company, that: (i) allow dentists to focus on the clinical aspects of dentistry by providing management resources to conduct the business and administrative aspects of dentistry; (ii) provide information and operating systems that are required to effectively manage in an increasingly complex reimbursement environment; (iii) assist with third----party payor contracting; (iv) realize economies of scale in purchasing and provide access to capital; and (v) provide dentists the opportunity to realize value for their practices.

BUSINESS STRATEGY

The Company''s objective is to be the leading dental practice management company in the United States. In order to achieve this objective, the Company''s business strategy is to:

Expand into carefully selected markets. The Company plans to expand its network of affiliated dental group practices into carefully selected and diverse geographic markets. The Company focuses on markets that: (i) offer the opportunity to gain market share leadership; (ii) have a prevalence of dental group practices; (iii) have favorable demographics and projected economic growth; and (iv) have access to dental schools. To date, the Company has identified approximately 125 markets that currently meet its market selection criteria. The Company believes that operating in multiple markets increases the attractiveness of the Company and its affiliated dental group practices to third party payors who seek to contract with dental providers that are strategically located in attractive markets and that offer a comprehensive range of multi---- disciplinary dental care services.

Affiliate with leading dental group practices. In entering a new market, the Company seeks to affiliate with a leading dental group practice in that market as a platform for expansion. A ""platform"" dental group practice is one which has a reputation for quality care, provides a comprehensive range of dental services, has a significant market presence and has a proven record of financial performance. The Company believes that by affiliating with leading dental group practices it will become more attractive to other practices, dentists and payors.

Increase market penetration. The Company seeks to be the market share leader in each market in which it operates. After affiliating with a leading dental group practice, the Company seeks to increase its market share by assisting the affiliate in recruiting new general and specialty dentists, expanding its patient base and opening new facilities. Additionally, the Company may affiliate with other dental practices or with specialty group practices that complement the platform dental group practice.

Add value to each affiliated dental group practice. The Company supports its affiliated dental group practices with a broad range of services designed to enhance their practice revenue, improve operating efficiencies and expand operating margins. The Company shares the best practices of its network with each affiliate and assists each affiliate with an analysis of its revenue and payor mix, capacity, utilization, staffing, scheduling and productivity. The

Company also provides its affiliates assistance with information systems, budgeting, financial reporting, facilities management, third----party payor contracting, supplies and equipment procurement, quality assurance initiatives, billing and collecting accounts receivable, marketing and recruiting, hiring and training support staff.

Focus on quality care. The Company pursues various initiatives to help its affiliates provide the highest quality of care and service. The Company''s goal is to have each affiliated dental group practice become accredited by the Accreditation Association of Ambulatory Health Care, Inc. (""AAAHC""). Through its National Professional Advisory Forum, the Company provides its affiliated dental group practices with the opportunity to share clinical knowledge and best clinical practices. The Company also implements comprehensive patient satisfaction surveys administered by independent third parties. The Company believes that its focus on quality care enhances: (i) its affiliates'' relationships with patients; (ii) its affiliates'' ability to recruit dentists; (iii) the Company''s ability to attract new dental groups as affiliates; and (iv) the Company''s attractiveness to third party payors.

APPENDIX 3

RESTON DENTAL ARTS CENTER
STATEMENT OF REVENUE AND EXPENSES - INCOME TAX BASIS
FOR THE FOUR MONTHS ENDED APRIL 30, 1998

	April 30, 1998	April 1998 Clinic Margin
Gross Revenue		
Patient revenues	$ 3,015,444	$ 3,015,444
Less: Refunds/returned checks	(36,925)	(36,925)
Adjusted Gross Revenue	2,978,519	2,978,519
Other Income		
Miscellaneous income	3,709	3,709
Interest income	1,258	1,258
	4,967	4,967
Clinic Expenses		
Direct Operating Expenses		
Hygienist salaries	257,753	257,753
Clinical wages	302,088	302,088
Post treatment wages	112,159	112,159
Payroll taxes/benefits	83,898	83,898
Lab wages	91,400	91,400
Lab supplies/outside costs	69,448	69,448
Supplies	219,704	219,704
Profit Sharing Plan	-	-
401K Employer Match	7,186	7,186
Total direct operating expenses	1,143,636	1,143,636
Facility and Debt Cost		
Rent	120,000	120,000
Rent, Sunrise II	24,000	24,000
Repairs/maintenance	36,366	31,616
Equipment lease	3,302	3,302
Utilities	10,830	10,830
Total facility/debt cost	194,498	189,748
Operating Expenses		
Employee recruitment	12,506	12,506
Advertising and marketing	18,146	18,146
Legal and accounting	14,110	-
Bank/collection fees	24,360	24,360
Charitable contributions	320	-

	April 30, 1998	April 1998 Clinic Margin
Administrative wages:		
Managers	35,343	35,343
Staff	66,601	66,601
Telephone staff	41,956	41,956
Temp employees	243	243
Cellular Phones	1,783	1,783
Depreciation	22,108	22,108
Dues/subscriptions	866	866
Auto/travel	166	166
Education	5,458	5,458
Insurance	8,356	8,356
Admin: 401K Plan	4,942	3,440
Office supplies/expenses	32,616	32,616
Postage	13,209	13,209
Other taxes	24,422	24,422
Virginia sales tax	623	623
Uniforms/laundry	10,841	10,841
Telephone & Answering Service	12,190	12,190
Cleaning/supplies	10,764	10,764
Employee promotion	7,993	7,993
Employee meals	1,097	1,097
Total operating expenses	371,019	355,087
Total clinic expenses before owner's expenses	1,709,153	1,688,471
Clinic Margin	1,274,333	1,295,015
ADP's Share 30%	-	388,505
Net income from practice before miscellaneous income and (expenses) and doctors expenses	1,274,333	906,511
Interest Expense	(14,141)	-
Income Tax	-	-
Associates wages	(131,402)	(131,402)
Contract doctors	(72,742)	(72,742)
Payroll taxes - Associates	(4,418)	(4,418)

	April 30, 1998	April 1998 Clinic Margin
Net income from practice before owner's expense	1,051,630	697,949
Owner's Expenses		
Wages	616,004	704,282
Doctors Bonus	-	-
Payroll taxes/benefits	39,921	39,921
Dues/subscriptions	4,612	4,612
Conventions/Meetings/Meals	5,161	5,161
Travel/entertainment	8,015	8,015
Education	2,741	2,741
Health insurance	-	-
Disability insurance	21,593	21,593
Life Insurance	6,190	6,190
Profit Sharing Plan	-	-
401K Employer Match	7,126	7,126
Total owner's expenses	711,363	799,641
Net income/(loss)	$ 340,267	$ (101,693)

Footnotes:

1) Wages: Clinic Margin column includes Jan 1, 1998 payroll. April 30, 1998 column only includes one payroll in Jan 98. Jan 1, 1998 payroll was dated and paid on December 31, 1997.

2) Installation for Cameras: Clinic Margin column adjusted as follows:

Repairs/Maintenance	4,750
Office Supplies/expense	1,502
	$ 6,252