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Research Report

Medical Office: A Value Proposition for Today's Real Estate Portfolio

May 2017

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Medical Office: A Value Proposition for Today's Real Estate Portfolio

As we enter a pause in the cycle where the pace of expansion in the office market has slowed from peak momentum, traditional investment opportunities begin to thin out, particularly for institutional grade product. Value-add or opportunistic plays that could ride further expansion become less strategic, and investments in secondary markets become even more tactical. Yet, this recent slowdown is more a function of slowing demand and absorption trends, as opposed to a combination of demand challenges and gross oversupply seen in past cycles. Moreover, the bifurcation between Downtown and Suburban office momentum is also a differentiator. These distinctions, however, lend merit to investment in certain subtypes of office product that could experience growth, offer stable cash yields or higher returns than traditional office, even as the overall office market plateaus. One such subtype is medical office space.

Certain influencers in today's office market, and even aspects of the current slowdown, are concurrently driving the medical office environment. The way demographic and demand trends shaped the most recent office market cycle have actually created new opportunity for medical office, specifically related to preferences in regards to access, amenities, service, and urbanization. Perhaps even more critical, the evolution in healthcare real estate in recent years allows this niche to take advantage of these shifts in the traditional office market.

Strong demographic components drive medical office demand

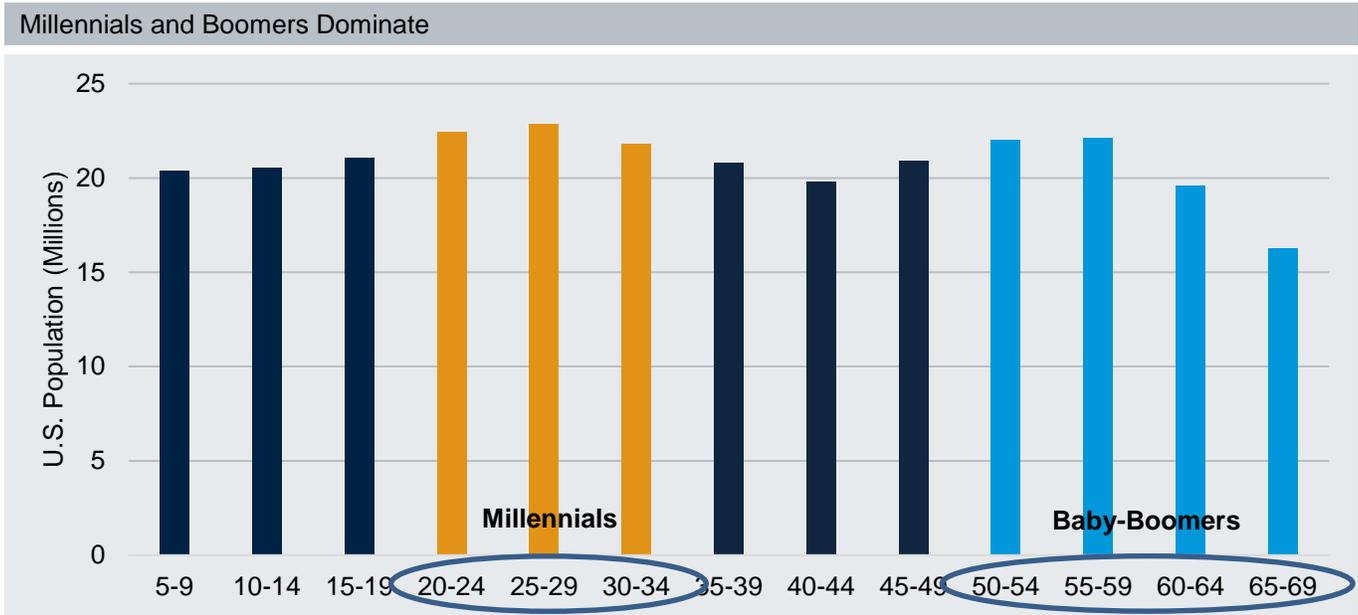
What we define today as "medical office" is a departure from the medical office of the pre-millennium. Today, a medical office can be better described as a multi-care facility that indeed includes physician offices, but also often boasts lab, imaging, ancillary care (e.g. physical therapy) and even ambulatory surgery space. A myriad of factors played into this shift, but demographics are widely considered a key catalyst. Aspects such as multi-service, accessibility, customer experience and lifestyle components desired by Millennials are changing the way healthcare is delivered. While the rise of the Millennial has undoubtedly been a force in the way real estate overall has morphed in the current cycle – both in terms of location and construction – for healthcare real estate, the aging Baby-boomers have also been a major driver.

The Millennial generation born between 1981 and 1997, sometimes referred to as Echo-boomers, is comprised of 75.4 million people, just edging out the 74.9 million Baby-boomer population, born between 1946 and 1964.¹ The sheer number of people in and around these age groups are driving demand for healthcare, and in effect, healthcare or medical office real estate. While rising demand for healthcare from an aging Baby-boomer population is relatively obvious, for the Millennial population, the need is not as clear. Millennial demand for healthcare is related to the sheer volume of Millennials combined with the fact that leading-edge Millennials (the oldest of whom are 36) are in their peak child-bearing years. According to the Pew Research Center, 82% of U.S. births in 2015 were to Millennials.²

¹ Pew Research Center, Census. March 2017.

² More than a Million Millennials are Becoming Moms Each Year, Pew Research Center. January 2017.

