

FINANCIAL ISSUES IN 2005

**EAST QUAY HEALTH
Practice Managers Training Morning**

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Mount Somerset Hotel

SUPERANNUATION

The 'old' system

Historically, the payment of superannuation has been relatively straightforward. The relevant amounts have simply been deducted by the PCT from the monthly and quarterly amounts due to the practice.

A number of allowances were paid which were 100% superannuable. These were target payments, seniority allowance, training grant and the sustained quality award.

All other superannuation payments were subject to a deduction for notional expenses. This was 34%. Therefore only 66% of other allowances are superannuable.

An SD86C was produced annually which details the superannuation contributions (at 6%) and the deemed superannuable income.

The superannuable income figure could be entirely misleading as it does not bear any relation to profit – but was just the superannuation contribution figure divided by 6 multiplied by 100.

These superannuation certificates were submitted by the PCT directly to the NHS pensions agency and form the basis of the final pension.

The PCT charged the relevant proportion of superannuation on every payment made to the practice and apportion this in profit sharing ratios between the partners. Where a partnership allocated PGEA and seniority to the individual partner, separate payments were made and superannuation charged individually to the Doctors.

Superannuation was also adjusted for hospital appointment income which was included as part of the overall partnership profits.

Under PMS there were no separately identifiable fees and allowances. A budget had to be agreed for superannuation contributions for the Doctors. This is then deducted from the PMS budget money on a monthly basis.

The historic superannuation under GMS was generally used as the starting point for amounts to be included in PMS budgets.

For all dispensing practices, superannuation was paid on only 66% of the 'on cost allowance' and the 'dispensing fees' received.

The 'New' System

All superannuation for the partners will now be based on the individual partners net NHS profits.

The NHS pension agency have now devised new 'Annual Certificates of Superannuation profits'. These were issued in April and are extremely complex forms. There are 4 pages of calculations and two pages of explanatory notes. There are also 4 pages of supplementary explanatory notes.

Each partner must have a form completed for each NHS year – which is to 31 March each year.

These forms must be completed and returned to the Health Authority by 28 February following the end of the NHS year. For example, for the year to 31 March 2005, the forms have to be with the Health Authority by 28 February 2006.

If your partnership accounts year end is not 31 March, then the previous finalised set of accounts will form the basis of the calculations. For example, the 30 September 2004 accounts will be included in the statements of NHS profits for the year to 31 March 2005.

The NHS profit figure is not just the profit from the accounts. It needs to take into account the partners individual expense claims, any personal medical income that is declared in tax returns or personal expense claims. It also has to include capital allowances (depreciation) on cars and partnership assets.

This profit figure then has to be adjusted for any non taxable items such as bank interest. It also has to take into account any income which has already had superannuation deducted such as hospital appointment income and out of hours earnings.

The NHS profit figure then has to exclude any non NHS income such as insurance medicals. We then have to calculate the proportion of expenses which relate to these non NHS earning and for most practices a standard method will be used which is a straight proportion.

If you are a non 31 March year end, then effectively, part of the income will have been superannuated twice. For example, for a 20 September 2004 year end, the profits from 1 October 2003 to 31 March 2004 will have had superannuation deducted under the old system – but will also have superannuation deducted under the new system . The profits from 1 October 2003 to 31 March 2004 are called the 'overlap' profits and will be deducted from the final calculation in the year a partner retires.

The forms have to be prepared by your partnership accountant. The boxes on the form will bear no relation to the actual figures in the partnership accounts as there are so many adjustments which are made in arriving at the figures. The GP's have to sign the forms and then they are sent to the Health authority for signature before being passed to the NHS pensions agency,

If the forms are not completed correctly this will lead to the wrong superannuation contributions being made which will affect the final pension being paid to the partners.

Can the figure be manipulated.

A number of practices are asking if expenses can be paid personally rather than by the practice in order to affect the calculations. For example professional subscriptions being paid personally rather than through the practice. As the certificates also take into account the personal expense claims, this will have no impact at all on the calculations.

Major changes from previous year

Historically, only the on cost allowance and the dispensing fee for dispensing practices were partly superannuable. Under the new regime, the total dispensary profits are now fully superannuable which will lead to a huge increase in contributions.

