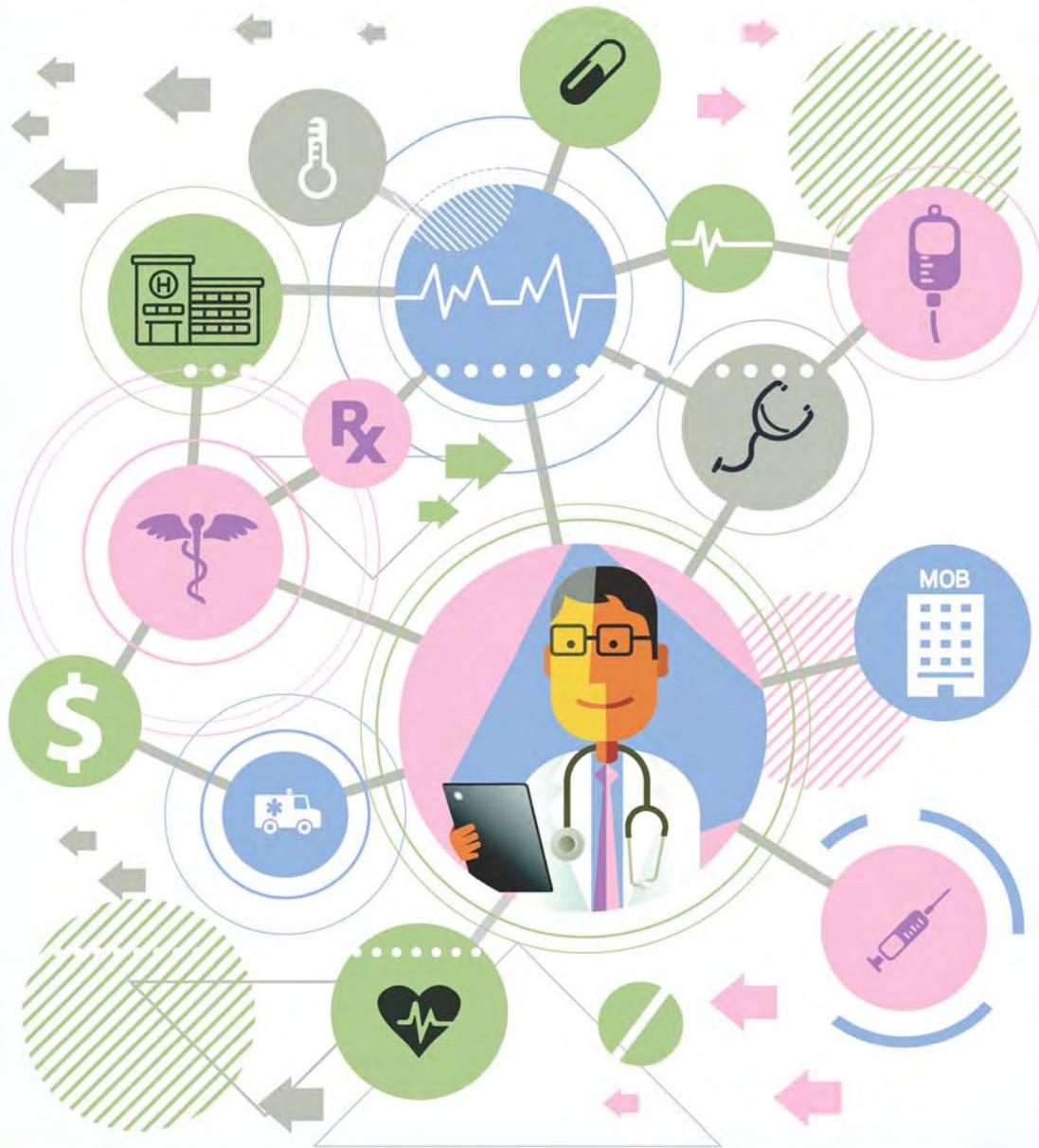


Resource Guide™

News, Insights and a Directory of Services from the Leaders in Healthcare Real Estate



Cover Story: How real estate helps healthcare connect the dots

PLUS: The top trends, the biggest deals, a directory of HRE professional services and more

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The 2016 HREI Resource Guide™ is also available on a dedicated web page

First – and probably most foremost for our display advertisers and the healthcare real estate (HRE) companies listed in the directory section – you should know that this publication, the 2016 HREI™ Resource Guide™, is mailed to our proprietary list of more than 5,000 hospital, health system and physician practice group executives.

But did you know that this complete publication is also available online at **HREIResourceGuide.com**?

There you will find a dedicated web page where you can download a complete PDF of this, the ninth annual HREI™ Resource Guide™ directory. You can also view individual articles, and there is a searchable version of the directory of HRE professional services. (The web page for this special edition of our monthly Healthcare Real Estate **Insights**™ magazine

can also be found at **HREInsights.com**.) There are also links to previous annual editions of the HREI™ Resource Guide™.

It is difficult for us to believe that this is the ninth annual edition of the HREI™ Resource Guide™. But it's true. Since 2008, hospital and healthcare executives have turned to this annual directory for valuable content and when they have needed healthcare real estate services.

From articles to help inform you about the latest HRE news and trends, to the sector's first – and still only – directory of professional services, this publication is designed as a useful tool.

We also hope that it serves as indispensable reference you'll keep at your fingertips – and "bookmarked" among your Internet browser favorites – throughout 2016.

Producing this publication is also a fun and interesting annual project for the HREI™ team. It gives us an opportunity to get to know many of you better as we work on articles and gather advertising and listings information.

Also, as the process continues each year, we are invariably introduced to at least a few organizations that are new to us – and perhaps new to the HRE sector. It's that dynamic nature that helps to keep this business intriguing. And many of those folks have become subscribers, advertisers and friends over the years.

If you have any questions or suggestions, please contact us at **Publisher@HREInsights.com**. And if you want to advertise or to be listed in the directory in 2017, rest assured that we will be reaching out to you about that opportunity later this year. □

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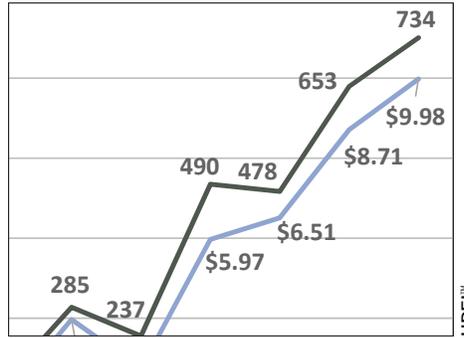
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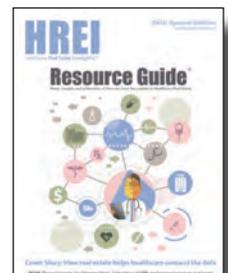
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Connecting caregivers, data and patients has become perhaps the top priority in the healthcare industry. We explore the role real estate. (Illustration by Manik N. Ratan and HREI™)



Age of connectivity

Real estate must help healthcare to connect the dots



Dear Reader:

Did you know that China is the world's largest smartphone market, with more than three times as many users as the United States? Or that India is projected to surpass the U.S. this year to become the second largest market? Or how about the simple fact that the worldwide number of smartphone users is projected to exceed 2 billion this year?

And that's just smartphones. It's clear that the world is more connected – at least digitally – than it's ever been, and it's growing more connected every day.

The rise of the "connection economy" is probably already having a big impact on the way you do business, and it is certain that the impact will only continue to grow. A recent article in *Forbes* magazine described the top 10 business trends that will drive success in 2016. What was No. 1? "Top-performing companies will focus on connecting customers," the article proclaimed, pointing to such fashionable examples as Uber, AirBnB, Facebook, Kickstarter and others that excel at connecting service providers and content with customers. "The connection economy rewards value created by building relationships and creating connections, rather than building assets by industrialism," the article declared. "This means the most valuable companies will connect buyer to seller, or consumer to content."

From a healthcare perspective, the obvious corollary is connecting caregivers and health data to patients. But the healthcare industry also needs a way to connect members of the care team with each other. That's crucial to the success of all of today's favored strategies, including integrated care, collaborative care, continuum of care, population health management (PHM) or whatever the delivery model *du jour* happens to be.

How is the healthcare real estate sector responding? Part of the answer can be found in "Connecting the dots," the article starting on page 11. Recognizing that the disruptive technologies of connectivity will reduce the demand for physical spaces, some healthcare real estate (HRE) developers are already placing greater emphasis on providing advice and capital. And if they develop fewer facilities, innovation and flexibility will be more important than ever.