Furthermore, taking care of physical health is a top priority for Millennials, per data collected from a 2016 survey by the Transamerica Center for Health Studies.³



Source: U.S. Census Bureau. March 2017

The differentiating aspect here is how they are driving the real estate component, including healthcare real estate. While Boomers are driving the quantitative aspect (volume of demand), Millennials are qualitatively changing the landscape through how healthcare is delivered.⁴ Just as Millennials influenced the way traditional office product is located, designed and amenitized, the same ideas of accessibility and optionality are being applied to the healthcare space. Millennials require innovation and have a preference for quick, on-demand care, with services at their fingertips. Accessibility to healthcare and related services is also paramount. This is where the rise of the multi-service healthcare facility comes in. The attraction of such a facility lies in the ease of accessibility to a variety of medical treatments encapsulated in one building.

While the multi-service aspect perhaps arose from the demands of the Millennial generation, it is likewise a huge benefit for Baby-boomers. The ease of care component speaks directly to an aging population who often need treatment for more than one condition at a time. Layer on factors such as the Affordable Care Act (ACA) enacted in 2010 and technological advances, the medical office is evolving to become a greater engine of service.

Although the future of the act is uncertain, the implementation ACA has expanded insurance availability. Between 2010 and 2014, the number of uninsured individuals declined from 16.3% of the population to 10.4%.⁵ The uninsured rate in 2010 was the highest rate on record since 1994, per the U.S. Census Bureau. The ACA has also influenced the way doctors treat and manage patient care. For example, procedures that were traditionally carried out in-patient are being transitioned to outpatient. Part of this is a result of technology innovation and investment, but is also related to lowering costs, both aspects promoted and mandated by the ACA. Outpatient visits per 1,000 of the population have increased 7.5% since 2010, according to the American Hospital Association.⁶ Notwithstanding a potential repeal and replacement of the ACA, the demographic component increasing the demand for healthcare and accessibility to healthcare will endure over the coming years, and continue to influence the investable landscape of medical office.

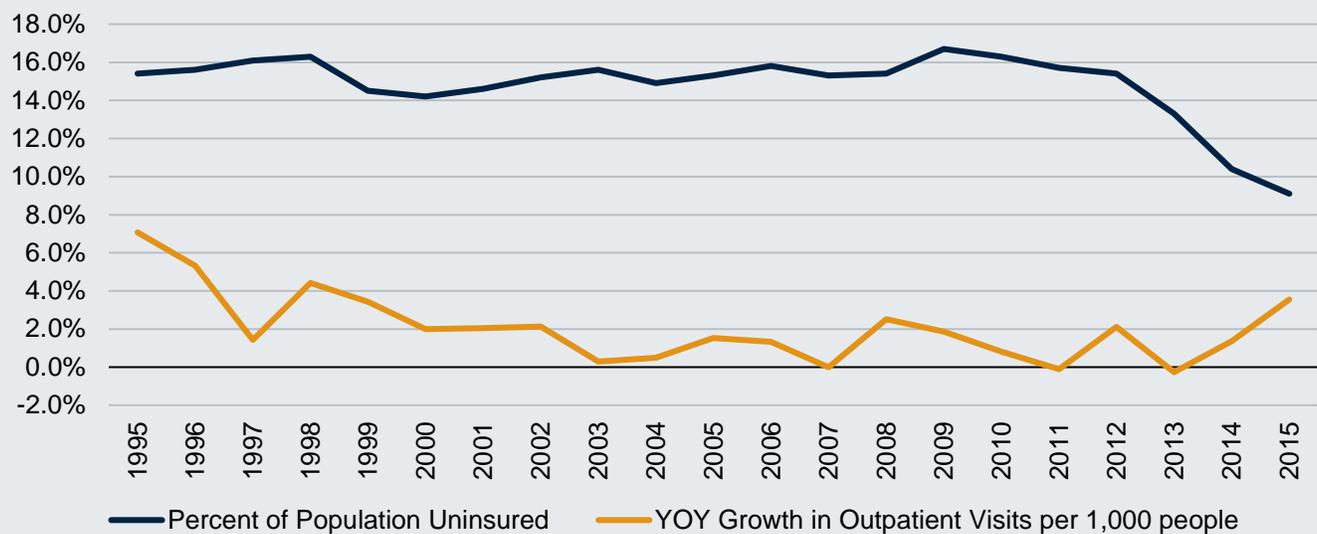
³ Millennial Survey: Young Adults' Healthcare Reality, Transamerica Center for Health Studies. June 2016.

⁴ Medical Office Outlook, Marcus & Millichap. 2017.

⁵ U.S. Census Bureau, Health Insurance Coverage in the United States. September 2016.

⁶ The American Hospital Association Annual Survey & U.S. Census Bureau. September 2016.

Gap in Uninsured and Outpatient Visits Narrows



Source: U.S. Census Bureau, The American Hospital Association & The Kaiser Family Foundation. September 2016.

Medical office growth not geographically bound

Related to the accessibility aspect of today's medical office, there is a stark difference between the strategic locations of a medical office versus a traditional office asset. Whereas the strategic location for a traditional office today is typically in an urbanized area, driven by Millennial preference to live and work in such an environment, location strategy for medical office has a wider geographic scope. Medical office benefits from a high volume of both Millennial and Baby-boomer demand, and the population in between, extending strategic locations to suburban areas. Therefore, both the urban and suburban markets have opportunity to grow their medical office component, and broadening the investable universe for this asset type.

