Strategic Considerations for Developing Health Care Real Estate Strategies that Help Health Systems Reduce Costs, Create Value, Increase Efficiencies, and Create a Better Patient Experience

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As the health care industry shifts toward value-based care and population health, market innovators are making the industry more efficient and effective. For example, innovative health systems such as Kaiser Permanente and InterMountain Healthcare are developing dynamic outpatient networks that are designed to keep patients out of the emergency room and reduce readmissions. Additionally, mega-mergers such as Cigna / Express Scripts ($67b) and CVS / Aetna ($69b), alongside a trillion-dollar health care private equity market, will continue to disrupt the traditional health care delivery model. Health systems must recognize these changing market dynamics and create new strategies to stay ahead of this wave of competition and innovation.

Most changes within a health care delivery system involve some facet of real estate. If a health system desires to expand within a marketplace, or create more convenient patient access points, real estate will be required. However, viewing real estate as simply a place to put more patients and doctors vastly undervalues its importance and forecloses the strategic advantages that real estate can provide to health systems. An effective real estate strategy also can help eliminate costs and create value at a time of increased financial pressures that result from the numerous and constant changes that occur in the industry. Health systems that understand how to maximize the benefit of their real estate holdings will be well positioned to compete against the innovators and disruptors within the health care marketplace.

While it might seem natural to utilize real estate strategically given the size and profitability of the real estate industry generally, the health care industry has often overlooked the impact of real estate for a few different reasons. First, real estate strategy and execution is often domiciled across multiple leadership silos – typically by some combination of market, service line, and real estate function (planning, construction, engineering, leasing, property management, etc.). When leadership and decision making is spread across an organization's multiple departments and territories, it can be difficult to gain consensus and make decisions that support the entire organization's best interest. Second, many systems do not know how to critically evaluate or utilize their real estate, and they lack commercial real estate and operational expertise. Without leadership in place that can analyze and implement innovative real estate strategies, many health systems have simply avoided innovation altogether. There is a certain level of comfort and a sense of security that comes from applying a real estate strategy that has always been used in the past, but there is also substantial risk in not taking the time to analyze whether that real estate strategy is the best one to use for the present and the future. If this is the case, health systems could be leaving valuable dollars on the table and can be exposed to competitive threats without even knowing it. Real estate should be working for, not against, the health system's goals and core mission.

It is imperative that health systems have a systematic approach to evaluate the best way to activate clinical initiatives and effectively utilize real estate strategy. Both economic and non-economic factors should be considered in crafting a real estate strategy. In a constantly changing industry, health systems that are unable or unwilling to innovate face the risk of being left behind. With the right advisor, real estate can be used to further advance a hospital's mission. This article will identify strategic considerations for different types of real estate strategies that

health systems can employ to help them and their advisors make informed real estate decisions and choose real estate strategies that will advance their missions and overall organizational goals.

Why Does Real Estate Strategy Matter?

When a real estate strategy works to further a health system's core organizational and clinical missions, the strategy can reduce costs, create value, increase efficiencies, and, most importantly, create a better patient experience. But first, anyone tasked with creating a real estate strategy should seek to understand what the organization's mission is—and how they want to achieve this mission—by asking questions similar to those provided below:

- Does our real estate support our broader strategic plans?
- Do we have the right services in the right locations?
- Where do we need to think more offensively?
- Where do we need to think more defensively?
- Can we use real estate to free up capital to reinvest in our organization?
- Are we paying too much rent?
- How can our operating expenses be reduced?[1]

By evaluating the opportunities for savings, value addition, and increased efficiencies, a health system can start making its real estate work to advance its core missions.

Most health systems have accumulated considerable real estate assets, and in many instances have been acquiring these assets for extended periods of time. Real estate provides the physical location through which health systems can offer their services (although this is not always the case anymore as health care technology continues to evolve), but why is it important to acquire real estate with a more concrete strategy in place? For starters, real estate can be up to 30% of a health system's assets on the balance sheet, and hospitals own approximately 75% of the nation's medical office buildings.[2] These are considerable assets that many health systems hold without utilizing any kind of strategy that will maximize their profits while allowing them to more effectively achieve their mission.