At the same time, as one of the speakers at the National Investment Center (NIC) conference said last fall, "As both the medical and social aspects of care continue to get more integrated and more connected, (patients are) going to be expecting you to deliver value and probably partner with people that you've never partnered with before."

Where all this is headed is complex and unpredictable. But recognizing that we are in the age of connectivity and responding with creative solutions is a vital step for HRE professionals who expect to remain relevant.

Murray W. Wolf, Publisher

P.S. This HREI™ Resource Guide™ is also available at HREIResourceGuide.com. The website includes all of editorial content, as well as a searchable database of the directory listings. So whether you prefer a printed hard copy or the online version, we hope this ninth annual guide will be a valuable resource for you throughout 2016.

HREI

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BEST HRE DEVELOPMENTS AND LEADERS RECOGNIZED

The winners of the third annual HREI™ Insights Awards™ were announced Dec. 3.



The nine awards honored excellence in healthcare real estate (HRE) development and executive leadership. This time the winners were:

- Best New Medical Office Building (MOB, less than 25,000 square feet): Rendina Healthcare Real Estate, Murrells Inlet ASC, Murrells Inlet, S.C.
 - MOB (25,000-49,999 s.f.): The Keith Corp., Mission Health - Mauzy-Phillips Medical Center at Blue Ridge, Spruce Pine, N.C.
 - MOB (50,000-99,999 s.f.): The Davis Group, Minnetonka Medical Center, Minnetonka, Minn.
 - MOB (100,000 s.f. or more): Ciminelli Real Estate Corp., Conventus, Buffalo, N.Y.
 - Best Renovated or Repurposed Healthcare Facility: Meridian, Rohnert Park Medical Office Building, Rohnert Park, Calif.
 - Hospitals and Other Inpatient Facilities: Parkland Health & Hospital System, Parkland, Dallas
 - Post-Acute & Senior Living Facilities: Caddis, Heartis Amarillo Assisted Living & Memory Care Facility, Amarillo, Texas
 - Healthcare Real Estate Executive of the Year: Erik Tellefson GE Capital (now with Capital One Healthcare)
 - Lifetime Achievement Award: Jim Meadows, Meadows & Ohly
- For complete coverage of the awards, please see "Winners came from coast to coast" in the January 2016 edition of HREI™.

100 NEW ASCs OPENED OR WERE ANNOUNCED IN 2015

Becker's says that the number of ASCs has been flat for years, but that might change.

There were about 5,464 Medicare-certified ambulatory surgery centers (ASCs) in the United States at the end of 2015, according to a recent article in *Becker's ASC Report*. Of that number, about 100 opened or were announced last year.

Becker's says that the number of ASCs has remained relatively flat in recent years, but that might shift. "The industry continues to evolve as political, economic and regulatory issues swiftly change the tide of the industry," the magazine said. The lower costs and high quality of independent ASCs could be a key driver.

Most of last year's new ASCs involved key specialties including orthopedics, spine surgery, gastroenterology, ophthalmology and pain management.

Some sizable recent projects that involve ASCs include:

- a \$56 million ambulatory care center being built on the University of Maryland Midtown Campus in Baltimore;
- a newly completed \$18.6 million expansion of Douglas Medical Center in Bolivar, Mo., by Citizens Memorial Hospital; and
- a recently completed \$15.6 million expansion by St. Vincent's Health System in Birmingham, Ala.

To read the article and see a complete list of the 100 new ASCs, please visit: BeckersASC.com.

ON THE RECORD

What's the outlook for development this year?



"2015 was a great year for construction in general, not necessarily all of it being by third-party capital. But a lot of hospitals have a lot of capital and a lot of projects that they've kept on the sidelines that are finally getting built and are going to be built."
Devereaux "Dev" Gregg, Senior VP, Erdman

Can HRE help with providers' goal of increasing connectivity?



"Absolutely. With the current healthcare model, everybody has to become more efficient... integrated. And to get everybody in the same building, that's a huge step towards that integration."
David Winfrey, Principal, Studio Leader, SmithGroup JJR Health

NEW STRATEGIES ARE EMERGING FROM M&As



Clearview Regional Medical Center in Monroe, Ga., is one of 38 hospitals to be spun off by Community Health Systems.

Photo courtesy of M.J. Harris

Unique structures emerging from consolidation frenzy

The number of U.S. hospital and health system mergers and acquisitions (M&As) has risen steadily since 2009, driven in large part by the effects of the Patient Protection and Affordable Care Act's (PPACA) of 2010.

M&As totaling about \$270 billion were announced last year, according to Bass Berry & Sims PLC. That was a record, but the law firm also says 2015 was also marked by unique transaction structures and continued private equity investment, particularly in certain sectors.

For example, for-profit hospital companies remained particularly active. In August, Community Health Systems Inc. (CHS, NYSE: CYH) announced plans to create two new entities: Quorum Health Corp., a publicly traded hospital company consisting of a group of 38 hospitals located in cities with populations of less than 50,000; and Quorum Health Resources, LLC, a hospital management advisory and consulting firm. Quorum Health Corp. will focus on "the unique challenges and opportunities facing smaller community hospitals" while allowing CHS to focus on larger, urban markets. The spin-off was expected to be completed by the end of the first quarter.

Meanwhile, 2015 also saw healthcare real estate investment trusts (REITs) get into the hospital operating business. In September, Medical Properties Trust, Inc. (MPT, NYSE: MPW) acquired Capella Healthcare in a \$900 million transaction. Under the terms of the deal, MPT purchased Capella's real estate assets and will jointly manage the operations of the 11 hospitals with Capella's senior management.

In a similar deal, Ventas Inc. (NYSE: VTR) acquired Ardent Health Services for \$1.75 billion. Ardent's current management and other investors repurchased the hospital operations and continue to operate the acquired facilities.

2016 should be 'fine'

A good year lies ahead, but have we seen the top of the HRE market?

John B. Mugford



As 2015 was coming to a close, a group of seasoned healthcare real estate (HRE) professionals voiced some trepidation about the year to come. They were concerned that the incredible run for medical office buildings (MOBs) and other healthcare real estate will probably come to an end in 2016 or 2017.

It's not that 2016 will be a bad year, they said. No, far from it. It's just that many of those on hand said they believe that 2015 was likely the peak year of the current record-setting run for MOB sales.

When it comes to HRE, investor demand for MOBs is considered a barometer for the health of the overall sector. If investors are clamoring to buy MOBs, then the sector itself can be considered a relevant and integral part of the healthcare delivery model.

As most everyone involved in HRE is probably aware, the total volume for MOB sales in 2015 broke the all-time yearly record, surpassing the previous record set in 2014 by a substantial 14.5 percent, according to data compiled from commercial real estate research firm Real Capital Analytics (RCA) Inc.. (For more on last year's MOB sales, please see "Almost \$10 billion" on page 12 of this publication.)

And yet, as 2015 was coming to a close and a group of seasoned HRE professionals talked about the year to come, they voiced some trepidation that the incredible run for medical facilities and medical real estate will most likely come to an end in 2016 or 2017.

It's not that 2016 will be a bad year. Far from it, according to the 25 or so members of Editorial Advisory Board of **Healthcare Real Estate Insights™** who gathered in November in Nashville, Tenn., for our annual one-day meeting. It's just that many of the board members said they believe that 2015 was likely the peak year of the current record-setting run for MOB sales. The run has been fueled by a tremendous amount of interest in the product type from a variety of investors, including those who were and are new to the space.

All of this demand, as well as low interest rates, has driven pricing to record highs and, subsequently, capitalization (cap) rates to record lows.

While most of the day's discussions were "off the record," allowing board members to more freely share their thoughts, we asked them to go "on the record" when discussing their predictions for 2016. For the most part, board members said they believe 2016 will be much like 2015 in terms of MOB sales, with a slight drop off in volume, and in terms of development, with a possible uptick.

But Mindy Berman, managing director of the Capital Markets group and leader of the healthcare team at Jones Lang LaSalle (NYSE: JLL), warned that 2016 will be rife with numerous other, perhaps initially unnoticed, changes.

"I think we're going to look back on 2016 as a year of change that we didn't even realize was happening as it was happening, and we're going to say, 'We should have known,'" Ms. Berman said. "This change will be masked by the fact that transactional volume is going to be roughly the same order of magnitude of the record year of 2015. So we'll see roughly the same amount of activity in 2016."

She added, however, that the changes that will be underfoot in 2016 are going to be "large" ones. "In addition to all of the mergers and acquisitions among health systems that are going to continue to take place, the cost pressures on the hospitals are going to increase significantly, alignments between physician groups are going to change, and some health insurers are going to become providers themselves," she said.