Because of the bifurcation of the traditional office market's recovery and expansion in the current cycle, the suburban markets in particular offer a lower barrier to entry for medical office. The migration of demand from urban to suburban and the resulting retraction in traditional office space within suburban markets has left many suburban campuses and office buildings vacant, opening opportunity for repositioning and redevelopment plays. Office conversion to medical use is a headline theme for suburban markets across the U.S., tied directly to the need for owners to repurpose suburban office investments considered functionally obsolete.

Additionally, broader and more seamless access is critical for patients but also for physician practices as they compete for new patients and business. In many metros, this has meant vacating facilities or buildings located on hospital campuses in favor of locations in closer proximity to a deeper patient base. Proximity to hospitals is still a critical consideration for location decisions, but according to developer LPA, healthcare is shifting more towards consumer demand for outpatient clinics closer to where patients live and work.⁷ Likewise, the trend towards micro-hospitals is gaining steam, where smaller scale hospitals also offering outpatient services help to offset the need to be close to mega-hospitals, trauma centers or teaching hospitals.⁸ These trends are driving non-hospital healthcare enterprises to establish a larger, comprehensive presence off-campus and outside of the urban core to suburban markets. Suburban product in particular is positioned to capture more demand growth from an aging population living in the outer rings of major metros, but also from preference for accessibility and to be treated at a comprehensive, multi-purpose facility.

⁷ How Healthcare is Borrowing from Retail, Hospitality, GlobeSt.com. April 2017.

⁸ 5 Healthcare CRE Trends to Watch in 2017, GlobeSt.com. April 2017.

That said, urban markets are in no way suffering from an outflow of medical office. On the contrary, medical office within urban areas continues to flourish, again related to the ease of care, and the proximity to a massive Millennial demand base, and to major research or teaching hospitals. Within the urban setting, there are typically two variations in medical office, off-campus and on-campus. Off-campus are those buildings that are not directly on or adjacent to a greater hospital campus, but many of these buildings still can service a variety of healthcare needs. On-campus includes those buildings located on a hospital campus or adjacent to the campus. Generally speaking, urban product – on-campus in particular – is poised to benefit from demand growth from a mixed population, including Millennials who prefer the ease of access, as well as an aging population who may require other more sophisticated medical services in the immediate area.

Urban medical office assets face limited competition in an urban setting with higher barriers to entry. Although the suburbs are suffering from a glut of available office space, either through lack of demand or through functional obsolescence, very few urban or Downtown markets are facing the same challenges. Furthermore, because of the nature of how healthcare-related tenants lease space and what their patients require, it is unlikely that the few large available blocks within these areas can successfully meet these needs, either in terms of the asset itself or the location. On the other hand, these stringent requirements also serve to preserve the stability, functionality and relevance of the limited supply of urban medical office buildings.

Not your traditional office lease

For both urban and suburban medical office product, not only does the function of the asset vary considerably from traditional office, but as a result, the structure and way space is leased vary as well. The variations can actually lend to a more stable, long-term investment on the medical office side, and healthcare policy change during the last few years (albeit questionable in the extent to which they will endure) only support the validation of medical office as a defensive strategy.

For a multi-tenant medical office building, the size of a typical medical office lease has expanded to the 4,500 to 9,000 SF range from a range between 2,500 to 3,500 SF prior to the ACA.⁹ This lease size is even greater when looking at the larger healthcare conglomerates or hospital systems offering a comprehensive, multi-purpose facility. These leases can be anywhere between 30,000 to 100,000 SF, according to Colliers.¹⁰ The length of lease term is also typically longer than that of a traditional office lease because of these higher-cost, more sophisticated and larger build-outs, and terms usually range from 7 to 10 years, if not longer.¹¹

With the requirements for more technology investment and more sophisticated equipment in a rising cost environment, tenant build-outs for space are rising and exceed a typical office build out. These costs can only be supported by larger organizations and may leave smaller, private practices at a disadvantage. Since larger healthcare conglomerates are becoming more common, however, the ability to lease out large spaces for healthcare needs is increasing, and will likely continue to increase.¹²

In the context of longer lease terms, larger leases, and more investment in build-out, there is inherently lower risk in lease up of a medical office asset, and in retaining tenancy. The typical medical office investment faces lower tenant turnover and so lease roll is less of a risk than in traditional office underwriting. More healthcare systems are tending to opt for expansions and renewals rather than relocation when their real estate needs change or their term is up, in an effort to keep costs lower.¹³ In fact, if there is lease roll during the hold period being underwritten, it is likely that the lease has been in place for some time, offering opportunity to roll rents up to market. Likewise, healthcare investors generally have longer hold times for medical office. In a 2017 survey by CBRE, 48% of healthcare investors have an average hold time of more than eight years.¹⁴

⁹ Health Systems Driving Leasing Activity, Colliers. September 2015.

¹⁰ Health Systems Driving Leasing Activity, Colliers. September 2015.

¹¹ The Nuances of Leasing Medical Office Space, Colliers. September 2014.