If a practice was making profits on the financing of the property then this historically was not superannuable. For example if cost or notional rent were £50,000 per annum and the loan interest on £30,000, the profit of £20,000 is now fully superannuable. It makes no difference if the loans for the property are partnership or personal. If there are personal loans, then the interest is included on the individual partners tax return and will have to be included on the certificate of pensionable profits.

A practice historically may have been extremely profitable – but the superannuation contributions were restricted as they were based on payments made to the practice and not on profits. This will mean under the new system that contributions will increase and pensions will be enhanced.

Doctors must be up to date with personal information

In order for the certificates to be completed, the partnership accounts must have been signed off. In addition, the partnership tax return, the partners personal expense claims and all partners personal tax returns must have been completed in order for the calculations to be finalised.

Other uses for the form

This will be the first time that the PCT will know the total net NHS profit made by each of the partners in the PCT area.

It will form the basis of seniority payments for the practices. Historically, three quarter and half time partners were not paid the full seniority allowance, it was restricted. Under the new GMS contract, there is no longer any concept of part time partners so a new system had to be devised to restrict seniority. This will now be based on each individual partners level of NHS profits. If a partner earns more than two thirds of the national average NHS profit then they will receive the full seniority allowance. If they earn between one third and two thirds then they will receive 60 % of the seniority allowance and if less than one third no seniority will be paid.

As the forms do not have to be with the pensions agency until February 2006, the earliest time in which we will know the average NHS profits will probably be April/May 2006. Therefore if a partner has been paid the unrestricted seniority allowance and it then transpires that they only earned 50% of the national average – there will be a clawback of the overpaid seniority. This will be more than one year after the financial year in which the seniority was originally paid. This will have particular consequences for partners who may have retired in the interim and practices will have to ask retired partner for money to be paid back into the practice.

Also it has not been made clear whether the national average will be for whole time equivalent partners or just a straight average. If it is a straight average, then the level will be lower and more partners will qualify for unrestricted seniority.

The forms can also be used for national comparison. We will for the first time have a very accurate picture of the national NHS profit earned by GP's in the UK.

Payment of superannuation

Under your new GMS contracts, the historic 'employers' superannuation contributions for the practice which were paid by the PCT were included as part of the calculation of the correction factor (MPIG).

The historic 7% contributed by the PCT was doubled to 14%. This was then inflated to arrive at figures for 2004/2005. Then in the global sum, additional money was included to contribute to the 14% contributions. This was 26p per weighted capitation for the year. In addition, the value of the quality and outcomes points increased from £75 for the average practice to £77.50 in order to give practice slightly more money for the 14% contributions.

The PCT should then have been deducting superannuation based on an estimate of the NHS profits for the practice. This would have been deducted on a monthly basis and would be for the 6% employees contributions as well as the 14% employers contribution.

For most PCT's they requested from practice accountants an estimate of the likely level of NHS profits. In Somerset however, the PCT's made estimates which had led to a few problems. For some Somerset PCT's, they also deducted a large proportion of superannuation from the final Quof achievement payment in April 2004 without reference to the individual practices.

Once the certificates of superannuable profits have been prepared, these will be checked against the contributions already deducted by the PCT during the financial year and an adjustment will be made. Practices will either have to pay a balance to the PCT - or they will refund any overpayments.

It was important that practices kept part of the quality and outcome money for this balance of superannuation as for many GMS practices this will be substantial. It represents not only the 6% 'employees' contributions but also the 14% 'employers'. So if your superannuable profits were higher than the PCT estimates by £20,000, then a balance of superannuation of 20% - i.e. £4,000 will have to be made.

For PMS practices, different approaches were taken by different PCT's. For most, they simply doubled the historic 7% contributions to 14% and then added a small additional amounts to equate to the additional 26p per patient paid to GMS practices. Some however have devised very complex calculations looking at each individual payment made to practices. In these circumstances, it appears that the PCT will have been making substantial extra funding available to these PMS practices.

Out of hours

From 1 October 2004, superannuation was payable on out of hours shifts. This has lead to enormous problems within practices. Firstly the payments were made to the individual partners. Then they were made directly to the practices and from February, most resorted back to paying the individual partners.