As for one of the most important factors and drivers of activity in the sector – interest rates and the cost of capital – several members of the board echoed the sentiments of Daryl Freling, managing partner of Dallas-based MedProperties Holdings LLC.





From left to right: Erik Tellefson, Scott Mason and Mark Toothacre.

HREI™ photos

“I think we’ll see flat interest rates for most of 2016, with cap rates remaining flat or even compressing a bit more than what we saw in 2015,” he said. “And I think even more private money will be buying into the space, causing higher prices. I see even more new, non-traditional healthcare-related investment capital to keep coming into the space as well.”

Due to high demand and rising prices for MOBs, Mr. Freling said that some investors will turn their attention and money to other types of healthcare facilities, such as hospitals and post-acute care facilities. “With those products you can still get some yield as opposed to where the traditional MOB properties are at now.”

As they made their predictions, a number of board members said they believe interest rates will increase in 2016, perhaps not substantially, but slightly. This could mean that some relief is in sight for cap rates, which, in normal environments, rise in tandem with interest rates. But in the current state of high demand in medical facilities from a wide range of investors, including equity investors, that might not necessarily be true. At least not initially, they said.

After several board members echoed that sentiment, Jud Jacobs, senior VP of development with Dallas-based Caddis, said half-jokingly that he was willing to “go out on a limb here and forecast that the yield on 10-year Treasuries, and thus interest rates, is going to be higher at the end of 2016 than it is at the beginning of the year. And I just hope it’s an orderly increase and not a jolt. Cap rates will eventually follow, but there’s a little wiggle room for that increase in cap rates to trail a little bit behind interest rates.”

Mark Toothacre, president of San Diego-based Pacific Medical Buildings, believes that interest rates will remain flat in 2016 because of the “national economy and the global economy and low interest rates around the world. The dollar is too strong and there just isn’t much room for long-term rates to rise.”

MOB sales to remain strong

As 2014 was coming to a close, John Smelter, senior director of HRE for Marcus & Millichap, predicted that 2015 would be an even better year for MOB sales.

“I had no idea that 2015 would end up being as big of a year as it has been, however,” he said. “But for a number of reasons, the dollar volume of MOB sales simply cannot grow at the same pace (in 2016) as in 2015,” Mr. Smelter predicted. “I think we will cut back in 2016 in terms of sales dollar volume and the number of transactions, and I don’t expect a whole heck of a lot of change in respect to interest rates, an increase of less than 50 basis points, which should not have much of an impact on cap rates.”

Mr. Smelter and his researchers at Marcus & Millichap compile their own MOB sales statistics that often do not jibe with those compiled by RCA. At the time of the meeting, he was predicting that about 500 MOBs of 20,000 square feet or larger would trade hands in 2015, an increase of nearly 25 percent over 2014.

“I truly believe that we’ll scale back a bit in 2016 from 2015,” he said. “Things will continue to be very good but they cannot continue at this pace for a number of reasons.” One main reason, he noted, is that should cap rates drop even more, perhaps below 7 percent on an average for all classes of MOBs, “that would not be sustainable. And the next question is, ‘Can we keep repeating that?’ And the answer is: ‘I don’t think so.’”

Several board members noted that while very few hospitals and health systems have sold, or monetized, real estate in recent years, there could be more monetizations in the year ahead.

“While the lease accounting changes for real estate that are coming on line are a deterrent for hospital systems to monetize, there will be some large hospital system monetizations in 2016 as the more forward-thinking, very large systems determine that it’s better to deploy their capital in places where they think it can be better used,” said Phillip J. “PJ” Camp, principal with New York-based Hammond Hanlon Camp (H2C) LLC.

Shane S. Seitz, an investment officer with Chicago-based Ventas Inc. (NYSE: VTR), one of the nation’s largest healthcare real estate investment trusts (REITs), agreed. “There are going to be a lot more hospital monetizations next year,” he said, noting that this could entail hospitals selling MOBs as well as, in the case of some of them, their own hospital facilities and then leasing them back. “There are some things in the pipeline that are going to come out in 2016,” he said.

“I think we’ll see more hospital monetizations than we’ve seen in a number of years.”

Michael Bennett, managing director and a sales professional with HFF Inc. (NYSE: HF), added that “if I were to put a number on it, I would say there’s a possibility of five or six monetizations in 2016.”

Deeni Taylor, executive VP of investments with Milwaukee-based Physicians Realty Trust (NYSE: DOC), a growing publicly traded REIT, disagreed, at least in the near-term.

“I see dispositions by large physician groups and developers being greater in 2016 than in 2015, volume wise,” he said. “But I think there will be very few, if any, monetizations or dispositions at the hospital or health system level in 2016 – they need to feel more financial pain before that happens. And I do think that could be a year or two away.”

Who are the buyers of MOBs?

As for who the buyers of MOBs will be in 2016, Chris Bodnar, co-leader of National Healthcare Capital Markets Group with CBRE Group Inc. (NYSE: CBRE), said he continues to see strong interest from institutional investors that are new to HRE.

They’re “seeking entry points in the healthcare real estate market,” he said. “A lot of these investors are reallocating funds from traditional office to healthcare in effort to hedge against projected market volatility. You don’t see the cyclical highs

and lows with medical office, so it’s becoming a staple in many institutions’ overall capital allocations as we reach market highs.

“We believe this consistent flow of new capital in our space will overshadow the volatility that the REITs are experiencing in the equity markets.”

As a result of that volatility, many of the publicly traded REITs have backed off a bit from acquiring MOBs, as they do not want to get into bidding wars that drive prices even higher at a time when their cost of capital is on the rise.

Mr. Smelter reported that his research indicates that the composition of the buyer pool remained relatively the same in 2015, with 57 percent being private capital and 35 percent being real estate investment trusts (REITs).

Mr. Seitz of Ventas said he will be interested to see how the REITs fare in early 2016. If their stock prices do not recover and they don’t buy much product, cap rates are likely to rise due to a lowered demand for properties.

Jonathan L. “John” Winer, executive VP with White Plains, N.Y.-based Seavest Healthcare Properties, said that the biggest buyer group in 2016 is likely to remain the private equity firms and funds as opposed to the publicly traded REITs.

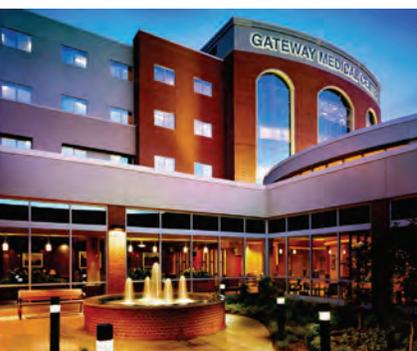
“And I think that the spreads between the ‘A’ quality assets and the ‘B’ assets will widen even more, as the catch phrase is going to be ‘flight to quality,’” he said.



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From left to right: Malcolm Sina, John Smelter, Shane Seitz and Michael Bennett.

HREI™ photos

Jeffrey H. “Jeff” Cooper, executive managing director with Savills Studley in New York, added that he believes another major buying group of MOBs in recent years could fade from prominence. “I think the bloom is off the rose” for the non-traded REITs. I think their ability to raise money is in a bit of a decline, and I think their days are actually in decline.”

Mark Toothacre, president of San Diego-based Pacific Medical Buildings (PMB) LLC, said he believes that the share prices of the publicly traded REITs will rebound during the coming year. “I have to believe that with everyone chasing yield, having a well-protected, conservative 6-ish dividend has got to attract capital,” he said. “I would think that’s going to happen and then the REITs will be buyers again.”

Trouble looming for hospitals, systems?

Scott Mason, a healthcare consultant and former hospital administrator, said he believes that 2016 will see the “very real possibility of a bankruptcy of a major academic medical center, which will really start to deliver the message that you just can’t cut off payments forever and not have consequences.” He added that he believes as many as 100 critical access hospitals (CAHs) – those with 25 beds or less and located in rural areas – will close or be converted to non-hospital, ambulatory facilities. “The federal payments they’re receiving are simply insufficient for them to stay in business.”

As far as Jon Sullivan, VP of real estate operations with Arlington, Texas-based Texas Health Resources, is concerned, health systems will start to feel more financial pressures in 2016. Several other board members were in agreement.

“Reimbursements are falling – there’s a lot of downward pressure in that area,” Mr. Sullivan said. “Systems will be focused on cost-cutting measures and will be looking throughout the entire company for ways to provide the same services for less. Also in 2016 there will still be a tremendous appetite for expansion, and I think we will have a number of new projects that we will be constructing in 2016.”

Because of these financial pressures and other reasons, some

board members said they believe that, eventually, health systems will start to rely more on third-party capital to perhaps develop and own outpatient facilities for them. They predict that more and more health systems in coming years will adapt real estate ownership and occupancy strategies that resemble those of hotel operating companies and other corporations.