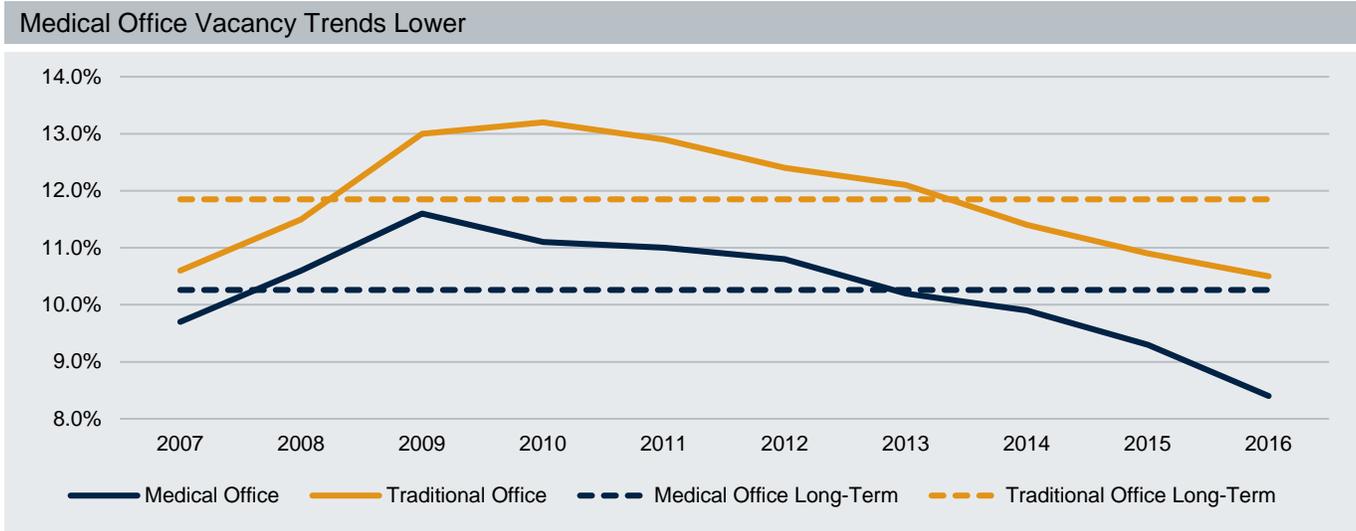
¹² Health Systems Driving Leasing Activity, Colliers. September 2015.

¹³ 5 Healthcare CRE Trends to Watch in 2017, GlobeSt.com. April 2017.

¹⁴ CBRE Healthcare Real Estate Investor & Developer Survey, U.S. Healthcare Capital Markets. April 2017.

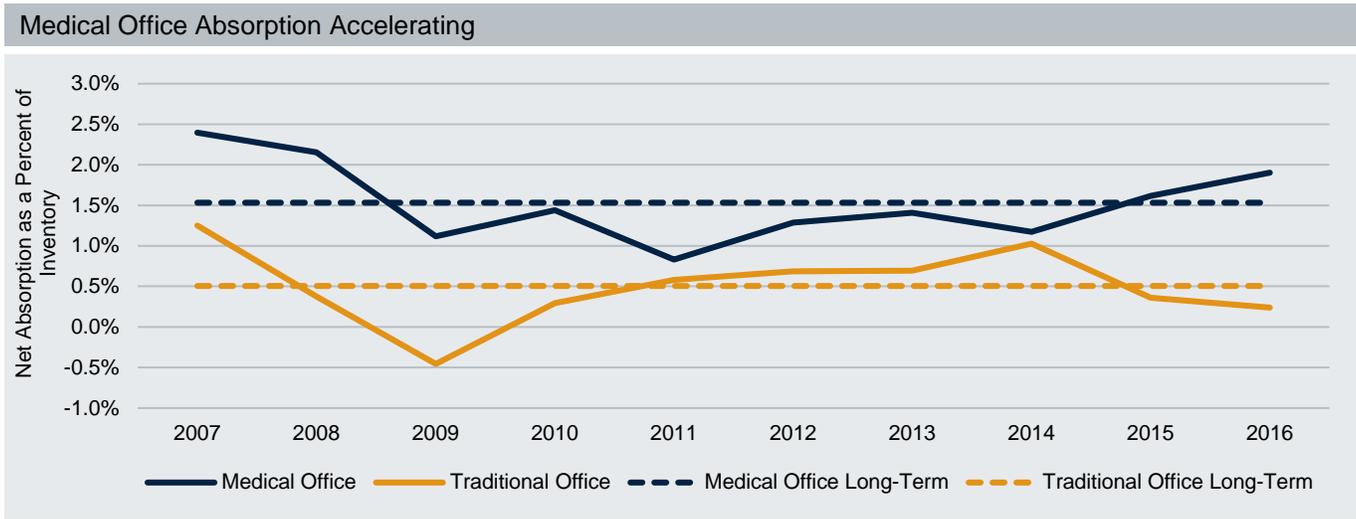
Trending: Medical office by the numbers

Historically speaking, the medical office market has outperformed traditional office market indicators on a national level in terms of both vacancy and absorption as a percent of inventory. According to CoStar Analytics, the long-term average for medical office vacancy trends about 160 basis points (bps) lower than traditional office, again related to lower tenant turnover and longer leases, but also related to lack of supply. Vacancy has steadily moved lower since 2009 both as a function of improving overall office market conditions and the ACA implementation. Since 2009, vacancy for medical office property nationally has retracted 320 bps compared with 250 bps for traditional office.¹⁵



Source: CoStar Analytics. March 2017.

