Rethinking real estate strategies
Responding to the new catalysts for change

Health care providers are significant owners and users of space. Traditionally, most providers have owned their spaces, particularly properties considered to be mission-critical facilities with high health care provider occupancy. Over the past 10 years, however, many hospitals have taken a different approach to real estate. Increasingly, they have redeployed capital invested in on-campus medical office buildings and acute care facilities by selling and leasing back facilities they own and engaging third-party developers to build, own and lease new facilities. The drivers for these transactions have been threefold: 1) generating capital to redistribute into strategically important businesses, 2) avoiding conflicts of interest inherent in owning real estate leased to physicians and 3) bypassing the management distraction that comes with serving as a landlord.

Now, recent regulatory, accounting and market developments may cause providers to rethink their long-term real estate needs and ownership strategies. Federal regulatory changes in the form of the Patient Protection and Affordable Care Act (PPACA)/Health Care and Education Reconciliation Act passed by Congress in February 2010, new lease accounting rule changes under consideration by the Financial Accounting Standards Board (FASB), and changes in the health care and real estate capital markets are new catalysts for change in health care real estate planning. This Provider Post reviews these developments and discusses how health care organizations can respond strategically.
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Regulatory changes force providers to reconsider real estate strategies

Recently passed health care reform legislation is not only transforming the health care delivery model for providers; it is also creating a need for more capital and imposing new demands on real estate planning.

Reducing operating expenses
Beginning in 2014, health care providers face an estimated $155 billion reduction in Medicare reimbursements over 10 years. In response, to maintain operating margins, they will need to reduce operating expenses, including those related to real estate operations. Facility operating expenses – utilities, maintenance, landscaping, property management, property taxes, rent, and property insurance – are significant expenses for most providers and need to be included in any initiative aimed at reducing operating expenses.

Preparing for the newly insured
PPACA is also expected to extend coverage by 2019 to 34 million previously uninsured Americans, many of whom may be in geographic areas not previously served by a particular provider. The anticipated influx of new patients, along with PPACA’s focus on accountable care organizations (ACOs) and consumers, may cause providers to adopt a more ambulatory, off-campus delivery model for greater efficiencies – including developing or leasing new space on and off campus, or expanding and consolidating existing space.
Accelerating consolidation
PPACA is expected also to accelerate provider consolidation as hospitals seek to diversify risk and revenue, expand access to capital markets, and leverage economies of scale to reduce operating expenses in the face of declining reimbursements. Also, the law prohibits new physician-owned hospitals from receiving Medicare and Medicaid reimbursement after 2010. As a result, physician-owned hospitals are rushing to open before the end of the year. Those that fail to meet this deadline could be potential acquisition targets for providers. This provider consolidation could result in excess or underutilized space that needs to be disposed of or redeveloped.

Accounting changes will move all leases on balance sheet
In August 2010, the FASB released an exposure draft concerning a proposed change to the existing lease accounting rules (known as ASC 840 “Leases”). This initiative is the culmination of a joint project between the FASB and the International Accounting Standards Board to achieve some uniformity between US and international generally accepted accounting standards regarding the treatment of leases.

Eliminating operating leases
Under current accounting rules, many space leases are accounted for as operating leases. In these cases, an expense is recognized each month as rent is paid, and no asset or liability is recorded on the balance sheet. Assets and liabilities will be equal to the present value of future lease payments, including renewal options and contingent rent, and will need to be monitored each reporting period and adjusted as these assumptions change. Rental payments previously classified as rent expense will now be recorded as amortization and interest expense.
Adapting to these requirements will require provider lessees to develop new processes, controls and reporting practices.

Proposing new accounting methods for lessors
Changes to accounting by lessors will also impact providers that lease space to physicians in medical office buildings or clinical facilities. Under the proposed rules:

- A lessor determined to retain significant risks and benefits associated with a property will be required to recognize a lease receivable and an offsetting lease liability in recognition of the lessor’s obligation to the lessee to use the leased property (the Performance Obligation Method).

- A lessor that has determined it does not retain significant risks or benefits associated with ownership must recognize a lease receivable and derecognize the portion of the property leased to the tenant (the Derecognition Method).

Under the Performance Obligation Method, lessors retain the leased property on the balance sheet and continue to depreciate it; under the Derecognition Method, they remove all or a portion of the property from the balance sheet and recognize a gain or loss immediately.

Assessing the implications
The ramifications of these pending changes in lease accounting are profound for many industries, including health care. With no more operating leases and the requirement for lessees to record debt equal to the future rent obligation, sale-leasebacks of entire facilities may not be as appealing. Shorter-term leases may become the preferred path for hospitals, especially for non-mission-critical space, while owning the building outright for strategically important facilities that they intend to use for the long term.

Along with the long-term strategic importance of the facility, providers need to consider the cost of debt capital relative to lease terms as well as the potential effect that additional debt in the form of lease obligations will have on debt covenant ratios and future borrowing capacity. The proposed rule also requires providers that lease space to project contingent rent and renewals, as well as to monitor the asset and liability...
on an ongoing basis for changes in these assumptions that could affect the balances. Adapting to these requirements will require provider lessees to develop new processes, controls and reporting practices.