Historically, hospitals have preferred to own their on-campus real estate for two reasons: (1) to maintain control—over the tenant mix (which includes keeping competition out) and operational flexibility, and (2) to maintain control of the economics, such as occupancy costs.

It is important to note that medical real estate is a valued commodity in the investor marketplace. A hospital-leased building holds significant value to investors due to the stability of the asset class and its historically stable performance in recessions. Investors view a long-term hospital lease in a similar light as a hospital-backed bond because the income stream from the lease is backed by the credit of the hospital. In addition to the credit behind the cash flow, real estate ownership inherently comes with an opportunity for asset appreciation over the long term. Medical office investors have acquired over $35b since 2016.

Figure 1. Medical Office Sales Volume 2002-2018

Source: Real Capital Analytics

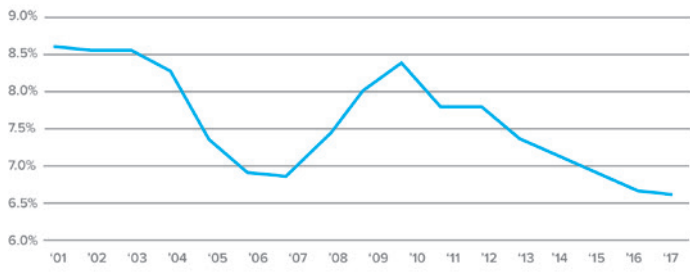
The uptick in transaction volume can be attributed to the medical office investment sector growing from a niche sub-market into an asset class that is targeted by new publicly-traded and private real estate investment trusts (REITs) that focus solely on medical real estate. Another reason for this uptick is that large pension and private equity funds are now targeting medical offices as a specific asset class within their asset allocation/diversification strategy. New entrants into this investment landscape have caused increased investor demand, which has resulted in the valuation of medical office buildings to be near an all-time high. While conventional reasons to own are important, there is no greater time than now for a health system to activate its real estate holdings through a strategic real estate plan due to the demand in this investment product type.

Figure 2A. 10 Year Treasury

Source: Walt Street Journal

An additional trigger in the MOB market has been historically low lending rates, which has in turn driven up prices to record levels. Ten-year Treasuries have floated below 4% since 2010 and reached 1.5% in the 2012-13 timeframe before some tightening from the Fed pushed rates up. Still, 10-year Treasuries have remained below 3% since 2014 (see 10 Year Treasury graph).

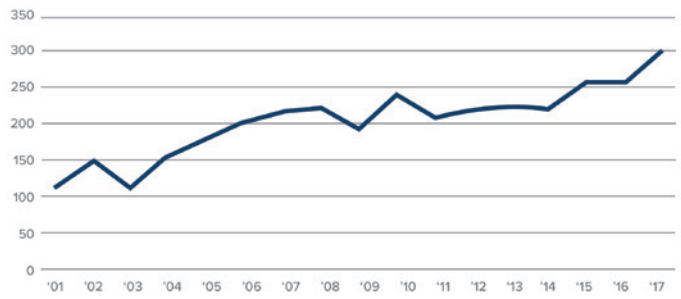
Figure 2B. Average Cap Rate



Source: Real Capital Analytics

The capitalization rate or "cap" rate for MOBs is a measure of financial return and is the effective inverse of a multiple. Cap rates for MOBs have trended down in much the same manner as lending rates, as would be expected (see Avg. Cap Rate graph).

Figure 2C. Average $ S/F



Source: Real Capital Analytics

The attractive loan rates and terms available since the 2008-09 meltdown have led to the record-setting sales prices and volumes. In terms of pricing, the average MOB sold for almost $300 per square foot last year, another record (see Avg. $ s/f graph).

Strategy Considerations for Existing Real Estate

Perhaps the easiest place for health systems to begin implementing innovative strategies for real estate is by optimizing their existing real estate assets. Real Estate Optimization is a series of processes that have been used in numerous industries for many years but have only recently been utilized in the health care industry. Whether it is the result of lower prioritization, incomplete data, outdated systems, lack of sufficient staff, a combination of these reasons, or for any other variety of reasons, health systems have been slow to recognize and take advantage of the potential savings and value created by real estate optimization applications.