Moreover, net absorption has also trended more positive for medical office properties. While traditional office recorded some negative absorption during the recession, medical office properties continued to absorb demand. The lowest point of absorption during the last 10 years for medical office was 2011, when 0.8% of inventory was absorbed. Still, that figure bests the 0.5% long-term average for traditional office absorption. Medical office inventory also increased 1.9% or by 13.8 million square feet between 2009 and 2011. Since 2015, net absorption for medical office product has accelerated even more, reaching nearly 2% of stock during 2016, in spite of 7.6 million square feet of deliveries (1% of 2015 stock) and vacancy hitting a 10-year low of 8.4% at the end of 2016.

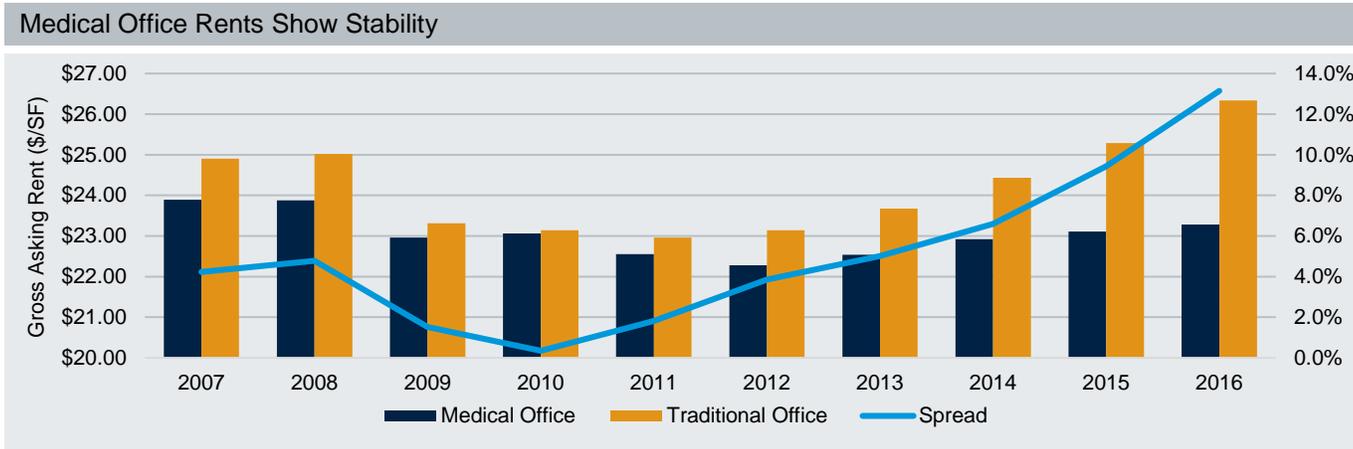


Source: CoStar Analytics. March 2017.

¹⁵ CoStar Analytics. March 2017.

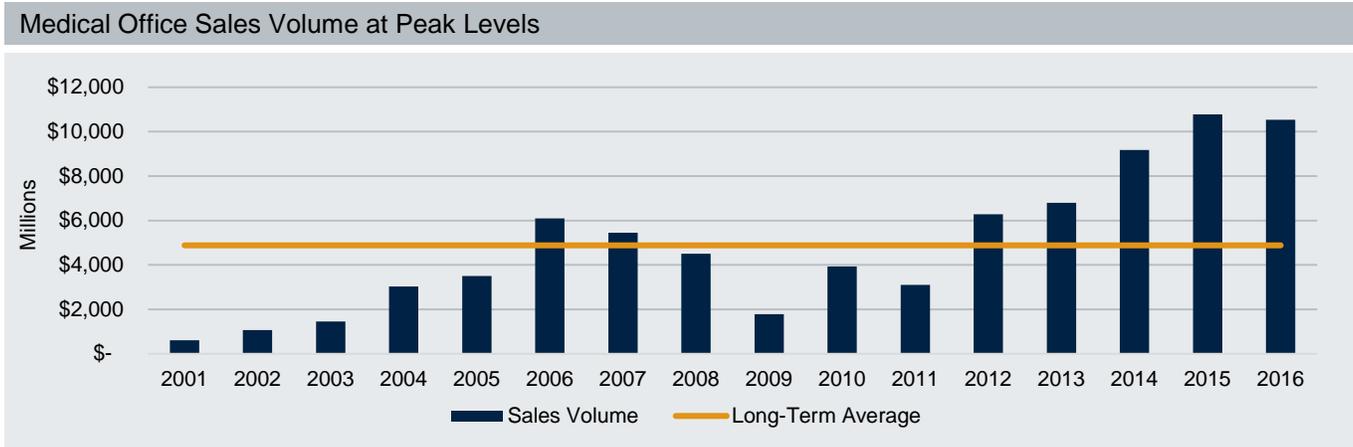
The combination of low vacancy and healthy absorption has allowed medical office lease rates to accelerate more in the last five years, compared with some retraction in rents during the recession. The driving factor holding back rents was a combination of lack of lease roll, an increase in medical office stock, and depressed overall office market conditions weighing on rents during the period between 2007 and 2011. Though medical office was able to transcend these trends in terms of absorption and vacancy rates, landlords had limited leverage to actually increase rents while overall office market asking rents were on the decline as well. This was occurring as traditional suburban office product was disproportionately affected by the pullback in office demand during the recession, and so, many landlords opted to repurpose their traditional office product to include medical use.

