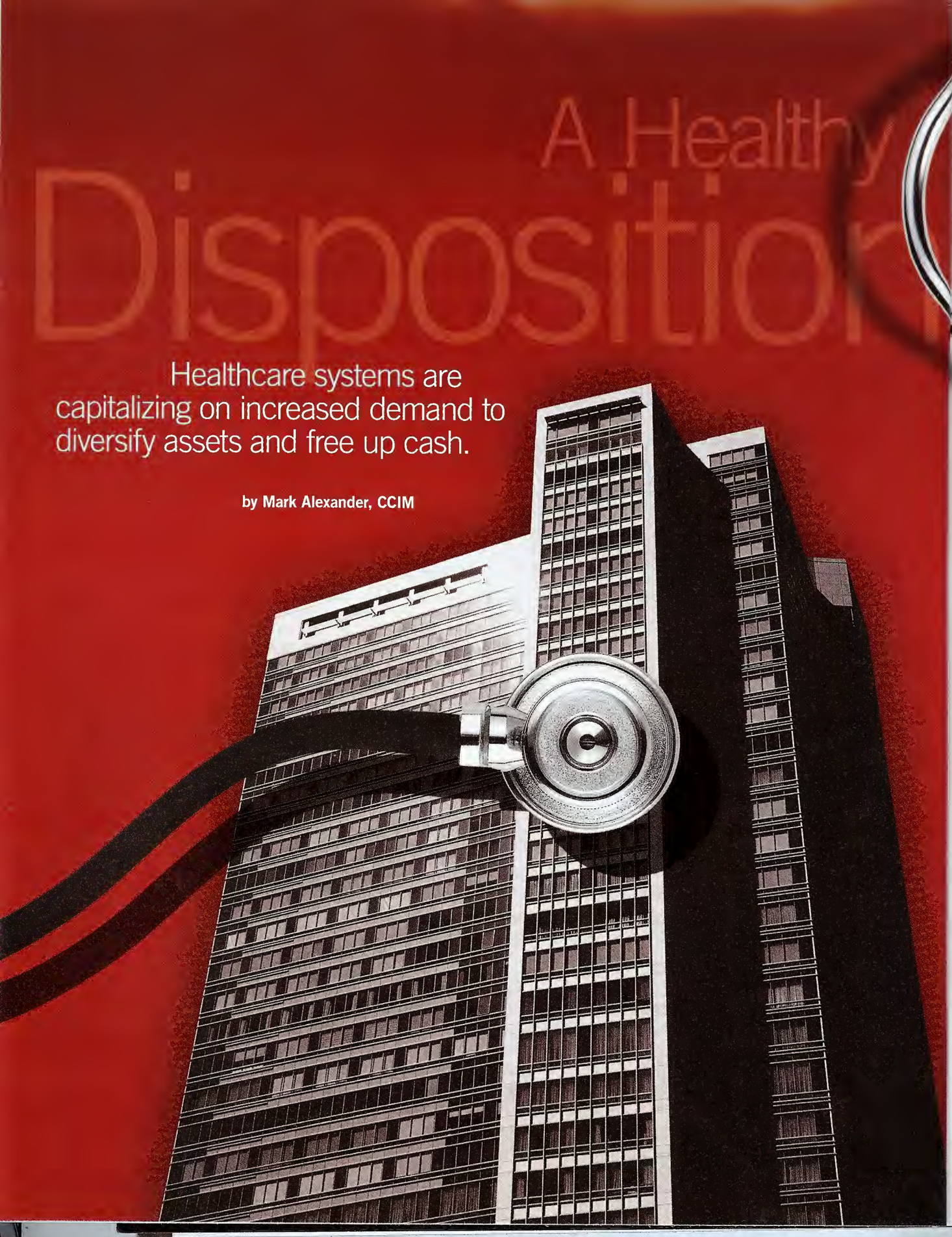
# A Healthy Disposition

Healthcare systems are capitalizing on increased demand to diversify assets and free up cash.

by Mark Alexander, CCIM



Medical office buildings enjoyed healthy transaction activity in 2010. Sales volume increased by 80 percent over 2009, according to Real Capital Analytics. MOB acquisitions totaled more than $3.1 billion in volume by year-end.

MOBs have attracted a great deal of attention from investors at all levels. Some of the transaction volume is driven by healthcare systems deciding to get out of the business of owning and leasing MOBs. Understanding how hospitals view their MOB investments can provide insight into how commercial real estate professionals can assist them.

