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HIGHLIGHTS

BNA INSIGHTS: Hospitals See Medical Office Buildings as Solid Growth Area
Andrew M. Chonoles, Ross Yustein, Jason Polevoy, and **Euchung Ung** of Kleinberg, Kaplan, Wolff & Cohen, P.C. detail the many factors that have driven the strong performance of medical office buildings as a real estate sector in recent years, despite the severe downturn in the rest of the real estate industry. **Page 297**

INDUSTRY SPOTLIGHT: Health Care Real Estate Set to Grow, Evolve, Profit
Laca Wong-Hammond, head of the health care real estate investment banking activities at financial adviser Raymond James, says health care providers hit the pause button on real estate decisions after the 2010 Patient Protection and Affordable Care Act passed, but property-related considerations are poised to move up on the priority list in the near future. **Page 316**

Boston Bombings May Influence Debate of Terrorism Risk Insurance Bill
People, rather than buildings, were the obvious targets of the April 15 bombings in Boston, but the incident may advance pending legislation to renew the federal terrorism risk insurance program, enacted in the aftermath of the Sept. 11, 2001, attacks. **Page 294**

Reid to Move Weakened Bill to Boost Energy Efficient Building Retrofits
Senate Majority Leader Reid says he plans to bring recently introduced legislation to encourage energy efficiency retrofits of commercial buildings to the Senate floor, although he does not specify when. **Page 322**

NAHB Forecasts Housing as Making Major Contribution to GDP Growth
Despite some recent softness in the U.S. economy due to budget cuts, the National Association of Home Builders says the gross domestic product should grow by about 3 percent in 2014, with the housing sector serving as one of the driving factors. **Page 312** . . . Also, economist Elliot Eisenberg says the overall level of distressed home sales is falling, while the ratio of short sales to foreclosures is increasing, and both of those trends point to a stronger housing market. **Page 312** . . . Meanwhile, a survey of real estate industry professionals at an Akerman Senterfitt U.S. Real Estate Summit indicates an upswing in attitudes toward the commercial real estate marketplace, led by high expectations for multi-family housing this year and for hotels and industrial facilities in 2014. **Page 313**

Last Updated in 2002, EPA Seeks Comment on Vapor Intrusion Guidance
The Environmental Protection Agency releases for public comment a draft final version of its long-awaited vapor intrusion guidance to ensure that exposure assessment and mitigation actions are undertaken in a consistent manner. **Page 324**

ONLINE RETAIL

BNA INSIGHTS: **Robert Willens**, president of the tax and consulting firm Robert Willens LLC, writes that the New York Supreme Court has upheld the constitutionality of the state's ''internet tax.'' **Page 308**

NEW YORK: The New York Department of Taxation and Finance releases an opinion that an out-of-state internet retailer that has no business activity in New York state is not subject to the state's corporate income tax. **Page 310**

ELECTRONIC COMMERCE: The Senate moves toward approval of internet sales tax legislation, but a procedural battle with the bill's opponents forces a final vote to be delayed until the week of May 6. **Page 309**

HOUSING

MORTGAGES: In the second of a two-part series of reports on results at the state level of a 2012 a settlement with five national mortgage servicers, Bloomberg BNA correspondents write that many states properly spent funds in a $2.5 billion pool to avoid preventable foreclosures and ameliorate effects of the foreclosure crisis. But some states spent their allocations in ways having nothing to do with mitigating or remediating damage caused by the servicers. **Page 301**

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Industry Spotlight

HEALTH CARE

How is health care real estate going to adapt to the Patient Protection and Affordable Care Act (ACA)? Are real estate investment trusts (REITs) and institutional investors hovering over this fast-growing aspect of commercial real estate (CRE)? Will doctors be seeing patients in shopping malls and converted supermarkets? Laca Wong-Hammond, head of the health care real estate investment banking activities at financial adviser Raymond James and one of Real Estate Forum's 2012 Women of Influence, spoke with BNA's Kevin Lambert about what she sees when she looks at a client's real estate, how third party investment capital is trumping tax-exempt funds, and how quite a few personal care physicians, just to break even, have to see 120 patients a week.

Trillion Dollar Health Care Real Estate Industry Poised to Grow, Evolve, Profit

BNA: Can you give me a picture of the current state of medical office buildings (MOBs)? Are the big players moving more aggressively, gobbling up the smaller ones?

Laca Wong-Hammond

Wong-Hammond: The big players obviously have better access to . . . a very attractive, very low cost of capital. However, the average health care real estate transaction is about $30 million to maybe $100 million in a portfolio situation. For a REIT that has a $25 billion asset value, you need a lot of these to really move the needle. So, do they really sharpen their pencils in a competitive bidding situation for a portfolio that is, say, $50 million? Not always the case. They don't always focus on this as a must-do. They are looking, sometimes, to buy other companies . . . their competitors, to really move the needle and create more shareholder value.