Those types of businesses typically lease their facilities instead of owning them. For health systems, leasing space will allow them to focus their attention and capital on endeavors, such as new service lines, that can garner better returns than real estate. Board members have long said that some health systems would be better served by ridding themselves of the headaches of owning real estate.

In light of the ongoing financial pressures facing health systems, Eric Fischer, managing director with Dallas-based Trammell Crow Co., said he believes there will likely be three or so “large hospital system mergers in the range of about \$10 billion apiece.” And while Mr. Fischer foresees strong demand for new HRE developments in 2016, he believes the “ratio of third-party development will remain the same as it has in the past.”

Peter Volas, senior director of real estate for the Cleveland Clinic, said hospital consolidations are going to continue at a rapid pace, as will the acquisition of physician practices by health systems. “Health systems are going to have to continue with their new cost-savings initiatives,” Mr. Volas said. “And this time it will be version 2.0 because a lot of the small stuff already has been run out of the system, and that’s going to lead to a number of dispositions of non-core assets. Sometimes those might be hospital-backed and sometimes not. It’s just a question of getting some of these things off our balance sheet.”

As health systems figure out ways to remain financially viable, more and more of them are likely to “focus on partnerships,” Mr. Volas added, “not only with other specialty groups but also with corporations.”

While a number of health systems will be struggling, several board members said that the larger health insurance companies are likely to make the move to providing their own healthcare services. This trend, according to some on the board, could provide new

opportunities for HRE firms that own, manage and develop healthcare facilities.

“The big insurance companies continue to buy more physician groups and I would not be surprised to see one of them buy a hospital and go the full Kaiser Permanente model in order to control both the expense side and not just the revenue side,” Mr. Seitz of Ventas noted.

“You’re seeing United Health Group and those types of groups looking at leasing full buildings to put their physicians in. That’s going to be a growth sector in our industry and I think they can be considered a more efficient user of real estate. The problem for them is going to be if they can figure out what it takes to work with physicians, which can be difficult, as we all know.”

Malcolm Sina, chairman of Palm Beach Gardens, Fla.-based Sina Companies LLC, noted that in the last year his company completed a real estate deal with insurance provider Humana (NYSE: HUM). “They came into town and partnered with the best primary care group, and we did a delivery execution model for them of 10,000 square feet,” Mr. Sina said. “We’re also about to sign a lease with a national company that’s going to partner with the most-prominent orthopedic surgeons in the market place, and they’ll take a big space in one of our buildings. This is just another indication of consolidation not only within the service sector but a cross-pollination of payers and providers as well.”

New development is overdue

As for development, most of the board members foresee more activity in 2016 and beyond. This is due, they said, to pent up demand from health systems, who in recent years have been reluctant to commit to projects because of the lingering effects of the Great Recession, uncertainty over the Patient Protection and Affordable Care Act (PPACA), falling reimbursement rates, and myriad changes taking place in the delivery of care.

“I think we’re going to see more off-campus outpatient facility development, as there is pent up demand there,” said Richard Rendina, chairman and CEO of Jupiter, Fla.-based Rendina Healthcare Real Estate. “I would like to hope that there will be monetizations of existing outpatient facilities to help fund those new projects.”

As hospitals and health systems continue to acquire physician groups, Mr. Rendina said, he believes more and more of the buildings that they occupy will become single-tenant facilities, leaving the market with fewer multi-tenant MOBs. At the same time, however, he also believes that the stronger, more financially sound physician groups will start to “solidify themselves as independent. I’m talking about orthopedics, neuro, ENT, specialties of that nature, as well as large multi-specialty groups that might be looking to monetize or develop new facilities, and certainly employ more physicians as well.”



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Mr. Toothacre of PMB agreed about pent-up demand. He said he also foresees another reason why new development could be on the upswing in 2016 and beyond. “Obsolescence could also drive development opportunities, as a lot of the existing product was built in the 1960s, 70s and 80s,” he said, noting that the new healthcare delivery model requires newer, more technologically advanced facilities. “I also believe there will be opportunities on the post-acute side.”

Devereaux “Dev” Gregg, senior VP of development with Madison, Wis.-based Erdman, said that 2015 was a great year for HRE “construction in general,” and that 2016 should be as well. “Not all of it is necessarily third-party capital,” he added. “But there are a lot of hospitals that have capital and projects that they’ve kept on the sidelines that they finally want built and are going to build.” Construction pricing, he said, increased by about 3 percent to 4 percent in 2015. He expects a similar, perhaps slightly larger, increase in 2016.

Mr. Bennett of HFF added that he believes that the country’s large surgery center groups, such as Dallas-based United Surgical Partners International (USPI) and Deerfield, Ill.-based Surgical Care Affiliates (SCA), will continue to partner with physician groups, creating a need for space and facilities in certain markets. “That could provide acquisition opportunities or development opportunities for firms and investors in the sector, depending on what side of the aisle you’re on.”

Another change on the horizon – that of site-neutral payments – could provide a boost for HRE firms, according to Keith Konkoli, executive VP in the healthcare arm at Indianapolis-based Duke Realty Corp. (NYSE: DRE). Under such a plan, providers would be reimbursed at the same rate for services provided in a hospital setting or an outpatient setting.

“I think the site-neutral payments issue is going to have an impact on our opportunities in real estate in general,” Mr. Konkoli said. “I believe that development volume will increase next year, as more systems are going to partner with different types of entities so that there will more system joint ventures. Those of us who can get our arms around the credit of those types of entities will probably have some additional opportunities. Growth in outpatient services sector-wide goes without saying.”

Final thoughts on the sector

Thomas W. “Tommy” Tift III, said that his firm, Atlanta-based HealthAmerica Realty Group, had its best year in 2015 since the company was founded 20 years ago.

“But unfortunately I agree with others here that the next year will be down a little bit, but still a good year,” he said. “The name of the game for healthcare providers is going to be cost-cutting and increasing market share. Interest rates are going to go up a little bit, but we have this big thing called the national debt out there and I don’t think the Fed will raise rates too much, as that would

be bad news for everyone. I still think next year is going to be a very good year, not as good as this year but still pretty good.”

Phillip J. “PJ” Camp, principal with New York-based Hammond Hanlon Camp (H2C), agreed with Mr. Mason in saying that a number of rural hospitals will fail in the coming year. “There will be new healthcare real estate development in a few areas, especially post-acute and skilled nursing – we haven’t seen many new SNFs being built in years and there just has to be some more of those,” he said. He also believes that wellness centers will make a comeback, and that retail-like, off-campus clinics are going to take off even more than they have in recent years.

“In 2016 and coming years the sector is going to figure out that some assets make a lot of sense and some don’t,” Mr. Camp noted. “The old fashioned, 40,000 square foot on-campus MOB built in the 1970s isn’t going to work for 80 percent of the health systems out there, and people are going to figure that out and get smarter about healthcare real estate.”

The coming years will see more “revenge of the healthcare consumer,” according to Dan Klein, who at the time of discussion was with Welltower Inc. (NYSE: HCN) and is now an executive VP with Healthcare Trust of America (NYSE: HTA).

“Consumers will be part of the decision about what system and what facility they choose, and what procedure they have done than ever before,” Mr. Klein said. He also believes that “lots of little technological innovations” will impact the delivery of healthcare services.

“I don’t believe 2016 will see a full-on, 100 percent disruptor to replace” the way healthcare is delivered,” he noted, adding that the future could see more disruptions in the model.

As HRE firms look to remain viable in the changing healthcare sector, Mr. Sina said that they need to become full-service firms capable of providing a wide array of development, advisory and other services. “In addition to consolidation on the health system side, there will be consolidation on the development side as well,” he said. “No longer will a firm be able to concentrate on just one part of the business. They will have to be full-service in the product types that they represent.”

Mr. Volas of the Cleveland Clinic added that the focus on easier access to healthcare is going to ramp up, “and that’s going to come in a variety of forms, be it technology or health spots going into retail centers, or walk-in clinics, anything that providers can do to create more market share for the health system.”

“The capital markets world is going to shift,” Ms. Berman of JLL said. “On the lending side there will be changes with the Basel III rules, capital requirements, and interest rates, which should tick upwards. The bottom line is that in 2017 we’ll look back and say, Wow, it’s going to be slow and insidious, but it will be a pivotal year of change. Insurers will look more to third-party capital because they are the ones who think more corporately.” □

Almost \$10 billion

Medical office buildings sales volume set yet another record in 2015

By John B. Mugford

We're running out of superlatives. Reporting the medical office building (MOB) sales totals in recent years has begun to sound like a broken, well, record. That's because each of the past two years has produced record-setting sales totals – by a lot.