The primary objectives are to reduce costs and create value across an organization's real estate portfolio, and to create and implement effective strategies that help fulfill the organization's mission. In today's health care environment, aggressive cost reductions/savings and creating/maintaining efficiencies are paramount to a health system's survival. With the right optimization strategies and framework in place, including sound data gathering and analysis followed by effective implementation strategies, health systems can use their real estate portfolios to outpace their competition and achieve tangible financial, operational, and strategic benefits. A brief summary of the steps within a Real Estate Optimization process is described below:[3]

1. *Portfolio Inventory*

   Create and maintain a current, workable inventory of the entire real estate portfolio, including building quality, current uses/tenancy, costs of ownership and/or leasing, lease expirations, and tenant mix. This information is the foundation of how a health system formulates strategies that can contain costs and create value in the portfolio.

2. *Portfolio Utilization*

   Utilize the Portfolio Inventory data to quantify cost reduction and value creation strategies, including consolidation opportunities, impact of owning vs. leasing, market cannibalization, and identification of properties to monetize.

3. *Leasing Strategies*

   Understand timing and relationship of lease expirations throughout the portfolio in lieu of a transaction by transaction basis. Consider lease rights such as Right of First Offers, Right of First Refusals, Use Restrictions, Building Exclusivities, etc.

4. *Capital Strategies*

   Develop capitalization strategies that utilize the most effective capital structure for a health system's real estate portfolio while balancing and supporting the organization's overall capital and strategic needs.

5. *Development Strategies*

   Create development pathways that align health system's anticipated use and/or operational strategies. This will be discussed in greater detail in the next section of this article.

6. *Facilities Management Effectiveness*

   Evaluate the facilities management organizational structure and personnel support to ensure it is meeting the health system's strategic, financial, and operational objectives in the most efficient and effective manner.

There are several goals that the health system should keep in mind when conducting these types of reviews and studies. First, health systems should seek to identify and eliminate, or restructure in some other way, unnecessary real estate costs. A simple way to become more profitable is to cut expenses that are not beneficial and that are holding up funds that could be used to benefit the hospital's mission. Second, duplicative cost centers (i.e. administrative office space) can be consolidated to ensure

that resources are being used effectively and that funds are not being wasted.[4] By reducing overhead costs associated with, for example, health care administration (such as office space and equipment costs, payroll costs, and turnover costs) a health system can better realize economies of scale and improve the system's overall financial viability. Third, health systems should build a strong real estate team internally or externally that will create continuity in strategies, negotiations, relationship management, operations, and lease compliance. Finally, health systems should consider the monetization of non-critical properties given the current market demand for such properties. If a property is not critical in furthering the health system's mission, leadership should consider whether the best use for the property would be to lease it in a different way or potentially sell it. By selling a non-critical property, the health system can free up capital that can then be reinvested into critical areas for the organization.

We are in a seller's market for medical office products. Monetization of medical office buildings that are already performing well financially can lead to even more gains and cash to deploy for other hospital strategies.[5] By taking advantage of the real estate assets that health systems already have, they can acquire more funds that can be used to recruit and better train new physicians and expand specialty services, upgrade to electronic medical records, advance ambulatory market strategies, and address decaying hospital infrastructures or reposition the inpatient platform altogether. It is important to note that the goal of a strategic monetization is NOT to sell real estate assets simply for the sake of access to capital; health systems should, when possible, continue to maintain control even when a property is sold. A successful monetization can allow a health system to maintain the benefits that have been enjoyed through ownership. This can be accomplished through utilization of ground leases, tenant leases, and real estate partners that understand and accept the health system's strategic interests. A health system does not need to control *all* the spaces, it just needs to control the *right* spaces.