Hungry for Yield. So what has been very exciting for us now is that the pension funds and the insurance companies are very hungry for yield. You know, corporate debt and Treasuries and all of . . . the safer assets, the investment grade corporate bonds and the like, are [producing] very low yields. So then they look to health care real estate as a class of real estate that has become very stable and safe, and so for them, a 6 percent yield is pretty good. We are seeing a lot of that competing with the REITs for deals, and as a result, for clients that need capital for new development projects or existing projects, they are sitting very pretty.

BNA: What keeps you busiest?

Wong-Hammond: It really goes to our service lines, and all of our service lines are actually pretty well balanced. We have five service lines in my division. It starts with the strategic options assessment (SOA) which is a comprehensive analysis of the real estate portfolio for an organization. The purpose of that is to develop a range of strategies for aligning the real estate portfolio with the broader corporate strategic business plan of the organization.

Then it includes evaluation and a recommendation for financial efficiencies and cost savings. This analysis is delivered in report format for, typically, a board of directors or executive management. We are doing a fair amount of that type of service, because with health care reform, there are a lot of changes that need to be understood better. So it is really a customized approach by client.

From there, our other services include acquisitions or a divestiture of assets portfolios or loans. We actually have a significant transaction for a client in the Northeast right now that has really embraced health care reform. They are an accountable care organization (ACO) and we are helping them monetize on their portfolio of existing outpatient facilities as well as some not even built new developments to help them take advantage of today's very attractive capital markets environment. Then [to] allow them to have extra capital to rebuild and refocus on their ACO model. So that's really exciting, and [it] allows us to utilize our monetization services.

Further along, a third process of ours that keeps me busy is the developer selection process. And this . . . process sources competitive bidding from developers and also capital sources for new construction projects. In a different part of the Northeast we are ad-

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vising a large health system on their whole ambulatory strategy, and in doing so they decided to use third party capital instead of using tax-exempt funds. [Tax-exempt funds] are very attractive right now, but the taxable capital, which is what the third parties, such as developers, private equity shops, or even the REITs will provide, gives them, they feel, a lot more flexibility. Actually, it is such a competitive situation now, with debt being as low with interest rates as it is, they really feel like, 'Let's give that a try and we will pay that premium for the flexibility it will afford us.'

BNA: How much of this activity came about due to the Patient Protection and Affordable Care Act (ACA)?

Wong-Hammond: I think as of late the act has not spurred on more health care real estate activity. If anything it has put a bit of a brake on it because—think about it—the organizations that are most affected by it are the care providers, hospitals, physicians, all the other ancillary businesses. And so . . . when the [ACA] came into being in 2010 they took a pause and they said, 'We have to focus corporate-wide about realigning our priorities.'

Real estate did not become top shelf priority at the time. Now it has been a couple of years . . . and the dust has settled. So the reaction to [ACA] has happened and now real estate initiatives have resurfaced into a higher priority.

The Rise of Health Care Real Estate. **BNA:** How strongly is health care real estate growing as an asset class?

The philosophy that our group subscribes to is really such that your real estate . . . should not be the one driving the corporate strategy.

Wong-Hammond: Actually, health care real estate as a transaction class really started taking up higher volume back in 2002 [when] it started becoming a more recognized investment class within CRE. It always used to be core office, hotel, industrial, retail. And now, health care real estate [has] surfaced as typical of a more popular investment class. Actually, the peak of all this transaction activity happened before the credit bubble, coincident with the rise of CRE investment. However, it is not that we heard that any of these investments have gone as dramatically undervalued or misperformed as much as their sister property types.

So the lack of activity since the credit bubble really isn't because the asset class fundamentally has a lot of risk. It is more because the sellers or the owners of these real estate types have been distracted and [have been] re-prioritizing as a result of the health care reform. So now I think in the next year or two we will see the spigot turn on again in terms of focus on real estate transactions, because one of the offshoots of health care reform is a different care delivery model. So that will create an incentive for a lot more new construction, as well as repurposing existing facilities to meet more efficient needs, and cost-saving parameters that will allow the caretakers to benefit from health care reform.

BNA: On the subject of repurposing, I understand that doctors are getting together in places like renovated supermarkets and sharing receptionists. Do you think that's going to be a trend?

Wong-Hammond: Sure. Your question is twofold: what kinds of repurposing are taking place and where is the repurposing happening? So, facility redesign actually has now become more prolific in terms of the need to see more patients at any given time, because reimbursements are being cut in basically all treatment types. I mean . . . the stats are something like, to break even, a [personal care physician] has to see 120 patients a week. So creating less office space and more exam room and patient space, a common waiting area, a common registration area, will create that sort of efficiency. It will allow them to flow a lot better. Some of these models [were] adopted years ago.