## Different Considerations

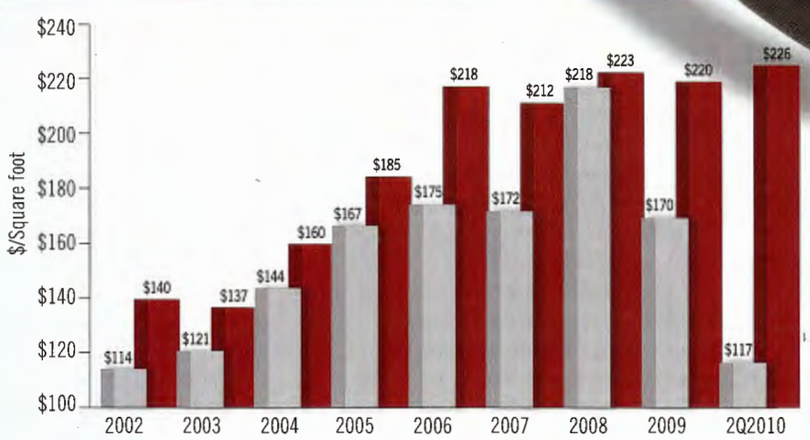
Doctors often purchase their own medical facilities as a long-term investment. Doctors can build equity owning MOBs during their careers, with an expectation to cash out equity near retirement by selling to a practice partner based on a market appraisal, or by structuring a sale-leaseback transaction with an investor to create a higher net present value of the MOB asset.

Hospitals typically have more-complex issues to assess. Most have an investment portfolio consisting primarily of equities. Some hospitals consider MOBs to be part of their investment portfolio. Other healthcare systems view their MOBs strictly from an accounting standpoint as an operating asset. A hospital system typically owns the buildings it occupies as well as other MOBs rented to doctors and other healthcare providers.

Hospital-occupied MOBs are good candidates for sale-leaseback transactions to monetize value in cases where the hospital has limited access to capital for property improvements or expansion or to free up cash to fund operations. However, not all healthcare providers need to monetize owner-occupied MOBs if they have strong credit with good access to capital at reasonable rates.

***Tenant-occupied.*** Hospital-owned, tenant-occupied MOBs have recently become a higher priority to sell for several reasons.

## MEDICAL OFFICE VALUES

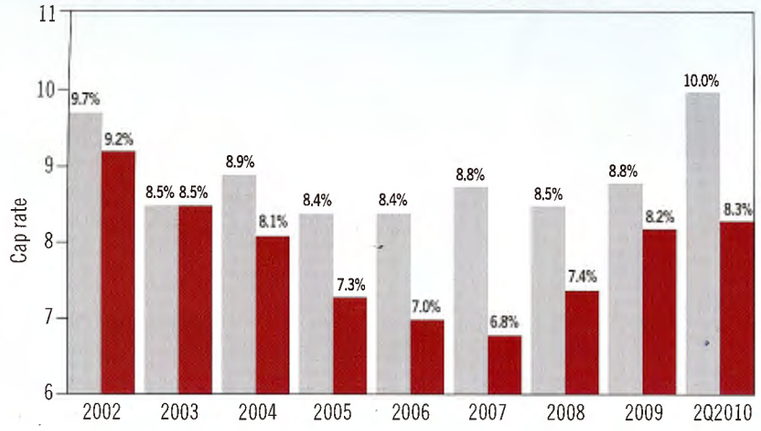



Average annual price psf for 53 MOBs sold by Mark Alexander in five states

Average annual price psf of MOBs $5 million or higher sold in U.S. per Real Capital Analytics

George Caswell/Getty Images; Robert Keenan/Veer

## MEDICAL OFFICE CAPITALIZATION RATES




Average annual cap rates for 53 MOBs sold by Mark Alexander in five states, with an average sale price of $1,031,000

Average annual cap rates of MOBs $5 million or higher sold in U.S. per Real Capital Analytics

MOBs are investments that tie up hospital capital that could be utilized more effectively on other strategic investments. Due to soft office market conditions across the U.S., many hospitals have increased vacancies with the opportunity cost of this capital tied up in their MOBs.

The estimated value of MOB holdings is added to the healthcare provider's investment portfolio. When the ratio of MOB holdings as a percentage of total portfolio assets increases, portfolio risk also increases from an investment perspective due to the lack of geographic and industry diversification inherent in MOBs. This is especially true if patient volumes decrease as is the case currently in many markets. Significant concerns about the slowly recovering economy combined with new political challenges to healthcare reform may cause hospitals to reassess the risk of holding a high percentage of MOBs in their overall investment portfolio.