And prior to the record-setting years of 2015 and 2014, the two previous years, 2012 and 2013, also saw incredible sales totals that neared the previous record year of 2006.

The two-year run of record-setting sales volume totals, however, is likely to end in 2016, according to the Editorial Advisory Board of *Healthcare Real Estate Insights™*, which comprises some of the healthcare real estate (HRE) sector's best-known professionals. They cite a number of factors that are likely to cause at least a slight decline in total sales volume in 2016 compared to 2015.

Those include historically high pricing, which is causing some traditional MOB investors to take a break from investing, potentially rising interest rates, a lack of product, and others.

“The dollar volume of MOB sales simply cannot grow at the same pace (in 2016) as in 2015,” said John Smelter, senior director of HRE for Marcus & Millichap, during the annual editorial board meeting in late 2015. (For more on the board's predictions for the coming year in HRE, please see “2016 should be ‘fine’” on page 4 of this publication.)

Even so, perhaps 2015 should be celebrated for what it was: a record-setting, incredible year, the likes of which might never be seen again – unless, perhaps, the largest ownership group of MOB's, the country's health systems, start selling their properties en masse as part of sector-wide shift in real estate strategy. (Which some board members say will actually happen at some point in the future.)

The fact is, the MOB sales statistics from 2015 were staggering. According to data compiled from real estate research firm Real Capital Analytics (RCA), the total sales volume for 2015 was \$9.98 billion, a remarkable figure that topped the previous record of \$8.71 billion, set in 2014, by 14.5 percent.

Also quite incredible was MOB pricing in 2015. The average capitalization (cap) rate for the year, or the first-year estimated return on an investment, was an all-time low of 6.8 percent, according to RCA's statistics. (The lower the cap, the higher the pricing.) The previous record low cap rate was in 2007, when the average was 6.9 percent. After the average cap rate hit 8.4 percent in 2010, it has generally been on the decline ever since.

The average price per square foot (PSF) for MOB deals of more than \$5 million in 2015 was \$268, the highest yearly PSF on record and a substantial increase over 2014's PSF of \$230.

Why the strong volume?

So, the question is: What drove sales to such heights in 2015?

According to some of the HRE sector's seasoned veterans, a perfect storm of investor demand from a wide range of investors, including many that are new to the space, the perceived stability of the sector, prolonged low interest rates, and high pricing, have all, in a way, had an effect.

That's because as demand has grown and prices have soared, many owners decided to sell their MOB's.



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“What a lot of people in the sector don’t realize is that 85 percent were private capital,” Mr. Smelter noted of the last year or so.

“Why did that occur? Maybe it was some of the physician groups getting out of their real estate, maybe it was the private investor that finally said, ‘We are at the height of the market, so let’s take advantage of the low interest rates and sell now.’

“This has had a lot to do with why we had so much transaction velocity (in 2015). Typically, private capital accounts for 60 percent to 65 percent of the seller type. They have typically been the top sellers of MOBs, but to get to that 85 percent level is very substantial.” He noted the buyer profile hasn’t changed much, as 57 percent were private capital entities and 35 percent were real estate investment trusts (REITs).

As noted, members of the board predicted that 2015 will likely be the peak year in the current string of strong years, adding that sales are likely to start declining, albeit not by a lot and not very quickly.

Even so, by the fourth quarter (Q4) of 2015 their prognoses looked spot on. That’s because Q4 of 2015 saw the lowest quarterly volume for the year, at \$2.2 billion. While that is a historically strong quarterly figure – only eight quarters since RCA began keeping MOB sales data in 2001 have topped the \$2 billion mark – it still marked a decline in sales from the previous five quarters.

The history of MOB sales

This year, in order to put the record-setting MOB sales of 2015 into perspective and to show how the sector has grown over the last 15 years, we’ve put together a chart showing the historical statistics gathered from RCA.

As noted earlier, the real estate data firm has been compiling data on MOB sales since 2001, which many consider to be about the time medical facilities became their own asset class. For details, please see “A look at the history of MOB sales” on the next page. □

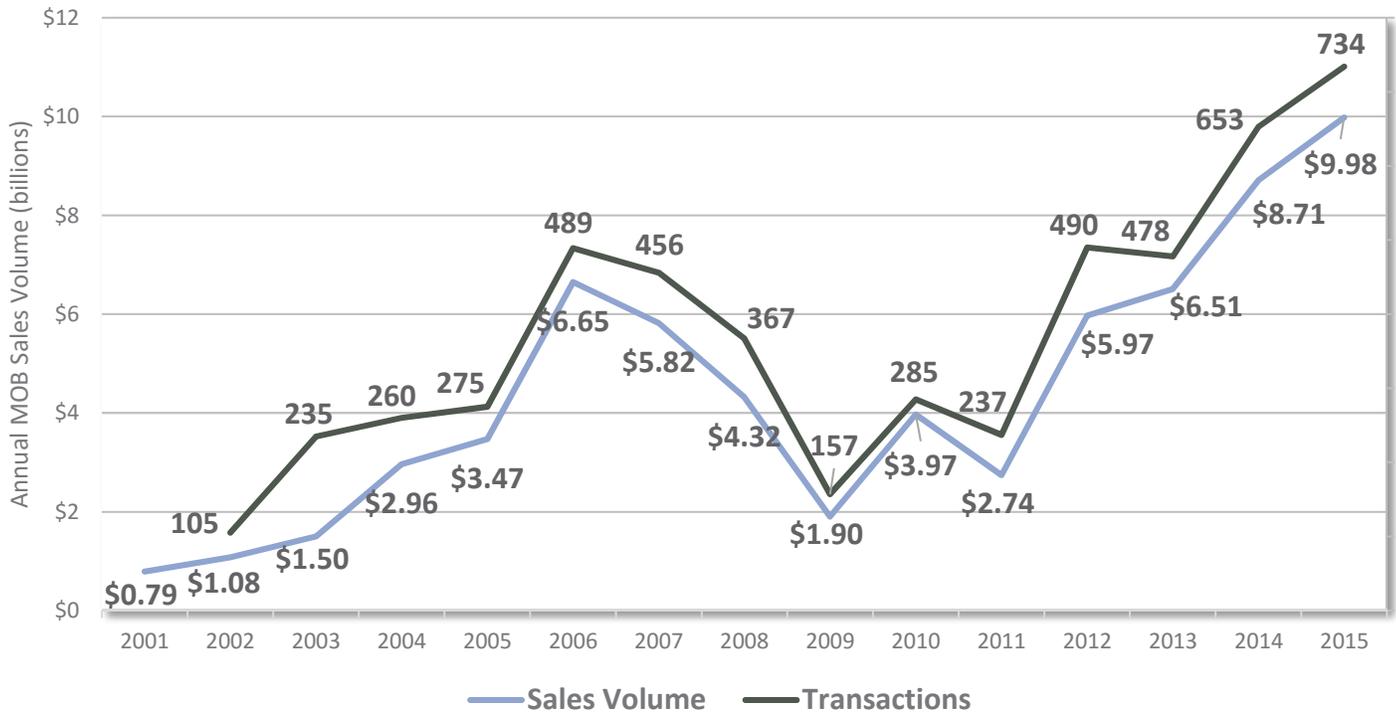
Selected largest 2015 MOB sales

Property Name/ Address/City, State	Closing Date	Price (000s)	Square Feet	Price/ S.F.	Buyer/Seller/Broker
G & L Realty Portfolio 8 buildings San Diego; Beverly Hills, Calif.	Q2	\$449,000	437,875	\$1,025	Buyer: JV of Welltower/CPP Seller: G&L Realty Broker: JLL
Memorial Hermann Portfolio 11 MOBs Greater Houston	Q2	\$225,000	1,200,000	\$187	Buyer: HCP Inc. Seller: Memorial Hermann Health Broker: HFF
833 Chestnut Building 833 Chestnut St. E. Philadelphia	Q2	\$160,900	705,000	\$228	Buyer: HCP Inc. Seller: Digital Realty Trust Broker: HFF
IMS Portfolio 4 buildings Greater Phoenix	Q3	\$141,000	406,894	\$347	Buyer: Physicians Realty Trust Seller: Integrated Medical Services Broker: NGKF
Independence MOB Portfolio 5 buildings N.Y., N.J., Mass., Kentucky	Q1	\$135,000	461,000	\$293	Buyer: G-A H.C. REIT III Seller: Kadima Medical Properties Broker: HealthAmerica Realty Group
HGH Dermatology Building 50 Staniford St. Boston	Q2	\$123,300	193,000	\$639	Buyer: RREEF America Seller: Equity Residential Broker: Cushman & Wakefield
21st Century Oncology Portfolio 20 buildings Fla., Calif., Ky., Nev., W.V.	Q2	\$117,000	220,000	\$531	Buyer: Carter Validus M.C. REIT Seller: Millenium Physician Group Broker: Marcus & Millichap
The Davis Group Portfolio 8 buildings Greater Minneapolis, South Dakota	Q1	\$116,300	362,354	\$321	Buyer: Physicians Realty Trust Seller: The Davis Group Broker: The Davis Group
Hackensack U Medical Plaza 30 Prospect Ave. Hackensack, N.J.	Q3	\$116,000	252,000	\$460	Buyer: Hackensack University Seller: ProMed Properties Brokers: Savills Studley
9033 Wilshire Blvd. 9033 Wilshire Blvd. Beverly Hills, Calif.	Q4	\$75,100	49,617	\$1,513	Buyer: UBS Realty Investors Seller: Archway Holdings Broker: Eastdil Secured

