HEALTHCARE REAL ESTATE ADVISORS

WHITE PAPER

A NEW GENERATION OF PROVIDERS AND ITS IMPACT ON PHYSICIAN-OWNED REAL ESTATE

"The new generation of providers grew up in a different era, they have different objectives, and operate in a different healthcare environment."

Collin Hart, CEO
ERE Healthcare Real Estate Advisors

LETTER FROM THE CEO

In our work with leading physician groups across the United States, we're often party to the internal discussions surrounding practice succession planning. What started as entrepreneurship and developed into an established and respected environment for delivering care now faces a transition. All entrepreneurs want to see their legacy go on, but in what form?

At the center of this transition is the necessity for balancing the interests of founding partners with those of incoming providers. And while our clients seek to recruit physicians with similar mindsets and ambition, the reality is that the new generation of providers grew up in a different era, they have different objectives, and operate in a different healthcare environment.

Our goal with this white paper is to summarize the numbers and trends we've gleaned working closely with our clients so that you have a clearer understanding of your options in the future.

Thank you for reading and please do not hesitate to contact us with questions, comments, or if you're seeking a solution.

Warm regards,

Collin Hart, MBA
CEO & Managing Director

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By Marc Flynn, Director
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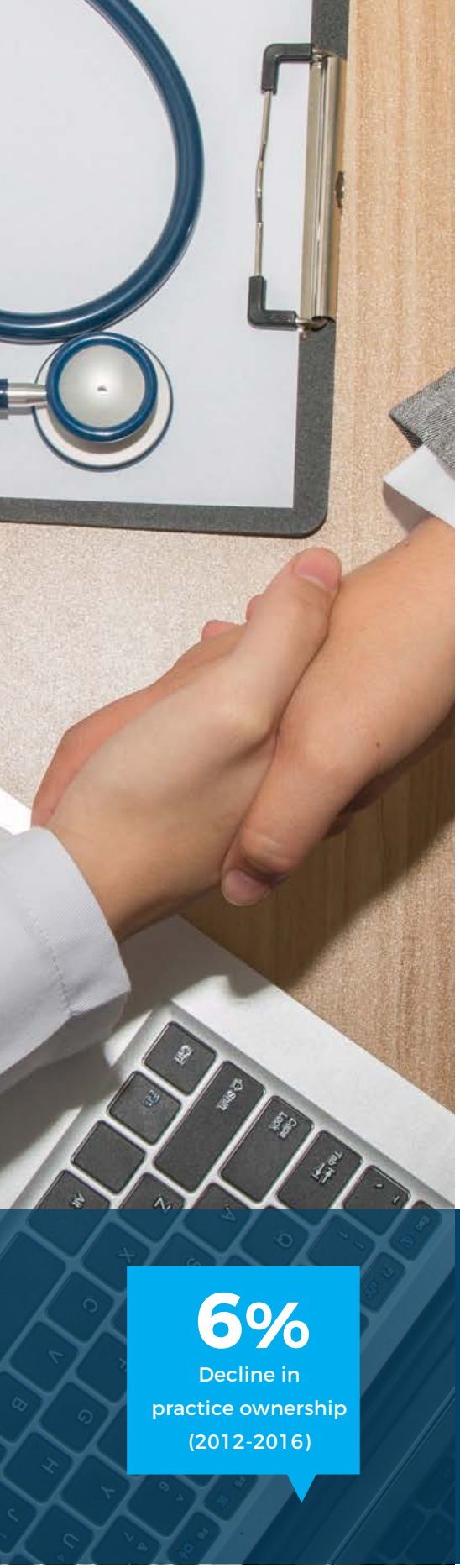


A NEW GENERATION OF PROVIDERS AND ITS IMPACT ON PHYSICIAN-OWNED REAL ESTATE

By Marc Flynn, ERE Healthcare Real Estate Advisors

General Eisenhower once said, "In preparing for battle, I have always found that plans are useless, but planning is indispensable." The same can be said for physicians planning their career. Despite the diligent and often analytical personalities of physicians, America's frequently changing healthcare environment makes it impossible for them to plan a career all the way through. While this appears challenging, the constant changes allow for new and profitable opportunities.

As physicians finish their education, they face the decision of having a career in medicine as an employee, whether it be in a private practice or hospital, or as a partner. Although the path to partnership might seem like the popular choice, the "American Dream" for physicians, the market has been trending in the opposite direction. 2016 was "the first year when less than half (47.1%) of patient care physicians had an ownership stake in their practice. In 2012, the ownership share of physicians had been about 6 percentage points higher at 53.2%" This is also evident in data from Merritt Hawkins, a leading physician recruitment firm, indicating that "over 90% of their search assignments feature employed practice settings while less than 10% feature independent practice." The select few who opt for the entrepreneurial route are typically compensated with a rewarding payoff, but not without the challenges of personal financial risk and a less balanced lifestyle. Given these healthcare innovators already have an independent personality, favoring flexibility in their decision-making, many choose to also own the real estate in which they practice.