Notably, in a recent report, Marcus and Millichap attributes the subdued rent growth during the last five years to changes in healthcare policy putting cost pressures on healthcare providers, and as such, landlords. The report also highlights rent growth for medical office buildings constructed prior to 2000 has outpaced the general medical office market.¹⁶ This could reflect repurposing of traditional office buildings to medical use. Today, the spread between asking rents for medical office and traditional office space is at an all-time high. The average gross asking rent for medical space also remains about 2.5% lower than 2007 to 2008 peak levels. With changes in healthcare policy and limited lease rollover, it is unlikely that rents will spike, but a low vacancy environment paired with strong demand sets the stage for sustained rent growth. According to CBRE’s healthcare investor survey, 55% of respondents expect rents to grow between 2% and 3% in 2017, while 43% forecast 1% to 2% growth.¹⁷



Source: CoStar Analytics. March 2017.

While rents may not accelerate at a pace comparable to what the traditional office market experiences during an expansion, medical office still provides stable cash flows to investors. The high demand, low supply environment and defensive nature of leasing in medical office has buoyed investor interest in the segment, particularly as traditional office pricing has eclipsed previous peak levels.



Source: Real Capital Analytics. March 2017.

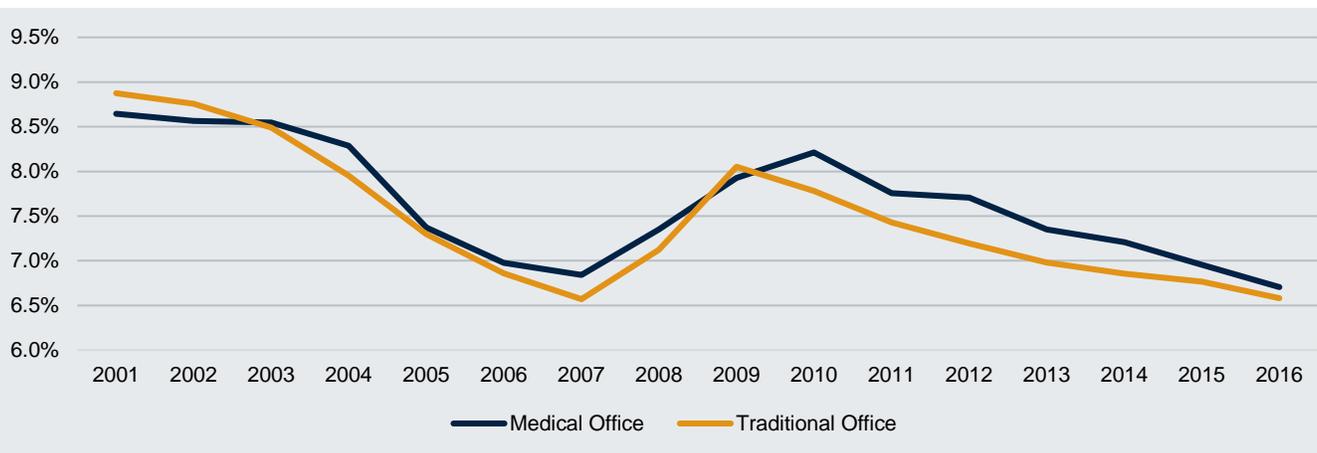
¹⁶ Medical Office Outlook, Marcus & Millichap. 2017.

¹⁷ CBRE Healthcare Real Estate Investor & Developer Survey, U.S. Healthcare Capital Markets. April 2017.

Investment sales metrics underscore the growing interest in adding medical office to portfolios in recent years. The year 2016 showed a slight pullback (-2.3% year-over-year), in part due to a thinning out of for-sale inventory, with \$10.5 billion in transactions. That said, transaction volume for medical office since 2012 has trended above the previous 2006 peak, per data from Real Capital Analytics. The office subtype achieved a new peak in 2015, with \$10.8 billion changing hands – 77% more volume than in 2006.¹⁸ The increase in investment activity is heightening competition in the sector, and slowly driving values. Investor sentiment echoes these trends; 78% of healthcare investors surveyed by CBRE responded they would be net buyers of medical office product in 2017.¹⁹

Yields remain higher than but are narrowing to traditional office. However, the 7.5% long-term average going-in cap rate for traditional office is actually on par with the 7.6% rate for medical office, per Real Capital Analytics. Spreads during the last five years have reached as wide as 50 bps (2012), but since have narrowed to a 12 bp spread: 6.7% for medical office versus 6.6% for traditional office.²⁰ Yields differ among variations in tenancy among medical office assets. According to Marcus and Millichap, on-campus medical office buildings typically come in with a sub-6% cap rate for single-tenant compared with a mid-6% to low 7% rate for multi-tenant assets. Off-campus medical office ranges from a mid-6% rate for buildings occupied with strong, credit tenants to higher rates in the 8% to 9% range for value-add opportunities or assets in secondary or tertiary locations.²¹

Medical Office Cap Rates Narrowing to Traditional Office



Source: Real Capital Analytics. March 2017.