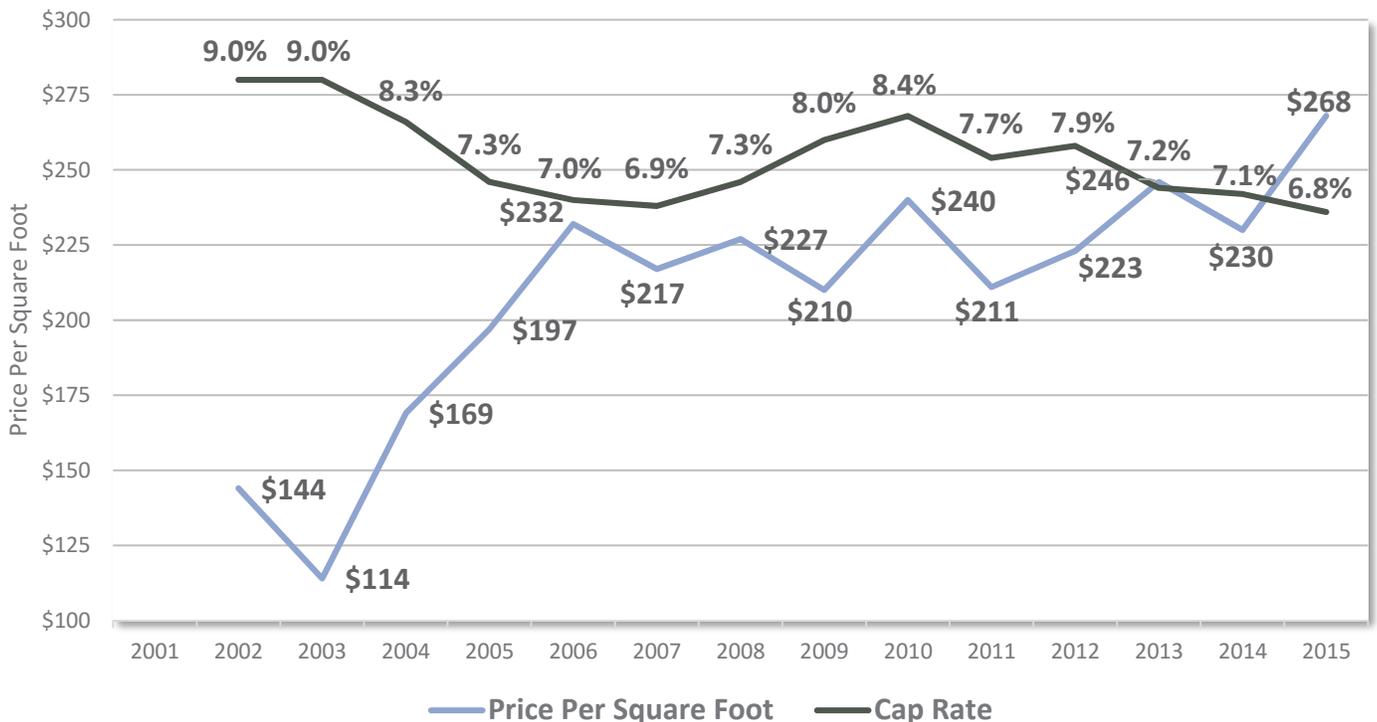
Source: Most data provided by Real Capital Analytics Inc., except some information and additional details obtained by Healthcare Real Estate Insights™. **Disclaimer:** This data is based on independent reports of properties and portfolios \$5 million and greater. The data is believed to be accurate but is not guaranteed. Wolf Marketing & Media LLC, publisher of HREI™, is not responsible for its accuracy.

A look at the history of MOB sales

MOB Sales Volume & Number of Transactions



MOB Prices Per Square Foot & Cap Rates



Source: Real Capital Analytics Inc. (data) and Healthcare Real Estate Insights™ (charts).

Connecting the dots

Business pundits say ‘connectivity’ is the new secret to success. Here’s why real estate still matters even as technology takes center stage.

By John B. Mugford

You’ve probably heard of “the Internet of Things.” That’s the buzzy vision of a world in which everyday household objects have network connectivity, allowing them to send and receive data. Now, whether your coffee maker really needs to “talk” with your toilet is open to debate. But there is no question that our world has never been more connected – and it’s getting more so every day.

So it’s little surprise that “The Connection Economy,” as some are calling it, has become a hot topic in the business world. And perhaps nowhere is connectivity more vital to success than in today’s healthcare business.

In large part driven by the mandates and incentives embodied by the Patient Protection and Affordable Care Act (PPACA), the healthcare industry is rife with buzzwords describing strategies, delivery models and processes that simply can’t exist without connectivity: integrated care, collaborative care, interdisciplinary care teams, continuum of care and population health management (PHM), to name just a few.

So if the healthcare industry is all about connectivity, where does the real estate come in?

A recent article in *Executive Insights* magazine stated that “three connection methods will successfully cover the vast majority of patient and provider interactions,” listing integrated call centers, interactive voice response (IVR) technology and 24/7 web portals.

That’s undoubtedly a sobering statement for many healthcare real estate (HRE) professionals. One can only assume that when the wheel was invented thousands of years ago, some enterprising humans who carried things on their backs for a living probably lost their jobs.

As has always been the case throughout history, myriad new discoveries, inventions and advancements have proven to be disruptive to the status quo, no matter what the era or sector.

However, in addition to the three previously mentioned healthcare connection methods, there will probably remain a significant need for face-to-face patient and provider interaction. And then there’s the matter of connectivity among members of the care team, which also frequently requires the use of physical spaces.

Even so, it is clear that the healthcare industry is being turned on its head by numerous game-changing, sector-altering, PPACA-driven disruptors, led by technology, which is changing the

delivery of healthcare so quickly that it’s spinning the heads of those involved, including those in real estate.

More technology, fewer buildings

“When I go to bed at night I think I know almost everything there is to know about healthcare,” Neil Carolan, a senior VP in the West region for Jupiter, Fla.-based Rendina Healthcare Real Estate, likes to say while moderating panel discussions at HRE conferences. “But when I wake up in the morning I realize I no longer know anything.”

Mr. Carolan waited to utter his familiar catch phrase until near the end of a panel session titled “Decision Drivers and the Future of Healthcare Development” at the RealShare National Healthcare Real Estate Conference in December 2015 in Scottsdale, Ariz.

He did so after the session’s panelists, two prominent health system real estate executives, two healthcare developers and an attorney, talked about the ways technologies are enhancing connectivity and affecting how providers use facilities, as well as how developers might need to adapt.

“You all know this, but telemedicine currently is, and will continue to be, a game-changer in healthcare over the next five to 10 years, especially as the technology is refined,” said Tom Uriona, corporate real estate director for Salt Lake City-based Intermountain Healthcare, which has 22 hospitals, 1,300 employed physicians and 800,000 members with its health insurance provider, SelectHealth.

“For a system like ours, in which we have both rural and urban locations, it will be monumental in how we provide patient care.”

Jeff Land, VP of corporate real estate for San Francisco-based Dignity Health, which has 9,000 physicians and 39 acute-care facilities in California, Arizona and Nevada, expanded on the game-changing role of telemedicine and its effect on real estate.

“Everyone knows we’re building fewer big hospital wings and, for

that matter, big hospitals in general – less bricks and sticks on major campuses – and that’s a trend that’s been going on for a number of years now,” Mr. Land noted. “We’re spending more on joint ventures and lower-acuity facilities.”