The health care environment is rapidly changing; it is paramount that health systems are aggressive in reducing costs and creating efficiencies if they want to avoid falling behind their competition. An effective real estate optimization plan can help a health system accomplish these goals while furthering the organization's core mission. Health systems can no longer overlook their real estate portfolios if they want to remain relevant because doing so will cause them to miss out on financial, operational, and strategic benefits that could make the difference between success and failure.

Strategy Considerations for New Real Estate

Health care is evolving, and real estate strategies must evolve with it. New health care delivery concepts that increase patient access for low acuity care include urgent care clinics within retail centers, corner pharmacies, and your local grocery store or supercenter parking lots. Additional strategies include the development of micro-hospitals, freestanding emergency departments, and specialty outpatient surgery centers. Collectively, these strategies are upending how real estate is being used to deliver care. Changes in technology and government regulations may also require new construction, or changes in existing construction, because existing buildings cannot always be cost-effectively retro-fitted to meet the new standard for patient care and, perhaps more importantly, patient experience.

For example, knee replacement procedures that were once limited to the hospital operating room with an overnight stay can now be performed in an outpatient setting with no overnight stay required. In this example, an outpatient medical office building or ambulatory surgery center must be designed to accommodate specialized, properly sized operating rooms, additional equipment infrastructure, recovery bays, and patient rehab areas. The design must be in strict compliance with Joint Commission on Accreditation of Hospital Organizations (JCAHO) requirements, which require specific ingress/egress guidelines and independent HVAC and emergency power, among other requirements. In addition to the regulatory compliance required for certification/accreditation, a health system must create an ambulatory environment that caters to this new customer (i.e., private patient discharge areas, increased amenities for family visitors/caretakers, increased hours of operation, food services, etc.).

It is important to note that there is not a one size fits all approach for new project development; every project requires the prioritization of project control, risk, and economics. There are, however, two primary real estate activation strategies:

1. *Leasing Existing Space*
2. *Development of New Space*

Regardless of which option is chosen, it is important to note that value is created by the hospital: a thoughtful real estate strategy can allow a hospital to capitalize on any delivery method chosen. A health system should evaluate and prioritize the following factors when determining which real estate delivery approach will best fit their unique situation:

- The current and future constraints of the selected market, such as land or existing space availability, condition, and cost.
- The amount of square footage required.
- The type of services offered (e.g. high acuity vs. low acuity) and related facility requirements.
- The strategic and financial commitment of the endeavor (exploratory market strategy or long-term investment).
- Growth expectations (incubator vs. stable venture).
- Branding opportunities and requirements.
- Level of control (required exclusivity, restrictions, naming rights, ROFO, ROFR, etc.).
- Level of flexibility (early terminations, expansion/relocation provisions, etc.).

- Ownership requirements (expected hold period, return requirements, understanding of medical office development / property management, physician / stakeholder participation).
- The costs of construction and development.
- Speed to market (timing requirements for the new venture to enter the market).

Leasing Considerations: Pros and Cons

Leasing existing space typically requires a lower initial commitment, lower initial capital outlay, offers a faster speed to market (compared to new development/construction), and higher levels of long-term flexibility (but also a lower degree of control). This may be an appropriate mechanism to create small access points within the community.

Figure 3. The Pros and Cons of Leasing

The Pros and Cons of Leasing

Typically, the pros and cons of leasing include the following:

PROS OF LEASING

- **Flexibility:** The tenant's commitment to a location is more flexible. This can be prudent if expanding into a new location.
- **Less Up-Front Capital:** Traditionally, leasing has required less up-front capital. As stated above, however, this benefit has been muted due to recent aggressive lending practices for medical real estate, which allow some creditworthy owners to obtain 100% financing at historically low interest rates. Additionally, tenants may be required to fund tenant improvement costs, which, in some cases, could be high and, thus, minimize this benefit.
- **Optionality:** If negotiated correctly, leasing can provide tenants with benefits of ownership by way of a future purchase option, right of first refusal / or offer, or some other provision that is specifically targeted to provide tenants with some of the benefits of ownership mentioned above.
- **Ease of Disposition:** There are less costs associated with disposition. The tenant can simply end the lease and move out at the end of the lease term.