As a result of increased investor interest in medical office and compelling going-in yields, buyer composition has likewise broadened. While private buyers still account for the greatest share of investment, Institutional Buyers and Equity Funds have become more active in the sector. REITs have retained a steady share of acquisitions during the last 10 years, at around 30%. Whereas Institutional and Equity Funds accounted for just 9.8% of acquisitions in 2006, by 2016, this share increased to 16.9%.²² The acceleration in Institutional and Equity Fund activity is tied to the solid performance expected for medical office in the coming years, particularly as the greater traditional office market shows signs of slowing, offering both an alternative to traditional office acquisitions and the chance to diversify portfolios where appropriate.

Past performance is not indicative of future results.

¹⁸ Real Capital Analytics. March 2017.

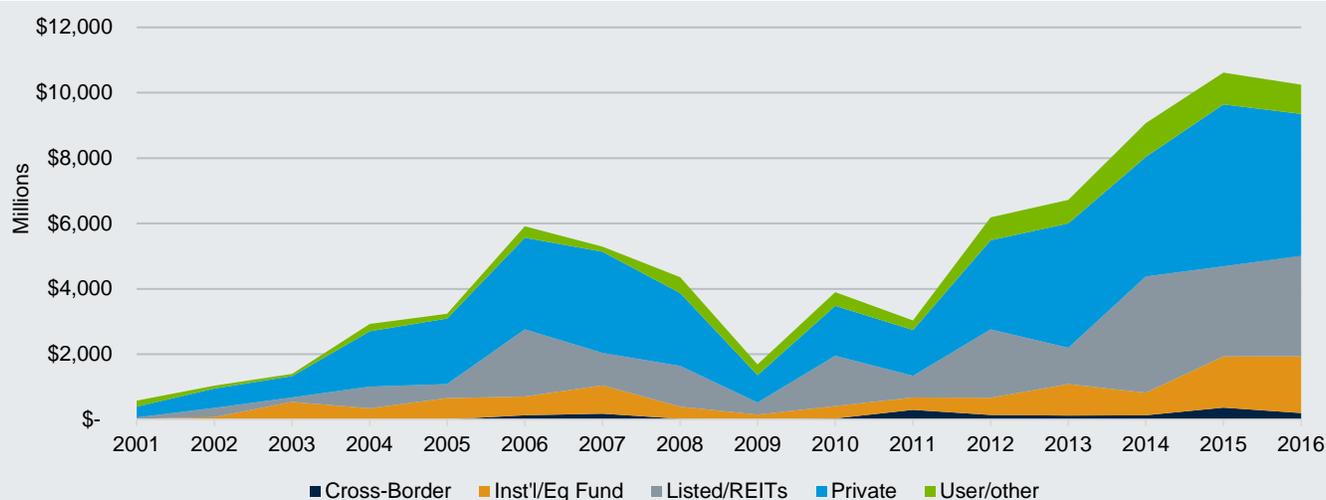
¹⁹ CBRE Healthcare Real Estate Investor & Developer Survey, U.S. Healthcare Capital Markets. April 2017.

²⁰ Real Capital Analytics. March 2017.

²¹ Medical Office Outlook, Marcus & Millichap. 2017.

²² Real Capital Analytics. March 2017.

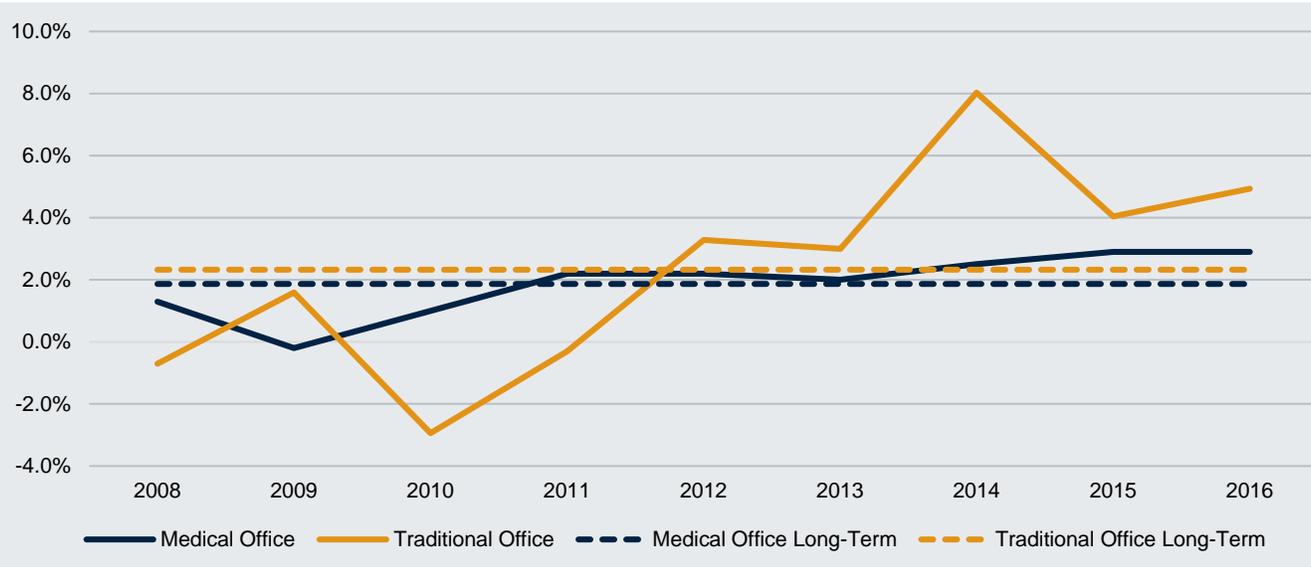
Medical Office Investor Base Expanding



Source: Real Capital Analytics. March 2017.