Being an owner-occupier has several advantages, including flexibility in the floor plan, an extra stream of income, and insulation from market conditions that affect occupancy costs. If a practice can't grow into the facility, the real estate still has intrinsic value and can be sold for close to cost or leased to another tenant.

While there are many benefits to owning practice real estate, the unique business nature of independent physician practices introduces potential strain. Real estate is already known as an "illiquid asset," so it doesn't help that most (approximately 81%) physician practices have multiple partners, further limiting liquidity. Commonly, ownership shares can't be sold independently of one another, except to an incoming partner or existing partner, creating undue expense and significantly limiting the buyer pool.

Over the last several decades, increased regulation and shifting market dynamics in healthcare have made becoming a practice partner less attractive. At the same time, the traditional model of practice real estate ownership faces hurdles.

6%
Decline in practice ownership (2012-2016)

"The traditional model of practice real estate ownership faces hurdles."

PHYSICIAN TURNOVER & SHORTAGE

Although real estate is likely the most valuable asset in a practice, it's ancillary to the operation, the business itself, and the providers. If a retiring physician can't find someone to buy his real estate at an acceptable price, he can simply keep it, continuing to receive the rental income as a source of passive cashflow. But that income is only viable if the practice and incoming partners are willing to continue paying the same rent. And while all practice partners would like to see their legacy continue, the numbers highlight a challenge.

For small to mid-size practices, especially in the specialty world, physician turnover is a major concern. Not only are physicians aging and retiring at a rapid rate, but the supply of physicians isn't increasing at a proportional rate. The supply of doctors "is likely to remain inhibited due in part to the 1997 cap Congress placed on graduate medical education funding through the Centers for Medicare and Medicaid Services (CMS). Largely because of the cap, residency training positions in the last 20 years have not kept pace with population growth or aging, nor have they kept pace with a 30% increase in medical school enrollment." To exacerbate the issue, healthcare demand is rising rapidly with 10,000 Baby Boomers turning 65 every day. Although seniors over 65 represent only 14% of the population, they account for over 34% of inpatient procedures.

Despite the rise in healthcare demand, a wave of physician retirement is imminent; 43% of physicians are 55 or older. As shown in Figure 1, specialty practices have a significantly higher percentage of physicians over the age of 55 and thus face a higher risk of a near-term physician turnover. While healthcare policy experts and analysts are well aware of the looming issue and constantly working on plans to overcome increasing physician shortages, many focus on efforts that end up benefiting primary care doctors, not specialty practices.

For large regional practices, losing a few physicians isn't a threat; however, 75% of physician groups have between 1-20 physicians. In these smaller practice settings, losing a single physician can have a significant impact on revenue, especially considering that more experienced physicians operate at a higher efficiency and account for a larger share of revenue. After a small to mid-size practice loses a top producer, it increases the pressure on other physicians to stick around, potentially delaying their retirement. Who then, will acquire the retiring physicians' real estate positions?

"Despite the rise in healthcare demand, a wave of physician retirement is imminent; 43% of physicians are 55 or older. "

Figure 1

Percentage of Physicians 55 or Older			
Specialty Physicians		Primary Care Physicians	
Pulmonology	73%	Internal Medicine	40%
Psychiatry	60%	Family Practice	38%
Cardiology (Non-Inv)	54%	Pediatrics	38%
Orthopedic Surgery	52%		
Urology	48%		
Ophthalmology	48%		
General Surgery	48%		
Gastroenterology	45%		
Anesthesiology	44%		

CHALLENGES IN RECRUITMENT FOR PHYSICIAN OWNED PRACTICES

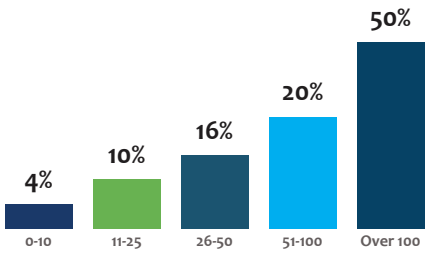
As demand for specialists increases, so does the competition…and cost. According to a survey by Merritt Hawkins, 70% of final-year medical residents reported receiving 50 or more recruitment solicitations during their training. Although physician recruitment is widely perceived as a service for medical groups in rural counties, that's no longer the case. In "the first 22 years of Merritt Hawkins studies, the number of search assignments conducted in communities of 100,000 or more never exceeded 50%." Today, over 62% of recruiting searches are in cities with over 100,000 people; and 73% of searches were for specialist positions; these are record numbers. According to an April 2018 report by the AAMC, there will be a projected shortage of approximately 121,300 physicians by 2030, with 72,000 or 59% of those listed as specialist positions.