Initially, superannuation was deducted. Then the superannuation was not deducted and the 14% superannuation was added to the payments of the shift fees.

Now the system should be straightforward. For GP's carrying out any shifts, they will be paid the shift fee PLUS the 14% employers superannuation contributions. A GP SOLO form needs to be completed monthly listing the shift fees received. This then needs to be signed by Mendip PCT before being returned to the individual partners who send the forms to Taunton together with a cheque for the 6% employers contributions and the 14% employers contributions. They will also have to pay over 'added years' contributions if these are being paid.

This differs greatly from Devon where the shift fee plus the 14% employers contributions are being paid directly to practices. The GP's do not have to complete GP solo forms monthly as the money will be included as part of the annual certificate of NHS profits.

It is essential that GP's keep copies of the GP solo forms as these will be required when completing the certificates of superannuable profits.

Locum payments

Where partners in a practice perform additional duties effectively as a locum, they are sometimes paid separately by the practice.

This money can now be separately superannuable by completing the GP SOLO forms for these payments. The advantage of this – rather than treating it as an additional share of profits for that partner – is that the PCT will pay the 14% employers superannuation contributions, not the practice.

Historically, superannuation on locum payments was not borne by the employing practice. If locums wished their income to be superannuable, then they had to pay the 6% employees contribution to the PCT and the PCT would pay the 14% employers contribution.

Under the new GMS contract, the intention was that all practices would in future have to pay the 14% employers contribution themselves and deduct the 6% employees contributions from the payments to the locums. This however is not happening yet (and is unlikely for the next few years) and PCT's will continue to pay the employers contribution.

The intention was that additional funding would be given to all practices under the global sum calculations to pay them an element of locum superannuation contributions which had historically been funded directly by PCT's. Problems arose with how this should be allocated as it was felt that locums were required more by smaller practice and therefore this would have to be recognised on the allocation of the money.

Problems with the 'New' System

Lack of understanding!

Tax relief could be an issue. With pension contributions it is only usually the contributions made in a tax year which you can claim tax relief on. Under this system, there is a balance of superannuation paid after the end of the tax year. Should this be included on a GP's tax return – or included in the subsequent year when the payment was made. This has yet to be clarified with the Inland Revenue.

Non GP partners. Where there are management partners, then a form also has to be completed for them. This appears to have been overlooked by Somerset PCT's who have been asking for details of the managing partners 'salary' for superannuation purposes in the last year.

For Non GP partners, you are effectively contributing superannuation to an occupational pension scheme whilst being self employed individuals. Under the strict Inland Revenue rules this is not allowed and some tax offices are denying tax relief on pension contributions for management partners.

Superannuation for salaried GP's

From 1 April 2004, the rules changed. Historically any salaried GP including flexible career scheme GP's and retainers were treated as any normal employee. You would deduct the employees superannuation contributions and these would be paid over to the NHS pension agency with the employers contributions on a monthly basis.

Now you continue to deduct the employees contributions from the salaried GP, but this is not paid over to the pensions agency. The PCT should be deducting the employees and the employers superannuation on a monthly basis from your GMS or PMS monies.

This has not happened for a huge proportion of practices within Somerset and partnerships should be aware that they may owe several thousand pounds in superannuation contributions.

You should also ensure that if pay rates change or hours change, then you will be required to advise the PCT who should adjust the superannuation deductions accordingly.

For GMS practices – it will not be obvious whether the employers superannuation is being deducted and this is usually just lumped in and included with the partners employers contributions.

INCREASE IN PROFITS

The increase in profits over the last year is likely to be relatively substantial. There are however a number of distorting factors which may not be recurring and which could lead to GP's over estimating their actual core profitability. In 2004/2005, the following factors may have increased profits compared to future years.

The Out of Hours Opt Out for some practices may be an actual saving as subscriptions paid to out of hours co-operatives were higher than the actual 6% opt out but for others, this will have a major impact which will only have been partly implemented in this last financial year.

Quality preparation money were extra additional payments for 2002/2003 and 2003/2004 only and these will have been included in your practice profits this year.

Quality information preparation payment was also a one off payment for two years only which will be non recurring.

The out of hours opt out is not just the only impact. You will also lose the out of hour's development money which in some areas was paid over to the individual practices.