Steady cash yields for well-leased, well-located medical office are supported by long-term leases and consistent demand. At the same time, NOI growth is not necessarily more favorable than traditional office because of the longer lease terms. According to Revista trailing twelve-month NOI growth for medical office was 2.9% as of fourth quarter 2016, compared with 4.1% growth for traditional CBD office and 5.1% for suburban (4.9% overall), per NCREIF. For those assets with a value-add component, however, there is an opportunity to roll rents to market and capitalize on larger leases, driving NOI growth for these types of acquisitions. Longer-term, NOI growth shows somewhat more stability for medical office. REITs in particular typically take a long-term hold strategy with a focus on larger deals and portfolios, according to JLL, so some of this activity could be absorbed by the Institutional side as well.²³

Medical Office NOI (TTM) Slightly Underperforms



Source: Real Capital Analytics. March 2017.

Past performance is not indicative of future results.

²³ JLL Healthcare Capital Markets. 2015.

Building a case for medical office

Certainly there are both downside and upside risks on the horizon for medical office investment. During the short term, however, these factors are not likely to shift greatly, or cause any immediate change in medical office as it applies to real estate. Even during the medium term, any structural changes in healthcare policy or demographic shifts are unlikely to result in material changes in real estate. In fact, as the traditional office market plateaus, medical office may be the most defensive entry point for office-related exposure as well as moderate diversification. As of 2015, according to JLL, as much as 79% of medical office was still owned by hospital systems and other healthcare providers, in part due to a low financing rate environment as of late.²⁴ As this environment changes, more entry points could arise to acquire some of these properties, particularly as mergers and acquisitions between hospitals and healthcare systems persist, and sale lease-backs offer a way to access capital. Projections by Accenture called for the number of independent physicians to decline to 33% of providers through 2016, compared with 57% in 2000.²⁵ Accessing capital will likely continue to become a more important consideration for healthcare providers and systems to remain competitive, opening the window wider for potential investment in medical office. Among reasons for healthcare provider/owners to monetize assets and reinvest capital include:

- Technology and facility improvement.
- Market-share growth.
- Avoid violations of the Anti-Kickback Statute.²⁶
- New lease accounting rules that change the impact of real estate leases on balance sheets.²⁷

In terms of the future of the ACA, there is still much to play out. The complex law has changed the way insurers and healthcare providers need to operate, and hence real estate. The components of the Act were originally to come into full effect by 2020, having begun in 2010. Now, the potential repeal of the ACA, and unknown impacts loom. Although there will be immediate effects should a repeal occur, it will take years to unwind the changes implemented in the last six years. This includes changes in real estate occupancy by healthcare-related users. Furthermore, some of the real estate trends that have transpired as a result of the ACA will likely remain, particularly the “retailization” of healthcare – although this could shift back to more on-campus hospital-based locations – and the consumer or customer experience aspect. The only more immediate major concern may be a lower number of insured patients which could erode demand, albeit minimally.²⁸

In regards to geography and location of target medical office, considerations looking ahead include the January 2017 implementation of the “Site-Neutral Payment Rule.” This Congress-led ruling could shift off-campus and retail activity back to on-campus sites. This provision calls for Medicare and Medicaid reimbursements for off-campus sites to decrease compared with reimbursement rates for on-campus locations. The change in reimbursements will force off-campus real estate operators and healthcare tenants to evaluate whether they can remain profitable with lower reimbursements. If not, then this could lead to off-campus outpatient facility closures, and more demand for on-campus facilities.²⁹

Lack of transparency in medical office capital markets, particularly related to income, returns and volatility, is a challenge in the investment process. That said, higher cap rates than traditional office mitigate some of this risk and as the asset class becomes more accepted as an institutional quality investment, investors will demand that the sector become more transparent. Medical office investment is likely to continue to become a more mainstream diversification and defensive play in portfolios going forward. Demographic and medical trends, including aging baby boomer and the shift towards outpatient care, coupled with healthcare real estate supplanting traditional office as a suburban market driver, support growing demand for and investment in medical office buildings. Even with medical and technological advances, the need for healthcare is unlikely to dissipate, and arguably could increase with more sophisticated diagnostic and treatment tools. The enduring demand for healthcare underscores the recession-insulated quality of medical office assets. Investments in medical office building tend to offer other downside protection as well, including: lower tenant turnover, steady occupancy rates, and credit tenancy which may lead to more stable or predictable cash flows and less volatility compared to traditional office buildings. The

²⁴ JLL Healthcare Capital Markets. 2015.

²⁵ Accenture, Bureau of Labor Statistics. 2015.

²⁶ Avoiding Pitfalls in Medical Office Transactions, Globe Street. March 2017. Violations of Anti-Kickback Statute could be triggered if multi-tenant leases are below “Fair Market Value.”

²⁷ Six Trends Affecting Healthcare Real Estate in 2017, Becker Hospital Review. February 2017. Providers will have to classify leases as debt on balance sheets in 2 to 3 years.

²⁸ Uncertainty Surrounding Obamacare Repeal Reigns in Healthcare Real Estate, Bisnow. February 2017.

²⁹ 2017 Health Care Marketplace, Colliers. 2017.

outlook for medical office is overwhelmingly positive for investors seeking to capture opportunity and office-like exposure in an otherwise challenging office market environment.

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