If your practice is located in a growing geographic area with appealing weather and proximity to well rated schools; recruitment may not be problematic, but the cost could be a concern. As the demand for providers increases, so does the cost of recruitment, forcing administrators to become more creative in the benefit packages they offer. Figure 3 displays eight commons benefits offered by practices and their average cost. In 2018, 5 of these 8 benefits, including Relocation Allowance, a CME Budget, Health Insurance, Malpractice Coverage, and Disability, were offered by 98-99% of practices, a record high. As the physician shortage grows, we can assume that incentive offerings will continue to rise, increasing the total cost of recruiting.

This trend of offering more incentives could benefit some practices, especially those who own their real estate. Perhaps, offering recruits the opportunity to buy into the facility is a tempting proposition. But if a practice is going to use their real estate as a recruiting tool, they must consider two points:

- At what value would a new partner buy into the real estate and how does that compare with other valuation methods?
- With medical school debt at an all-time high, are young physicians willing to (or can they afford to) buy into real estate?

FIGURE 2
NUMBER OF RECRUITMENT OFFERS/ FINAL YEAR MEDICAL RESIDENTS



CHANGES IN STUDENT LOAN DEBT

Through conversations with physician groups across the US, we consistently hear that the younger generation is not interested in owning practice real estate. Once again, the story lies in the numbers: physicians today begin their medical careers with more student loan debt than any previous generation. Though the percentage of med school students graduating with debt hasn't changed substantially over the last 35 years, the total amount of debt has risen dramatically to a mean of $175,000 per student; nearly 25% of new graduates owe over $200,000. What's more troubling, according to the Association of American Medical Colleges, is when you consider that repayment of a $175,000 principal balance equates to a total repayment (including interest) of $492,000 over 25 years post-residency.

FIGURE 3
PERCENTAGE OF SEARCHES OFFERING INCENTIVES

Benefit Offered	2014	2015	2016	2017	2018	Avg. 2018 Cost
Relocation	90%	84%	95%	95%	98%	$9,441
Signing Bonus	70%	73%	77%	76%	70%	$33,707
Continuing Medical Education	91%	95%	97%	95%	98%	$3,888
Health Insurance	97%	99%	98%	98%	99%	-
Malpractice	99%	99%	99%	98%	99%	-
Retirement/401k	94%	96%	96%	95%	94%	-
Disability	86%	92%	97%	91%	98%	-
Educational Loan Repayment	26%	25%	26%	25%	18%	$82,833
Anesthesiology	44%					

Highlight denotes 5-year high

In a 2011 article on the history of student debt in the journal, *Academic Medicine*, the authors warn that "if tuition and debt continue to increase at rates out of proportion to both the consumer price index and increases in average physician income, approximately 50% of physicians' after-tax income could be consumed by loan payments for average debt burdens approaching seven figures by 2030. The scenario could be even worse if physician incomes hold stable or trend slightly downward."

Increasing debt and a desire for work-life balance are driving the new generation of physicians towards an employed model of practice. Partnership is still an option for those entering as employees - some practices offer a "buy-in" program to tenured providers. This is commonly structured over several years with a portion of the soon-to-be-partner's compensation applied towards partnership shares. This is specifically appealing to potential partners because there isn't a single, sizable, out of pocket investment. Still, this buy-in model is rarely used to acquire real estate shares, which typically favor a single transaction requiring a large investment. This makes the appeal of real estate ownership even less attractive to incoming physicians already saddled with debt. With no traditional exit strategy, what are senior practice real estate owners to do?

CONTINUED REAL ESTATE OWNERSHIP

Changing market dynamics are disrupting traditional practice succession planning tools, including real estate mechanisms. So why shouldn't retiring partners continue to own the real estate? While many physicians enjoy the passive cash-flow associated with their real estate investment, such an arrangement between active and retired partners has the potential to create conflict.

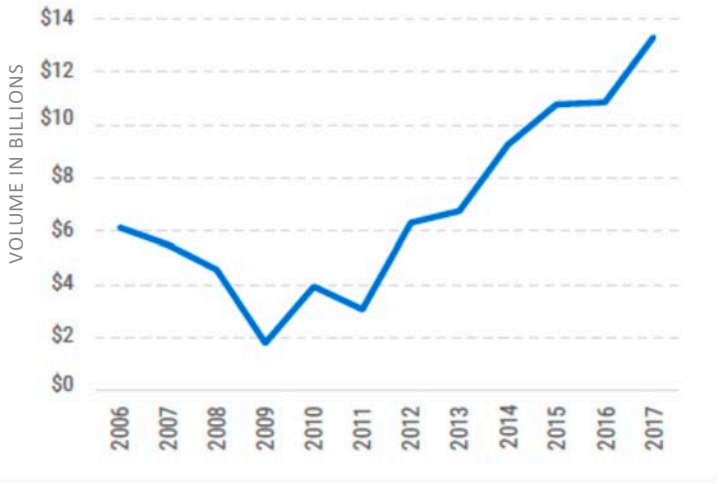
With all practice partners having a stake in the real estate, interests are aligned. The practice's decisions on rent and building expenses equally affect all partners. But when a physician decides to retire and no longer has influence on the practice, the tenant in their building, misalignment occurs. As more physicians retire from a practice, it results in active practice partners paying rent to retired real estate partners. "Why am I paying rent to you and you're not even working?" Active physicians may challenge the rental payments, a retiree's source of income, changing the nature of their original investment.