Sale-leaseback of select hospital-occupied buildings and/or straight sales of tenant-occupied buildings can provide that asset diversification and improve the cash positions at a time when cash can be utilized to take advantage of more strategic opportunities. For example, Carle Foundation Hospital sold its 92,000-square-foot MOB in Bloomington, Ill., for $24.25 million, or $264 per square foot, at an 8.5 percent capitalization rate, according to Robert Tonkinson, former CFO of the Carle Foundation based in Urbana, Ill.

### Other Concerns

Two new statutes enacted by Congress in 2009 may bring greater governmental scrutiny and action for hospitals and healthcare systems. The 2009 Fraud Enforcement and Recovery Act and the Patient Protection and Affordable Care Act affect a hospital's decision to self-disclose Stark Law violations related to hospital-physician leasing arrangements. (MOB leases are considered financial arrangements that fall under the Stark Law, which prohibits physicians from referring Medicare patients to a healthcare facility with which they have a financial relationship.)

The impact of these rules on MOBs could be significant and cause many healthcare firms to sell their MOBs to third parties, if only to avoid the potential risks. Hospitals that wish to retain their MOB interests may consider outsourcing MOB management to commercial MOB specialists as an added layer of insulation from Stark Law liability.

The most transparent way out of this newly heightened government scrutiny, however, may be to monetize MOBs with sales or sale-master leasebacks. This avoids the inherent potential conflict posed by a doctor who refers patients to a hospital, and later asks the same hospital for six months free rent to sign a new lease. In this situation, the negotiation is driven by federal health care regulations with heavy fines levied on hospitals that don't follow the rules. When a doctor asks a private MOB owner for six months free rent to sign that same new lease next to the hospital, it becomes a simple business decision driven by market forces, without the negative baggage of perceived conflicts of provider-owned MOBs.

### MOB Values Up

There is exceptional demand today supporting stronger-than-ever values for large MOBs with healthy credit tenants on long-term leases in major U.S. markets. For example, Healthcare Trust of America purchased more than $800 million in healthcare assets in 2010, including 53 MOBs. More than half of those purchases were made in 4Q10. One purchase was the Deaconess Clinic of Evansville, Ind., a five-building sale totaling 260,500 sf for $45.26 million, or $174 psf, at an 8.25 percent cap rate in March 2010 using a 14-year term master leaseback.

The average annual price for MOBs in sales larger than $5 million has risen steadily from $140 per square foot in 2002 to $218 psf at the top of the market in 2006 to $239 psf by the end of 3Q10, according to RCA.

But what about smaller MOB deals in smaller markets? I personally brokered the sale of 53 MOBs with an average sale price of approximately $1.03 million per transac-

## MEDICAL OFFICE SALES VOLUME, 3Q10

| Region | # of sales | Volume (in $ millions) | Average psf |
|---|---|---|---|
| West | 14 | 115.3 | $226 |
| Southwest | 7 | 75.7 | $223 |
| Southeast | 13 | 171.0 | $219 |
| Midwest | 2 | 39.6 | $222 |
| Northeast | 3 | 18.9 | $363 |
| Mid-Atlantic | 4 | 26.2 | $118 |

Source: Real Capital Analytics, CBRE

## REFORM BOLSTERS MOB MARKETS

Politics aside, when the Obama administration passed the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Tax Credits Reconciliation Act of 2010, it opened the healthcare system to more than 30 million newly insured persons through 2019. If each new patient creates the industry-rule-of-thumb demand of 1.9 square feet of medical office space per person, then the newly insured will create a national demand for 57 million sf of medical office space in the next eight years.

What does that mean for robust secondary markets such as Dallas-Fort Worth? The DFW market contains 4.9 million insured and approximately 1.6 million uninsured legal residents, according to the State of Texas Office of the Comptroller. As DFW's population grows by 1.95 percent over the next five years, as the Bureau of Labor Statistics predicts, healthcare providers will increase healthcare jobs at a rate of 4.6 percent. Under healthcare reform, patient loads in the DFW market will increase by roughly 25 percent, equating to more than 3 million sf of new medical office by 2019.

Of DFW's 329 million sf of office space, 23 million sf are medical office buildings, CoStar reports. The DFW office market runs an 18.1 percent vacancy rate compared with 16 percent for MOBs, down from 17 percent in 2010, also according to CoStar. The declining MOB vacancy rate and limited new construction in the DFW market means that it has entered the recovery stage of the market cycle. Healthcare providers will continue to absorb DFW's 3.7 million sf of vacant medical office space, and as lending loosens, we expect to see the 3 million sf of pending demand create an increase in build-to-suit projects and speculative development.