The payment of arrears of GMS fees and allowances may also slightly distort profits and will also have an implication on cash flow in the last year.

Money from community hospital bed fund payments also have been renegotiated leading to a fall in income, the impact of which will not be felt in full until the coming year.

A number of PCT's paid large sums of incentive money to practice in 2003/2004 which are likely to be non recurring.

Assuming however that practices correction factors were calculated correctly, the level of historic funding will have been maintained together with a significant increase from the quality and outcomes framework. Overall, money being paid to practices increased by 10%. The assumption was that costs would increase significantly from previous years to meet the quality and outcomes points. However, for the majority of practices we deal with, this has not been the case and points have been achieved by reallocating and reorganising the way in which staff and doctors work rather than simply employing more staff. This does mean that the increase in profits is likely to be higher than 10%.

In the coming year, the core funding for practices will not change. The GMS Global Sum and correction factor are fixed with no inflationary increase at all. The Global Sum payment will be £54.72 per weighted patient. This now includes the superannuation premium and appraisal premium which were paid separately before.

The Global Sum payment in the last year was £54 per patient plus 26p for the appraisal premium and 21p for superannuation premium giving a total of £54.47 so in fact there has been a 0.45% increase in overall funding.

For PMS practices, the baseline is likely to increase by .37% although some PCT's are not applying any uplift at all.

PMS practices do however benefit from the quality points offset falling from 168 points to 109 points.

For all practices, the dispensing fees will increase by 5.4% and enhanced service payments will increase by 3.225%.

All practices will continue to benefit from the changes of these seniority payments not only as you will all have one years extra reckonable services but this is the third year of the continuing uplift to seniority payments.

The biggest factor in the coming year however is the increase in quality and outcomes points from £77.50 to £124.60.

So what will be the likely impact on the average practice of three doctors and 5,891 patients for 2005/2006.

		£
Practice Profits to 31 March 2005	Say	300,000
Out of hours opt out	6 months only	(9,627)
Quality preparation money		(3,250)
Quality information preparation		(5,000)
Out of hours development money		(5,400)
		<u>276,723</u>
Increased income from quality and outcomes framework		47,100
Increased employers superannuation		(3,335)
		<u><u>320,488</u></u> 6.83%

This increase however does not take into account any increase in costs.

The subsequent years

At this stage, there is huge uncertainty over the payment structuring in future years. The calculation for the weighted list size is likely to be reviewed and updated considerably. The quality and outcomes framework is also being reviewed and will change, probably from 2007 making it much more difficult to achieve the level of points. In addition, the increase in funding to primary care was initially for a sustained increase of 10% for three years only so it is likely that practices will experience a period of significant increase in profits funded by a fairly static period.

Where can we see increases in income

The value of quality and outcomes points will increase.

Many practices underperformed in enhanced service areas and additional money can be earned in subsequent years.

By negotiating for additional enhanced services within the practice.

By earning more in terms of quality and outcomes points.

LIST SIZE

List size is a key factor in maintaining and increasing profitability.

The impact of any shifts in list size will vary considerably depending upon the practice.

For GMS practices, an increase in patient numbers will lead to a £54.72 increase in the Global Sum. In addition, there will be quality points money. A practice earning 1,000 quality points is likely to earn an additional £21.15 for every patient. This does mean total income is likely to increase by £75.87 per patient. There may also be an increase in enhanced service payments but this will not be significant. So for a practice whose list increases by 100 patients, the likely impact is an increase in funding of £7,587.

For PMS practices, the situation is vastly different. Whilst they will still benefit from the increase in quality and outcomes points, any changes in list size will affect the overall PMS baseline budget which is the equivalent of the Global Sum and the correction factor for GMS GPs. So potentially, for PMS practices where the baseline is around £75 per patient, an increase of 100 patient will give additional funding of £9,615. Equally, if there are falls in list size, these will be felt much more by PMS practices than GMS practices.

VAT

There have been two recent VAT cases heard at the European Court of Justice – one from Germany and one from France (November 2003).

The judgement in both cases was that VAT exemption is strictly limited to therapeutic care. This is the prevention, diagnosis or treatment of illness.

Historically in the UK, VAT exemption has applied to all services provided by medically qualified staff because of their qualifications.