To avoid tension among partners, the practice could mandate that retiring physicians sell their real estate shares to new or existing partners, a "buy-in, buy-out agreement." However, new partners are hesitant to take out more debt, while existing partners may be thinking about their own exit strategy. Assuming someone is willing to buy the real estate shares, the practice is now faced with determining a value for the real estate. Typically this is done through an appraisal process, but is that the most favorable to the selling shareholder?

AN ALTERNATIVE EXIT STRATEGY

Last year, over $13.3 billion in medical office properties changed hands, well above the volume of $10.8 billion in 2016. At the same time, "pricing for healthcare real estate hit an all-time high with an average price of $295 per square foot, a 16% increase over the previous year. Medical office asset values have grown an average of 7% each year with an overall increase of 55% since the lowest point in 2009."

FIGURE 4
VOLUME OF MEDICAL OFFICE INVESTMENT



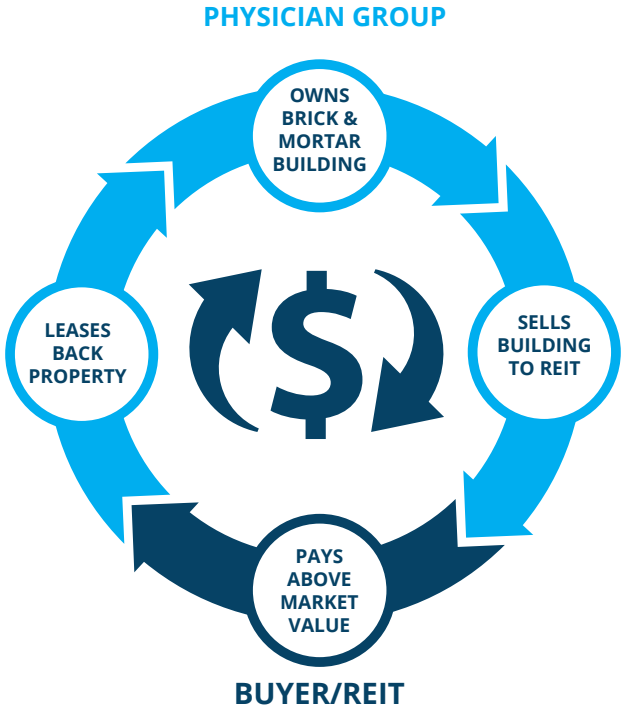
But was this driven by physicians buying each other out of their practice real estate? Not exactly.

For many physician groups, it makes sense to sell their real estate to a third party in a sale and leaseback transaction. A sale and leaseback is a type of real estate transaction in which a partnership sells its real estate and simultaneously signs a long-term lease, allowing the practice to continue operating, uninterrupted. By structuring the asset as a cash-flowing investment, it creates a secure stream of income for passive investors, providing for maximized value to the selling partners. Often these passive investors are institutional real estate groups, private real estate funds, or REITs (real estate investment trusts). A physician group opting into a sale and leaseback during a generational transition often makes sense, facilitating an exit strategy and helping avoid potential partnership and market challenges.

"We consistently hear that the younger generation is not interested in owning the practice real estate. "

Because of the high demand for medical real estate leased to top performing practices, physician groups can usually monetize their real estate without personal guarantees, with a landlord who will finance future expansion projects, and a lease that includes provisions allowing for future assignment. This frees partners of personal liability once they retire, and still allows younger partners to plan for growth. Pricing in these transactions is also favorable, often reaching cap rates in the range of 6.75% - 7.50%, which translates to a 13.3x-14.8x multiple of annual rent. For those physicians who enjoyed the idea of passive cash flow, receiving the equivalent of 13-15 years worth of cash flow in one lump sum may be attractive.

FIGURE 5
SALE AND LEASEBACK MECHANICS



CONCLUSION

Senior physicians seeking a succession plan for their practice and real estate ownership may not be able to rely on the next generation of physicians. Instead, they can look towards institutional investors. For the 43% of physicians over 55, it's an opportune time to devise an exit strategy. Lucky for them, institutional money has created several unique opportunities to cash out.

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