For example, we had a client that only has this clinic model, and they had multiple specialties in a building, but every floor just had one common registration area, regardless of [which doctor] you were seeing. It was all centralized, and you had nurse stations instead of nurse offices. There were very few physician offices. The spacious corner offices . . . would be downsized to create more patient rooms. So really, the footprint of the common area is shrinking.

BNA: Could I backpedal to that patient statistic? Is that sort of assembly-line healing sustainable?

Wong-Hammond: The 120 per week statistic is for a break-even bottom line, given the many stresses with lower reimbursements. However, many PCPs are part of a multi-specialty group practice, so the diversity of revenues helps even out the time and revenue pressures. Also, many doctors use nurse practitioners or extenders to assist in a patient treatment, thereby freeing up their efforts and time.

Repurposing Dollar General for Health Care. You wanted to know what kind of facilities are useful to be repurposed into health care facilities. A supermarket is a great example; [others] are closed big box retailers like Circuit City, even Dollar Generals, [and] restaurants. And do you know what they all have in common? The [previous tenants] took pains to make sure that their locations were visible, accessible, and typically they are supported by other retailers that are complementary to their business line.

So it is a huge draw. Retail and medical are great feeders to each other. They are great friends that really support each other's initiatives. Wouldn't it be great if Grandma took Junior to check in while she picked up her dry cleaning and groceries and came back and picked him up after he was done? So that just creates a nice flow and ease of accessibility for the patient.

That is not only the path of health care reform; it is creating smaller vehicles where it is a lot more accessible. And in the supermarket situation [there] is a larger footprint, so the docs probably created some sort of urgent care section . . . which acts like a day surgery center, versus the patients needing to go into the hospital. So definitely a lot of that is happening and that is why we see the flurry of activity picking up in health care real estate.

BNA: Isn't it in fact better for doctors to cluster?

Wong-Hammond: From the patient perspective it absolutely is. How does that translate to what it means for health care real estate? Does it mean bigger facilities?

Sure. You'll see multi-story medical office buildings with multiple specialties. However . . . typically, patients . . . have a core primary care physician that makes referrals and . . . those primary care physicians don't need to be housed in the multi-specialty groups or the larger buildings unless they are affiliated with them.

They might have a great agreement with a hospital for imaging purposes but then they have another affiliation with another set of docs who are for cardiology and the like. For them, where do they house themselves? So we are seeing a lot of these independent primary care groups, for example, be self-contained in a smaller clinic situation . . . somewhere out in the community. That way, [they are] more nimble to refer the best caretaker for whatever ails their patient.

BNA: Are the strategic financial goals of MOB tempered by the fact that their business is saving lives, rather then vending some sort of commodity?

Wong-Hammond: The financial and the mission-driven goals may clash, because for an organization to exist, they have to be in the black and they can't sustain a loss indefinitely. So when you evaluate a medical office building, what is really important is to make sure the asset is not oversized for what the demands are of the community. If something is 100,000 square feet but you only have leased out 50 percent, the hopes that the rest of the 50 percent will be used by care providers in the near future is really not very realistic.

So feasibility studies need to be done, pre-leasing needs to be set up, and lastly the contrasting nature of say, too small of a building. Say you built 20,000 square feet, all of a sudden you are busting at the seams and you are landlocked, or it becomes very expensive to add additional floors. That is also a bad exercise. And so I think it is very important to bring in a[n] adviser like us. What we do is, before you actually engage in a transaction, we pro forma all those implications, including liabilities and potential downsides onto your financials.

There are a lot of robotic surgeries that are happening—telemedicines and all that, so when you go into even your favorite surgery center and you get an MRI and your neighbor tells you, 'I just got this amazing new [MRI with] these 3D scans,' next time you may switch over.

BNA: So society can conceivably save lives through proper real estate evaluation?

Wong-Hammond: Absolutely. A lot of the capital is trapped in real estate, and a lot of the capital that is leaked gets lost through real estate. So real estate is a huge component. When you look at the balance sheet of health systems, for example . . . the PPE, the property plan and equipment component, is a very sizable component of their balance sheet. And when you look at their income statements, a lot of this goes to ongoing capital maintenance that goes with their real estate. So, a great approach to finding capital—we would say senior management needs to look at their real estate and make sure that it is being efficient. We had a client that had an empty building, right next to their hospital, that they were not using, so just sustaining and making sure that it was environmentally sound and the basic upkeep of that had a cost.

But to them, they were so busy making sure they had other initiatives in play, like recruiting more physicians, or going out to other communities, they all but forgot about this abandoned building. So it sometimes really takes a strategic options assessment to have a holistic view of everything that the organization touches in terms of real estate. [To] recalibrate, saying, 'Can we consolidate some practices, can we consolidate some usages, repurpose some of the common space and/or, are we having duplicative properties?' So, real estate . . . when deployed properly, can be a great catalyst to drive the mission and also to service the community.