But looking further out into the future, Mr. Land said he believes the number of exam rooms needed by providers will be reduced significantly because many doctors and nurses will be housed in call center-like facilities, monitoring their patients’ health and/or diseases using any number of applications (apps) and small devices attached to smart phones, including cloud-based stethoscopes, for example.

“You can do the math, as real estate remains the second largest expense on (a health system’s) sheet and the second largest rock on the balance sheet for the ratings agencies... as well as the liability associated with all of these spaces,” Mr. Land said.

“All of this is likely to change and I believe it will. It’s not just telemedicine but all of the disruptive technologies and the big data applications for pathways; well, you can extrapolate what they mean, what they mean to real estate.”

Still a need for developers

When Mr. Carolan noted that “every developer in this room just started to perspire heavily,” one of the developers on the panel, John Pollock, chief operating officer of San Ramon, Calif.-based Meridian, said that perhaps his firm might want to focus on simply developing “call centers” for providers.

However, Mr. Land quickly dismissed the notion that the development of healthcare facilities will soon be a thing of the past.

“It’s not like the base of facilities is going away, but it will change, and everyone has to get ready for it,” he said. “The likelihood that over the next 10 years that we reduce or shift these clinics more to what amount to medical homes spaces and remote technology centers and the like in healthcare, that’s coming like a freight train.”

Mr. Pollock and Randy McGrane, CEO of Phoenix-based Ensemble Real Estate Solutions, said that while healthcare is indeed changing, there are still plenty of opportunities for companies that think innovatively and adapt to the changing delivery model, which includes the increasing use technology.

“Any developer who wants to remain viable needs to understand the strategy of the health system and come up with innovative solutions for them,” Mr. McGrane noted.

“Your platform needs to be flexible, as sometimes you’re going to add advisory, sometimes you’re going to add efficient fee development, sometimes you’re going to add capital, and sometimes you’re going to tell them to do nothing.

“You need to be able to put aside your own monetary gain, which is the game we play in this business, and come up with solutions for your clients that will resolve their problems and provide them an economic benefit. That’s how you gain their trust and their business, by providing your services in a transparent way that solves their problems and advances their missions.”

Even in the world of medical technological advancements, Messrs. Pollock and McGrane said there will still be a need for facilities that have flexible designs and large spaces, and that are in locations that are easily identifiable and accessible for patients.

Such facilities are still one of the best ways for health systems to expand their brands into new markets and to keep their name in front of patients in existing ones.

Andrew Fogg, an attorney and partner with Cox Castle & Nicholson LLP in Los Angeles, said developers involved in healthcare, which his firm serves, are doing their best to build facilities for providers that can be “easily modified in the future as their needs and strategies change. Their clients want floor plates that are flexible. We’re hearing this much more today than we did five years ago.”

Meridian, Mr. Pollock added, has found success in recent years by “looking at how we can provide flexible space in large enough blocks that give the provider the flexibility they need at prices that can be sustained under the new reimbursement models.”

The company develops plenty of new, ground-up projects, but in recent years has been focusing much of its attention on value-add redevelopment projects.

“During the downturn, we ended up with a lot of product, which was also driven by the uncertainty of the ACA,” he said. “Those were some dark times that we had to fight through.

“But today we’re seeing greater demand from the providers wanting their brand out in the community, and the visibility that comes with the distributed delivery model. This has been fantastic for us. We’ve enjoyed the complexities and challenges presented to us to provide the spaces and the affordable rates for them.”

“We’ve been taking some older buildings, including general office buildings, and repositioning them to meet the demands of the healthcare providers – these facilities are flexible and accessible and very convenient for their patients,” Mr. Pollock said.

As an example, the company recently acquired a building in downtown Oakland, which is an “incredibly robust market right now, and it’s the ugliest building I can imagine,” he said. “But it happens to have enough parking to meet the needs of a health system and because we purchased it at a great price, because it’s vacant and because it’s in a location that’s great for patients, the health systems have practically lined up to occupy this space.”

Flexibility is a must

“If you start with the preconceived notion of what the building looks like, you’re going down the wrong path,” Mr. McGrane said. “We’re working with a hospital system that started out by saying they wanted an MOB, which is a term I don’t think applies anymore, and we said, ‘Hold on, let’s wind it back a bit and figure this out and determine what you need and why you need it.’ Then we said that we would examine every way possible to solve the problem before we build a building.”

In many instances, Mr. McGrane said, a health system that wants one large off-campus building might be better served by having two or three smaller ones in order to better “execute a population health management strategy.”

Mr. Fogg, the attorney, said that even though he is not a developer, believes that there are new opportunities in California because of changes in “our environment laws. This would be urban development, which has been previously constrained by traffic laws, which are changing drastically,” he said. “The laws are changing from how many minutes it takes to get through an intersection to how many miles are traveled per trip.

“As a result, if facilities are put in the right locations, they will generate more trips, but shorter trips. This could really pave the way for new developments in urban core areas.”

Going hand in hand with all of the changes in technology, according to Mr. Land, are drastic changes in the way patients are taking control of making their own healthcare decisions and choosing their own doctors, otherwise known as consumerism. “We are all about changing the experience for the patient, their families, our staff and our visitors,” Mr. Land said.

As a healthcare insurance provider and a health system, Intermountain Healthcare, according to Mr. Urione, is heavily involved in population management. “Because of that, and because of the way we are integrated, our focus is on reaching patients where they are,” he said. “So we’re focused on building facilities in communities that are clinic based and house our employed physicians. And on our campuses we’re focused on affiliated providers in a manner to hopefully meet that need too.”

Intermountain Healthcare, he noted, has a history of owning its own facilities, in large part because it has “been fortunate enough to have the financial strength and capital means to build our own facilities... Could this change? The honest answer is, ‘Ask me next year.’”

As for Dignity Health, the large provider is “on both sides of the fence,” Mr. Land noted. “I would say that we want to develop internally when we will occupy more than 40 percent of a facility. But if we occupy less than 40 percent, we have no need to own it and would welcome developer involvement in those spaces.” □



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Keeping tenants happy

Property management isn't glamorous, but it plays a key role

By John B. Mugford

Here at Healthcare Real Estate Insights™, we haven't written that many stories about property management over the years. Perhaps, this is because property management doesn't make for as interesting headlines, like acquiring and developing medical office buildings (MOBs) does.

However, considering the record-setting prices that investors have been paying for medical office buildings (MOBs) in recent years, we figured now was as good of a time as any to take a look at the subject. As we've found out through talking to a few people involved in managing buildings, good property management can make a big difference when it comes to keeping doctor/tenants, as well as the visitor/patients to a building, happy.

And keeping those two users happy can undoubtedly go a long way towards retaining the value of a building.

"It's an interesting topic, the role that property management plays in the ownership of a medical office building," says Lloyd Mallah, who as VP of asset management for White Plains, N.Y.-based Seavest Healthcare Real Estate often hires and works closely with third-party property management firms that oversee its numerous MOBs nationwide. "The most important aspect of a medical office building is the confidence that the patients have in the facility. We need to have our buildings elevate, certainly not detract from, the business operations of the physicians and the health systems inside them."

Managing any commercial office property, including general offices, can be rife with a host of challenges and, perhaps, problems each and every day. If such problems persist and become severe, they can, of course, lead to testy tenants who might feel compelled to leave the building when their leases expire.

However, according to those involved in healthcare real estate, managing MOBs ups the ante even more, as the reputations of the practitioners and health systems occupying such facilities are intertwined with the building's appearance, both inside and out, with how well the mechanical systems work each and every day, such as the elevators and HVAC systems, and, above all, with the cleanliness of every visible square inch.

"We find that managing a medical office building is the pinnacle property management assignment," says Kelly Manion, senior VP in the healthcare real estate division at Holladay Properties, which provides property management services for about 6.5 million square feet of medical space.

"And that's because if you look at the complexity of managing a Class A medical building in comparison to managing a Class

A commercial office building, you see a lot more foot traffic visiting the physicians in that building than at most commercial buildings. All of that traffic, of course, puts more of a burden on the building, whether it's on the long-term conditions of the carpeting, tile, doors, elevators and restrooms, you name it, there's much more of an impact."

Mr. Mallah says that a property management firm not only needs to have plenty of experience managing medical buildings, but its people – those on site day in and day out – must also have experience working with doctors. "It's important to have the right people there doing the right things," he says. "There's a lot riding on a medical building. If something looks out of place, if something does not look clean, if the elevator breaks down quite often, patients won't want to go there, even if they like their doctor."

Doctors can be demanding

That brings up the topic of working with doctors and hospitals, who are what Mr. Mallah calls "unique" customers.