CONS OF LEASING

- **Lack of Control:** A landlord could refuse to renew the tenant's lease or could lease a nearby space to tenant's business competitors.
- **Higher Occupancy Cost:** Tenants typically have a higher on-going cost of occupancy than owners. At the end of the lease, tenants can face higher rental rates and less lucrative concession packages.
- **Inability to Dispose Early:** If the tenant desires to move prior to the end of the lease term, there could be costly penalties or even worse, the inability to terminate the lease.
- **Lack of Terminal Value:** Tenants do not own an asset with value at the end of the lease. As a result, the value of tenant's lease payments and tenant improvement investments cannot be recaptured once the lease ends.

Development Considerations

The alternative to leasing existing space is often development of new space, and it is decidedly more nuanced. There are a variety of paths a health system can take when it decides there is a need for a new facility to be developed, whether on- or off-campus. The key decision factor for determining the appropriate development strategy is understanding the health system's anticipated use and/or operational strategy for the development project, the amount of risk they are willing to take on, and the required level of control. For example, if Generic Health System (GHS) needs a new medical office building on its main campus and plans to fill 80% of the space with its employed physicians and programs, the decision on who should develop that building and how it should be financed may be quite different than the development of an off-campus, multi-tenanted MOB where GHS only needs 20% of the space.

There are four basic development scenarios for a health system to consider in terms of ownership/capital strategies for new development:

- Self-Development—Long-Term Hold
- Self-Development—Sell after Stabilization
- Third-Party Developer—Institutional Capital
- Third-Party Developer—Entrepreneurial Capital

There are also variations or hybrids on these scenarios, such as a joint venture, which will not be addressed in this article.

Self-development typically requires the largest amount of up-front capital (or debt financing), but also provides the highest level of control. The hospital will be able to control all project details (e.g. design, budget, schedule, space use, tenants, signage, etc.) and will also be able to control rental rates and lease terms. Long-term ownership and operations are more easily controlled under this strategy. This strategy also ensures that the project can start without meeting a lease commitment threshold which increases the speed to market. On the other hand, this strategy may create a significant demand on hospital management's time and resources (although this can be offset by hiring an outside party to manage the project). It also puts the project's capital in competition with other capital needs and therefore may not be the most effective strategy for health systems with current financial concerns or limited cash for deployment.

Unfortunately, this strategy raises the possibility of compliance risks (if the property is being leased to physicians) and will impact the health systems financial statements. Regulatory changes have been a major factor in decisions by health systems and physicians to sell real estate over the past 20 years.[6] Concerns about physician self-referral in the wake of the federal Anti-Kickback laws and the Stark laws has caused many health systems to decide that the risk of penalties was not worth the risks of owning land and serving as a landlord to physician tenants. Changes in financial theory have also led these organizations to realize that the capital returns accompanying their real estate portfolios were frequently less than what the expected return would have been for an investment in another area, such as mergers, physician alignment, or equipment.

Opportunistic health systems have benefited financially by self-developing or hiring a fee-for-service developer to manage a project and subsequently sell the stabilized asset to an investor. This allows a system to benefit from full control throughout the development process, create favorable lease structures, and select the long-term partner that will own and operate the facility. This method can also lead to a profit to the benefit of the hospital upon sale of the property.

Alternatively, engaging a third-party owner/development partner might be appealing for a few different reasons. By placing a developer in the "first chair" to coordinate project activities, it limits the amount of capital that is required and reduces the strain on the hospital to manage the project. It also allows the developer, who has development and construction management expertise, to utilize his or her skillset in overseeing the project. This strategy may also be executed faster as the third-party developer is incentivized to develop, lease, and open the property quickly. Development, construction, compliance, and lease-up risks are also removed from the hospital as the developer oversees these concerns. For example, a serious compliance risk is mitigated if a third-party owns the medical office building that is leased to referral sources.

This strategy does, however, present some cons. Development fees and lease rates could be higher than a hospital self-performing or hiring services on a "fee-basis." A hospital will need to carefully consider the financial implications of this strategy before electing to follow it. There is also the danger that the project's start date could be dependent on securing an appropriate level of lease commitments. Leasing and ownership control can be less solidified as a result of this strategy, and hospitals run the risk of losing full control over these areas.