At some stage, pre-employment medicals, medicals to assess the level of insurance premiums, reports in litigation and negligence cases will all become taxable.

This however will only apply to those practices who are already registered for VAT and those very large practices where the turnover from these sources of income is higher than £60,000 per annum as they will be forced to register for VAT.

CAPITAL GAINS TAX

Capital gains tax is becoming an issue with the ceasing of retirement relief and the rapidly increasing value of premises.

As goodwill is illegal under the NHS Act, it is really only capital gains tax for property owning GP's which is a potential issue.

In order to calculate any capital gain, you need to compare the disposal proceeds of the asset with the eligible base cost. The disposal proceeds will be after all incidental expenses such as estate agents and solicitors fees.

The potentially difficult part is working out the base cost. For many partnerships, the partners will have owned a share in the property for some considerable time and property ownership percentages may have changed significantly during the ownership period of the property.

For each individual partner, you need to work out the actual original cost (including any professional or incidental costs) and for every period of ownership change to the date of sale of the property, you need to calculate the additional costs incurred for each GP. It may be for some partners, that they have actually sold proportions of their property share as the partnership has expanded. For example, a partner may have originally owned 1/4 of the surgery premises however when a 5th partner was taken on; effectively 1/5 of each partner's share was sold on to the incoming partner. There should have been a capital gains tax computation carried out at that date of sale to the incoming partner, which would proportionately reduce the original base cost for each partner. For example if the base costs of your share were originally £100,000 by selling a 1/5, you would be left with a base cost of £80,000 regardless of whether the sold proportion was disposed of at a profit or loss.

When calculating the base cost of any asset, you should include only amounts of actual expenditure, ignoring any revaluations. It is common amongst medical practices to revalue the property on any change of partnership so it is likely that the balance sheet value of the premises does not reflect the actual expenditure.

Any expenditure in terms of improvements to the property can be included as part of the base cost. Please bear in mind that these payments for additions to the property will be net of any improvement grant, fund-holding savings, and fund holding management allowance or Health Authority reimbursement.

Where practice premises have been built by a partnership, it is likely that the rolled up interest incurred during the construction phase has been added to the balance sheet cost of the surgery premises which should then equate to the cost rent value as this is an allowable cost for cost rent purposes. Please bear in mind that your accountant should have claimed for income tax relief at the date of the construction of the surgery and so this capitalised interest will not be eligible as part of the base cost for capital gains tax purposes.

In general the cost of an asset acquired before 31 March 1982 is taken to be its value on that date and so if you have used the surgery premises for a significant length of time, you may require a valuation of the premises at 31 March 1982.

By deducting the base cost from the sale proceeds, you are arriving at the capital gain.

Indexation allowance

Up to April 1998, an indexation allowance is given to potentially reduce or eliminate a gain (but the allowance cannot create a loss). Indexation allowance for partnerships and individuals ceased after April 1998 and was replaced by taper relief.

The indexation allowance is basically adding inflation to the March 1982 value or cost of the premises. Where improvement expenditure has been incurred indexation must be calculated separately.

The indexation allowance is still calculated from 31 March 1982 up to April 1998 but cannot be increased after that date.

Taper Relief

Taper relief replaced indexation allowance for individuals from 5 April 1998. Taper relief reduces potential capital gains on a sliding scale according to the complete number of tax years that the asset has been held. This is counted from the date of acquisition or 6 April 1998 which ever is later.

A higher rate of taper relief applies to business assets compared to non-business assets and for surgery premises, this would obviously be a business asset if you were a partner in the practice.

An extra year of taper relief is added for any non business asset owned before 17 March 1998. For example, if an investment property is disposed of before 5 April 2003, you would qualify for four years of taper relief, ie, 6 April 1998 to 5 April 2002, plus you would qualify for an extra year. This 'extra' year does not apply to business assets so would not apply to the sale of surgery premises.

Taper relief works by reducing the potential capital gain by a percentage. For business assets this has been revised so that the maximum relief is applicable after only two years rather than four years for assets disposed of on or after 6 April 2002, as set out in the table below:-

<u>No of whole years in qualifying holding period</u>	<u>Percentage reduction available</u>	<u>Percentage of chargeable gain</u>
	<u>%</u>	<u>%</u>
1	50	50
2	75	25
3	75	25
4	75	25

Please bear in mind that for non-business assets, the maximum taper relief is only available after a ten year holding period and the maximum percentage reduction available is 40%.