"It's very difficult for someone who is not used to working with hospitals and doctors to manage a medical building because they just are not used to the level of service they need to provide," he says. "Doctors and health systems have much higher expectations for the building than the typical corporate tenant."

"They are our customers, and if we cannot meet their needs, as stringent as they tend to be, then our buildings will not have the reputation that I want them to have," he adds. "And I always want our buildings to be best in class in their markets, and that is what we at Seavest are investing in. Even if we are investing in a little bit of an older building, we want the service and the image and the view of the patients to consider it a best in class."

When patients complain to their doctors about something wrong with the building or the grounds, from a crack in the sidewalk to the elevator not working to the restrooms being dirty, the doctors complain to the property manager and the owner.

That's why Seavest typically hires firms with experience in managing medical facilities and that understand the relationship between the building owner and the tenants, especially the anchor tenant, which for Seavest is often a health system.

"Property management firms who consider medical buildings to just be real estate don't understand what they need to understand," Mr. Mallah notes.

As noted, keeping a commercial office building looking good and functioning properly is certainly important, but the tenants in such buildings are more apt to move to new location if they can find lower rental rate – even if their building is well managed.

When it comes to medical office tenants and the buildings they occupy, the scenario is usually more complicated. Most medical tenants have a business strategy for being in the building they occupy, be it an on-campus MOB or an off-campus building in a retail-like location.

Medical tenants, including practices owned by a local hospital, are much more reluctant to move, according to property managers and building owners, unless a change in strategy dictates such a relocation. As a result, if the MOBs they occupy are not up to their standards, nor the standards of their patients, they are ready and willing to give their landlord and property manager an earful.

And as everyone in healthcare real estate knows, referrals from within the relatively small healthcare sector can go a long way towards maintaining and growing a business.

Best practices can help retain tenants

“The ‘golden ticket’ of managing an MOB is tenant retention,” adds Mr. Manion of Holladay Properties. “It’s mathematically and fundamentally less expensive to keep current tenants happy and maintain them than it is to have to find and source a new one. In the MOB sector, those tenants aren’t as easy to find as perhaps general office tenants.”

To retain tenants, many MOB property management firms follow a list of best practices for managing MOBs, often passed on to them by the building owner. Large, institutional owners, such as real estate investment trusts (REITs) and others with large portfolios and a long history of owning MOBs, typically have developed their own list of best practices that they want their hired, third-party managers to follow.

These can include accounting and budget practices, building operations and efficiency policies, marketing and branding guidelines, and others. Perhaps most important, however, is the notion that the property management firm must have its people, engineers, janitorial personnel, and others on site as often as possible, as they are the ones who need respond to tenant requests and to keep the building operational and looking good.

Most large institutional owners, however, understand that best practices vary from building to building and market to market.

“It really comes down to doing whatever is necessary to retain your current tenants and, if there is space to be filled, to attract new ones,” says Jason Hinkel, an asset manager with Dallas-based Caddis, a healthcare real estate company

with a portfolio of about 2.5 million square feet of owned and/or managed space. “A good property management firm should have a strong presence in a certain market and really understand that market and the buildings, health systems, and practitioners in it,” he adds.

Mr. Hinkel and others involved in property management note that when a manager truly understands a market, he or she also knows what service companies to hire in order to make repairs or solve problems as quickly and cost-effectively as possible. They also know when tenants are leaving certain buildings and perhaps why they left.

“At the end of the day, the property management firm and its people are the eyes and the ears and the boots on the ground for the owner, and that’s the real key to making sure you are bringing the right solution to the table.”

Mr. Manion notes that owners of large MOB portfolios often have a number of different vendors managing their properties throughout the country. “A big REIT is likely to gather everyone in a room on an annual basis and talk about what’s working and what isn’t working and then extrapolate from that synergy some of the little things that drive that golden ticket of keeping the tenant in place,” he says. □



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2016 Healthcare & Healthcare Real Estate Events

Date	Event	Organization	Location	Website
Jan. 27-29	Annual Meeting	ASHA	Phoenix	SeniorsHousing.org
Feb 16	Hospitals and Medical Facilities Summit	CRDMI/IFMA	Tampa, Fla.	SquareFootage.net
Feb 23-24	Next Generation Healthcare Facilities Summit	IQPC	Los Angeles	IQPC.org
March 2	InterFace Healthcare Real Estate West	InterFace/France	Los Angeles	InterfaceConferenceGroup.com
March 2	Greater New York Healthcare Real Estate Summit	CapRate Events	New York	CRE-Events.com
March 8-12	Annual Conference	AMGA	Orlando	AMGA.org
March 9-11	Spring Investment Forum	NIC	Dallas	NIC.org
March 10	Hospitals and Medical Facilities Summit	CRDMI/IFMA	Phoenix	SquareFootage.net
March 14-17	Congress on Healthcare Leadership	ACHE	Chicago	ACHE.org
March 20-23	Int. Summit & Exhibition on Health Facility Planning, Design & Construction (PDC)	ASHE/AHA	San Diego	ASHE.org
March 22	Northern California Healthcare Real Estate Summit	CapRate Events	San Francisco	CRE-Events.com
April 4-9	Environments for Aging Conference	EFA	Austin	EnvironmentsForAging.com
April 6	Hospitals and Medical Facilities Summit	CRDMI/IFMA	Minneapolis	SquareFootage.net
April 13	Chicago & Midwest Healthcare Real Estate Summit	CapRate Events	Chicago	CRE-Events.com
April 27-30	Annual Meeting	Becker's Hospital Review	Chicago	BeckersHospitalReview.com
April 19-21	Spring Meeting	ULI	Philadelphia	ULI.org
May 3-5	MOB & Healthcare Facilities Conference	BOMA	Orlando	BOMA.org
May 19-21	National Convention and Design Expo	AIA	Philadelphia	AIA.org
June 1	InterFace Healthcare Real Estate Carolinas	InterFace/France	Charlotte, N.C.	InterfaceConferenceGroup.com
June 7-9	REIT Week	NAREIT	New York City	NAREIT.com
June 26-29	ANI: The Healthcare Finance Conference	HFMA	Las Vegas	HFMA.org
July 10-13	Annual Conference and Technical Exhibition	ASHE	Denver	ASHE.org
July 17-19	Annual Leadership Summit	Health Forum/AHA	San Diego	AHA.org
Aug. 9	Hospitals and Medical Facilities Summit	CRDMI/IFMA	Seattle	SquareFootage.net
September	InterFace Healthcare Real Estate Southwest (National Conference)	InterFace/France	Dallas	InterfaceConferenceGroup.com
Sept. 11-14	SHSMD Connections 2016	SHSMD	Chicago	SHSMD.org
Sept. 14-16	Annual Conference	NIC	Washington, D.C.	NIC.org
Sept. 19	Hospitals and Medical Facilities Summit	CRDMI/IFMA	New York City	SquareFootage.net
Sept. 19-21	Healthcare Facilities Symposium and Expo	JD Events	Orlando	HCareFacilities.com
Sept. 25-28	Annual Meeting for Commercial Real Estate	NAIOP	Scottsdale	NAIOP.org
Oct. 4-5	National Executive Forum	Revista	Broomfield, Colo.	RevistaMed.com
Oct. 25-27	Fall Meeting and Urban Land Expo	ULI	Dallas	ULI.org
Oct. 30-Nov. 2	Annual Conference	MGMA	San Francisco	MGMA.com
November	InterFace Healthcare Real Estate Southeast	InterFace/France	Nashville, Tenn.	InterfaceConferenceGroup.com
Nov. 13-15	Healthcare Design Conference	CHD & Vendome Group	Houston	HealthcareDesignMagazine.com
Dec. 7-8	RealShare Healthcare Real Estate 2016	RealShare /ALM	Scottsdale, Ariz.	RealShareConferences.com

Disclaimer: All information verified as of Jan. 15, 2016. Please check with listed organizations for updates.



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Acquisitions



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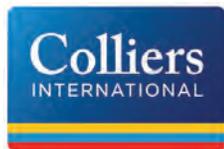
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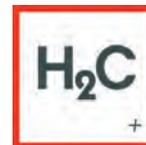
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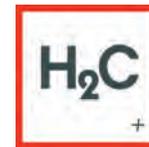
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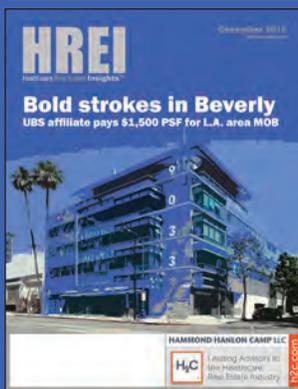


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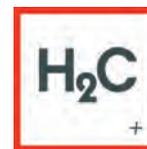
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