BNA: Do you participate or at least evaluate the worth of fitting MOBs into new spaces, of selecting the best-fitting MOBS for hospital campuses or shopping malls?

Wong-Hammond: Absolutely. And that is part of our strategic options assessment. The philosophy that our group subscribes to is really such that your real estate . . . should not be the one driving the corporate strategy.

When You're Hot. BNA: Could you tell me in numbers how hot MOB actually is?

Wong-Hammond: Sure. Look, people think health care real estate as an asset class is a very small asset class because of the volume that traded hands over the years—I think at the height it was maybe $5 billion for a 12-month period . . . But when you look at the entire industry of health care real estate, that is, hospitals, medical office buildings, surgery centers, all the way to senior living and care centers—which are a very core and significant corner of health care real estate—in total it's about $1.3 trillion in size. So that's not a small amount. But often when you look at medical office buildings . . . they can be standalone or housed within larger, mixed-use office buildings. So for us and the general public they may say, well, [relatively] medical seems like such a small component. How is it possible that there is so much transaction volume? I mean, you have to look nationally at a lot of the products you don't see in urban environments because they are embedded inside other mixed-use facilities. So, $1.3 trillion is a pretty large and exciting number and there is a lot we can do with what is in existence. There are a lot of new developments coming on tap. I think in a few years time we will see that number grow tremendously.

From Charity Case to Target Demographic. BNA: What would be the most important issue, let us say in the next year, coming up for MOB? This could be economic, legislative, technological, or whatever.

Wong-Hammond: The next big hurdle, I think, is when health care reform begins to insure those that are currently under charity care, or basically the uninsured patient base. There is one school of thought where every additional patient needs additional physician office space. Now these patients [have] become a lot more attractive as a consumer to different providers. What will be more interesting is, 'Do I have that new facility that looks like it is a first-rate medical office building to attract this now newly insured patient?' Or is this patient going to say, 'I used to go there because they never

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billed me back, but now that I have insurance I'm going to go five miles east because actually I see a much more superb and new facility.' Therefore the new facility must have better doctors.

Secondly there is the technology. There are a lot of robotic surgeries that are happening—telemedicines and all that, so when you go into even your favorite surgery center and you get an MRI and your neighbor tells you, 'I just got this amazing new [MRI with] these 3D scans,' next time you may switch over. Technology investment, equipment investment is very, very expensive, but very important as well, as the challenges of changing payments keep putting downward pressure on the top line revenues, while these investments hit the bottom line—a double blow. That is an offshoot of health care reform. But then you have to make these investments because otherwise you are going to lose your consumer base.

BNA: What are hospitals going to look like in the future?

Wong-Hammond: I think one of the near-term predicaments is that the acute care inpatient beds that they have will no longer be as filled as they used to be, or are not utilized that much. And the reason why is health care reform is reimbursing better for shorter lengths of stay. So [with] the shorter length of stay . . . more beds are available to the community. But if their incentive is to shorten this length of stay, the empty beds [stay] vacant, taking up space rather than producing revenue. So what happens is a lot of these hospitals are thinking, 'What do we do with these extra beds. [To] repurpose [them] into other functions like rehabilitation or private rooms? We need half the number of beds, but guess what? Patients like to come here when they have a private room, because as they are healing, they are feeling like it is their own environment.' So, the conversion to downsizing beds to private rooms is one thing.

Another client of ours is converting their inpatient beds to rehabilitation beds and using that as a service to ally with rehab[ilitation] companies and also nursing home providers. When somebody [comes in] with a hip replacement, they can then have rehab in a repurposed patient bed in a rehab center and then move along the spectrum of care to a nursing home facility for a 30-day stay. And if they are better then they can go home. I think the most acute problem to do with acute care products is what to do with their excess beds.

BNA: In light of these possibilities, it looks like ACA will have a definite effect on health care real estate activity after all.

Wong-Hammond: You're right, it's just that the priority of real estate has been shuffled lower. [The] first priority is clinical realignment, then physician recruitment, then capital, and others. Now I believe since much of those initiatives have been put in motion . . . real estate is back in the forefront of near term priorities.

BNA: Do you think your upcoming (May 1) Building Owners & Managers Association (BOMA) medical office building and health care facilities conference will raise awareness and public recognition of health care real estate?

Wong Hammond: Absolutely. Right now there is so much uncertainty on health care reform and so much a focus on innovative means to deliver care, to repurpose real estate and innovations within a corporate strategy. We have a venture capitalist coming in to speak with us . . . He's a venture capital[ist] using the premiums from the insurance from Blue Cross/Blue Shield to invest in new venture matters within the health care space. I think this conference will be a real catalyst to spur on new ideas and activity.