As this demand comes online, we are targeting class A, stabilized, multitenant MOB product in strong DFW submarkets. We focus on institutional class properties with long-term leases in markets with strong population growth, high median incomes, and strong traffic counts near regional hospital systems. These properties are competitive because they are foundational to the pending MOB demand and are poised for growth.

MOB capitalization rates in the DFW market range from 7 percent for class A, on-campus institutional product to 10 percent for average medical space with vacancy rates in excess of 16 percent. We are seeing real estate investment trusts such as Grubb & Ellis Healthcare REIT, Healthcare Realty Trust, Healthcare Trust of America, and Nationwide Health Properties as well as foreign money competing for choice assets.

These investors are buying with cash, relying on lines of credit and equity investors, while my clients are pursuing leverage to enhance their returns. Our clients are capitalizing on premium nonrecourse financing, relying on lenders such as life companies, which are interested in class A MOBs for the right borrower and strong tenant. In our analyses, we are underwriting to assumptions such as 75 percent loan to value, 25-year amortization at 6.1 percent, which are some of the best terms available to investors with strong balance sheets and ample liquidity.

—Alex Johnson, CCIM, is president and principal broker of Laurex Realty Advisors in Plano, Texas, and an instructor for the CCIM Institute. Contact him at alexjohnson@laurexrealty.com.

tion, located in tertiary markets in Florida, North Carolina, South Carolina, Georgia, and Illinois from 2002 through 2Q10.

The accompanying charts compare the annual prices of deals over $5 million tracked by RCA and my deals. From 2002 through 2005, there was an average MOB price difference of only $20 psf between the big deals/big markets and the small deals/small markets.

In that same period, cap rates for large transactions averaged only 0.6 percent lower than those for small deal/small market prices. But the gap started to widen from 2006 through 2008, when the big MOB deals averaged $30 psf higher and the cap rates for big deals compressed to average 1.5 percent lower than the cap rates for the small deals.

There was a striking difference from 2009 through 2Q10 as big deals in big markets pulled away and averaged $80 psf higher than the small deals in small markets, with the cap rate differential moderating to only 1.1 percent. This condition over the last two years reveals an interesting trend. The more sophisticated investors (like hospital systems) that own big MOBs in big cities realized that, in addition to the other good reasons, the top of the market is actually now, so they are selling.

Doctors predominately own smaller MOBs in smaller markets and are somewhat isolated from the realities of the current favorable market condition for MOBs. They have tended to remain on the sidelines during these last two years believing their MOB values are down like the rest of the real estate market, when in fact the opposite is true. The majority of small MOB sales over the last two years were mostly distressed, vacant properties that sold at very low prices, creating the disparity of $80 psf between large ($5+ million) and small ($1 million) recorded MOB transactions.

This should change, however, in 2011 as the gap between large and small MOB deals narrows when doctors in smaller markets realize MOBs have escaped the declines of other segments and that now is one of the best times ever to sell medical office space at strong valuations.

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COMMERCIAL INVESTMENT Real Estate

# IN THIS ISSUE

The commercial real estate market sizzled in December 2010, racking up more than $27 billion in sales — the most active month since 2007, according to Real Capital Analytics. And, as reporter Beth Mattson-Teig tells it in the cover story on p.26, secondary and tertiary markets are seeing a good share of deals. And so are CCIMs. Associate Editor Rich Rosfelder interviewed several designees who closed deals ranging from $2.5 million to $800 million in markets of all sizes. Read how they utilized their CCIM skills starting on p.36.

> "Clearly the desire — and the money — to get deals done exist." p.22

# FEATURED WRITERS

Federal government leasing is a $5 billion niche that operates in every state. Brenda Johnson, CCIM, CPM, a senior leasing specialist, and Ted Mahoney, senior warranted contracting officer with the General Services Administration, clearly explain how to tap into this program on p.32. Medical office acquisitions increased 80 percent in 2010, and on p.22, Mark Alexander, CCIM, senior medical office adviser with Sperry Van Ness, discusses how that activity is spreading to smaller markets this year. And Patrick Fitzgerald, CCIM, vice president for commercial real estate at BankUnited, looks at ways lenders and investors can use data to avoid the mistakes of the past on p.39.

Johnson

Alexander

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How can CCIMs create affordable yet effective Web videos? Read "Broadcast Your Business" on p.20, and then watch as Lauri Greenblatt Hines, CCIM, president of Promus Commercial in San Diego, steps in front of the pocket camcorder to discuss how property managers can add value and attract tenants.

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