Capital Gains Tax Annual Exemption

Even where, by carrying out the detailed calculations, you still end up with a capital gain, this can be mitigated because each individual has a capital gains tax annual exemption. This is currently £7,700. Effectively, on the first £7,700 of capital gains in this tax year, there will be no tax payable. This is assuming that no other disposals of assets have been made during the year that has given rise to a capital gain. If assets have been sold during the same tax year which give rise to a capital loss, these can be set against capital gain on the building and reduce the overall tax burden.

At What Rate is Tax Paid

Any capital gain is taxable at 10% to the extent that an individual's taxable income is below the starting rate limit (£1,920 for 2002/2003), at 20% to the extent of any unused part of the basic rate band and at 40% on the remainder. For most GP's it is likely that any capital gain is taxed at 40%.

When is Tax Payable

Capital gains tax is payable on 31 January in the year following that tax year of sale. For example if the surgery premises were sold on 30 June 2003 the gain would be included in your 2003/2004 tax return and tax would be payable on 31 January 2005.

If a gain appears unavoidable, a partner may consider switching a share of the property to their spouse. Taper relief is calculated not from the date of transfer, but from the date at which you originally acquired your share (or 6 April 1998). One potential problem is that for your spouse, as they were not a partner in the business, the asset will be treated as investment property so that Taper relief is less generous.

NATIONAL INSURANCE

All self employed people are liable for national insurance (other than those who have reached state retirement age).

There are however several sorts of national insurance which may be paid.

Class 1 national insurance is paid on any employment income and is deducted directly at source. This is currently 11% for earnings over £94 per week and 1% on earnings over £630 per week. However this rate is reduced to 9.4% if you are part of the superannuation scheme.

Class 2 national insurance contributions are payable by anyone with self employment income. This includes all locum income. The current rates are £2.10 per week and this is normally paid by monthly direct debit or quarterly bill. If however your self employment earnings are below £4,345 per annum, you can apply for low earning exemption and therefore don't pay. You must however register with the Inland Revenue as a self employed individual.

Class 3 national insurance are voluntary contributions to maintain your national insurance contributions record in order to qualify for full state pension and are payable by individuals who are not working. The rates are £7.35 per week.

Class 4 national insurance contributions are based on profits from self employment and the rates are 8% for earnings between £4,895 and £32,760 per annum and 1% for any profits over this level.

If you have employed earnings and self-employment income, you could easily be overpaying superannuation and you have the right to reclaim this over payment on an annual basis. This can be done either by claiming a refund each year OR by deferring the payment of class 4 national insurance contributions until after the end of a tax year at which stage a review is undertaken of all your sources of income and a bill will be issued for any class 4 contributions required.

TAXATION PAYMENTS

If partnership profits have increased substantially, then taxation payments in January 2006 will be significantly higher than usual.

If a partner's taxable profits increased by £20,000, then the January 2006 taxation bill will be £12,300 higher than the July 2005 taxation bill.

SURGERY PREMISES

There have been a number of practices who have been advised that moving the partnership property into a limited company will have tax advantages for the partners.

These comments are not specific to any practice but generally apply in most circumstances – however, the way in which partnerships are financed and structured can be very different and you will need to seek specific advice if you are seriously considering this option for your practice.

1 **Cost/Notional Rent**

At present, partnerships enjoy a stream of cost/notional rent for the premises based on the original purchase and refurbishment of the building or on the rentable value of the surgery. This is guaranteed as long as the premises continue to be owned and used by the medical partnership. By selling the building to a separate limited company (albeit owned by the partners) this would effectively mean the stream of cost/notional rent should cease. Cost/notional rent is only available if premises are owned directly by the partnership. The limited company would rent the premises to the practice and the PCT will reimburse the rent being charged as long as this is a normal commercial rentable value as assessed by the district valuer. Effectively, this is notional rent.

If you are currently receiving cost rent and the notional rent figure is substantially less than the cost rent, it means an instant additional cost to the practice.