**Capital market changes force providers to seek alternative sources – health care real estate is a bright spot**

Along with the need for significant capital created by health care reform, providers are faced also with continuing changes in the capital markets that will impact real estate decision-making. As a result of turmoil in the tax-exempt debt markets in recent years, nonprofit providers are realizing the need to diversify their financing sources in order to avoid relying as heavily on this market as they have historically. Also, capital for lower-rated and nonprofit providers has become more expensive, making it harder for them to justify investing in owned real estate. For providers that still own a significant amount of property, real estate as an alternative source of capital is garnering renewed attention.

**Looking at capitalization rates**

Although all sectors of commercial real estate were negatively impacted by the recession and its aftermath, the health care real estate sector fared better than most property types. Chart 1, page 6, shows medical office capitalization rates (the ratio of property net operating income to value) over the past five years. Note that capitalization rates are inversely related to value.

Although medical office building capitalization rates have trended upward since mid-2007 along with those for other property types, for most of the downturn, the degree of increase for medical office was proportionally much less. Chart 2, page 6, shows capitalization rates by property type as a percentage of the minimum capitalization rate over the last five years. According to Real Capital Analytics, the trailing 12-month minimum capitalization rate for medical office buildings was reached in the second quarter 2007 at 6.9%. Over the course of the downturn, medical office capitalization rates increased (and values fell) at a lower proportion than rates and values for other property types. This trend has not escaped the notice of real estate investors and has resulted in increased capital flows into medical office as well as other sectors of health care real estate. Several health-care-focused real estate investment trusts (REITs) raised significant capital for investment in 2009 and 2010, including recently announced equity issues by Medical Properties Trust ($242 million) and Health Care REIT ($366 million). In 2010, public and private health care REITs have been among the most active buyers of medical real estate. Most of this transaction activity has been focused on high-quality, on-campus assets with highly rated health systems.

**Coping with the squeeze**

At the same time, commercial banks have tightened lending standards, the availability of debt through the commercial mortgage-backed securities market remains insignificant, and equity providers have increased their return requirements. Banks are now requiring 60% to 70% pre-leasing of medical office buildings before they will fund loans for new construction, and then only at 65% to 70% of total value. As a result, some smaller private developers of health care real estate have become capital constrained and unable to finance new or planned projects, particularly those in off-campus locations and secondary/tertiary markets. This could potentially limit a source of outside financing for some new projects.

While it is impossible to time the market perfectly, providers considering monetizing or using third-party developers to construct and own medical office or other health care facilities should monitor real estate capital markets conditions in order to make informed transaction decisions.

Chart 2. Capitalization rates as a percentage of minimum, 2Q 2005–2Q 2010
How providers can prepare: four important considerations

These regulatory, accounting and capital market changes warrant a thoughtful and strategic analysis of your overall real estate strategy as opposed to a piecemeal approach that considers individual assets or campuses in isolation. In the wake of PPACA, as the direction of the industry becomes clearer, a solid understanding of your organization's current owned and leased real estate portfolio can help you make decisions that proactively incorporate these changes and are consistent with your overall business strategy.

Following are key steps for consideration in strategically assessing your organization's current and future real estate portfolio:

1. **Include real estate strategy as you revise your long-term business plan as a result of health care reform.** Real estate is a significant capital investment and an ongoing driver of operating expenses, so making decisions that don't align with your organization's long-term business strategy can have significant consequences. Consider the amount of flexibility that you will need in the future to expand or contract your real estate “footprint” in response to changes in your service delivery model, base of employed physicians, and market area.

2. **Gather and update information on your system's current owned and leased portfolio.** Many providers do not track or update this information regularly, which in turn makes developing an informed real estate strategy difficult. Understand what is owned as well as what is leased, and for how long. Evaluate the strategic importance of each facility in light of health care reform and your updated business plan.

3. **Assess the effect that the lease accounting rule changes will have on your balance sheet, operating statement and financial performance indicators.** Understand how these changes will impact real estate decision-making in your organization and what processes and controls will be needed to monitor the lease asset and related liability on an ongoing basis. Consider how these changes will impact your debt covenant ratios and begin discussions with lenders to modify them if necessary.

4. **Analyze existing assets as well as planned development projects, and establish criteria for sourcing outside capital versus internal funding or continuing to own.** If you haven't considered monetizing or using third-party development capital, or haven't considered it recently, you may want to re-evaluate this strategy in light of current capital markets conditions and future capital needs. For some providers, we expect that continuing to own is the best strategy, while for others, selling existing assets or using outside developers for new assets may offer the most potential for return on investment.

**Ernst & Young can help**

Recent regulatory, accounting and market developments present a number of difficult challenges for health care organizations. The real estate advisory and accounting professionals at Ernst & Young are ready to help you rethink real estate needs and ownership strategies.

We welcome the opportunity to discuss your strategies and how we may assist you in proactive real estate planning and development.