2 **Improvement Grant**

Improvement grants are usually only available for premises where they are owned directly by the GP partnership. By transferring the property to a separate limited company, you are effectively giving up the right to use improvement grants for future developments and improvements within the surgery building.

3 **Partnership Loan**

If you have a partnership loan for the surgery premises, there should be no problem with the lender transferring the loan into the limited company although there would of course be loan arrangement fees and their legal fees to pay.

The company would purchase the property at its market value. This would be used to extinguish any current partnership loan potentially with a surplus to be paid to the property owning partners. The individual partners would then use this money to repay any personal borrowings they had on the property.

4 **Capital Gains Tax**

The partners would effectively be disposing of their ownership in the property to a third party. This means that capital gains tax computations would have to be prepared for each of the individual partners. Although it is unlikely that a capital gain would arise, these calculations still need to be performed.

5 **Stamp Duty**

Stamp duty is payable on the transfer of assets. Although the individual partnership shares being transferred may be less than the £150,000 commercial property threshold, the transactions would be treated as linked and related transactions for the purposes of calculating stamp duty. As a result, the total transfer value of the premises would be chargeable. This would give rise to a significant stamp duty liability on the transfer. This is a huge cost and there would have to be a substantial and ongoing benefit in order to recoup this one off cost. The cost is also not eligible for income tax relief but will be taken into account for capital gains tax purposes if the company ever sold the property.

6 **Setting up a Company**

Setting up a company is relatively straight forward and can be set up for around £250 plus VAT. There would be a small ongoing cost for preparing annual accounts and submitting an annual return to Companies House but generally speaking, the costs would be minimal. The important thing is how many shares would be set up in the company.

I would recommend that this were at least 1,000 shares divided between the partners in their relative property sharing ratios. When a new partner joins, they simply purchase the shares in the company from the outgoing partner or, if it is an additional partner, they buy shares from each of the partners for their ownership of the company.

The shares in the company would have to be valued and this would effectively be the valuation of the property.

7 **Lease**

A formal lease would have to be drawn up between the limited company and the partnership setting out the terms and conditions. This would include who is responsible for maintenance of the building, insurance, redecoration and also set out the term of the lease. This would have to be a full commercial lease which, in addition to the cost for transferring the property into the company would mean legal costs of several thousand pounds.

8 **Taxation**

I do not see how there could be any significant taxation savings from transferring the property into a company, and indeed, this could increase the tax liability for the partners.

Assuming the rent less the loan interest yields a profit of £10,000 in the company this would not be immediately taxable to corporation tax as the first £10,000 of profit are not taxable. However, in order to pay these profits out to the shareholders, the company would need to pay out dividends. Assuming that your partners are all higher rate tax payers, this would lead to a personal tax liability on these dividends. After taking into account the dividend tax credit, the additional personal tax to pay on this £10,000 profit would be £2,500. In addition, as soon as the partnership declares the dividend, it has to pay 19% corporation tax on the dividend. This would be a further £1,900. So in total, the tax bill for the property profits would be £4,400 i.e. 44%. This is actually higher than if the property were retained within the partnership.

The only way to reduce the potential tax bill would be if spouses of partner's own shares in the company and spouses were not working or were lower rate tax payers. This could mean that only the 19% corporation tax is payable. This does however mean that if the property were transferred into the company, some partners could benefit from a slight saving in tax whereas some could end up paying more tax (particularly those job share couples within the practice). The corporation tax rules changed last year and prior to this, there may have been an overall saving in income tax.

9 **Capital Gains Tax**

Capital gains tax is always an issue with a limited company. If the building were ever sold, the company would make the capital gain and therefore be chargeable to capital gains tax. Companies do not benefit from the generous taper relief which reduce capital gains but do benefit from indexation (effectively inflation to the cost) when working out the gain. In addition, there would be personal tax to pay when dividends are declared paying out the proceeds from the sale of the building to the individual partners, so effectively a double tax charge. So not only may the capital gains tax be higher than if it were owned by the partnership but also there would be an income tax liability when the proceeds were paid out.

Overall, my advice would be to retain ownership of the property within the partnership as there are no apparent tax savings of transferring to a limited company and in fact it could end up costing the partners a substantial amount of money as well as an increased annual tax bill.