The chart below summarizes some of the fundamental differences between self-development and third-party development models:

Figure 4. Self-Development vs. Third-Party Development

	DEVELOPMENT STRATEGIES			
	Self Develop (Long-Term Hold)	**Self Develop (Sell after Stabilization)**	**Third-Party Developer (Institutional Capital)**	**Third-Party Developer (Entrepreneurial Capital)**
GHS OCCUPANCY	100% Master Lease GHS Subleases 20K SF	80% Master Lease GHS Leases 20K SF	80% Master Lease Developer Leases 20K SF	80% Master Lease Developer Leases 20K SF
Lease/Debt Service Payments: 20 Years	$38.6M	$37.0M	$37.0M	$42.0M
Third-Party Rental Revenue	($9.3M)	-	-	-
Gain on Sale to Investor	-	($3.3M)	-	-
Total GHS Occupancy Cost: 20 Years	**$29.3M**	**$33.7M**	**$37.0M**	**$42.0M**
NPV of Total Occupancy Cost (5.0%)	**$18.4M**	**$19.2M**	**$22.4M**	**$25.3M**

It should also be noted that not all developers are created equal. Medical office developers should be evaluated by their experience and their cost of capital, as both will have an impact on a potential project. As this article suggests, the intricacies of medical office real estate are incredibly complex and require seasoned developers, owners, property managers, leasing teams, and legal teams that understand and have experience in the health care industry. Developers without health care experience may not understand nuances such as hospital ground leases, financing structures, referral relationships and related regulatory concerns, medical building construction standards, infection control protocols, above-average parking requirements, or extended hours of operations. Another major impact on developer selection concerns a developer's source of capital and their required return on investment. These two variables (cost and return) are what ultimately result in a building rent rate. For illustration purposes, an institutional developer with a 4% cost of capital and a 3% risk and return premium can provide a hospital with a lower rent rate than an entrepreneurial developer with a 5% cost of capital and a 4% risk and return premium. Compounded over a long-term lease, the financial impact can be significant, easily totaling millions of dollars in cost to the health system tenant. The market attraction to new medical office investment product has required medical developers to become ultra-competitive and to accept low returns for quality, new medical office projects. Furthermore, most developers that specialize in other asset classes such as retail, multi-family, or industrial are accustomed to receiving higher return margins than a competitive medical office development yields (due to the stability of hospital tenancy and recession resistance as previously discussed).

In each one of these cases, the anticipated use of space for the health system, the amount of risk that the system is willing to take in the process, and the amount of control required provides the foundation for the decisions about which party should develop the building and how it should be financed. The financing decision can mean the difference in millions of dollars to the health system. In our previous example, GHS was looking at various options for a new, off-campus 100,000 square foot MOB in which it plans to take 80,000 square feet. The total occupancy costs (whether in the form of lease payments or debt service payments) for the four scenarios listed above, over a 20-year period, are projected as follows:

Figure 5. Occupancy Costs Projection Based on Hypothetical Health System

	Developer Model	Self-Develop (Ownership)
Project Scope Control	Influence dependent on negotiated terms	Full control
Capital Requirement	Limited to costs above Tenant Improvement Allowance	Higher upfront costs; includes land acquisition and all development costs
Construction Risk	Limited to Tenant Improvements	Yes, can be partially mitigated though contracts
Development Risk	No	Yes
Physician Ownership Opportunity	Limited participation, up to 49%	Up to 100%
Flexibility	Developer will require 10+ year lease commitment	Long-term commitment
Ownership / Management Control	Limited; Ground Lease structure can provide partial control	Full control of tenant mix, operations and future ownership via sale
Value Creation Participation	No, unless Hospital participates in JV	Yes, through monetization
Real Estate Return on Invested Capital	No, unless Hospital participates in JV	Yes, through rent

The scenario shown above is just one consideration for GHS. Clearly, the residual value of the MOB, the leasing risk associated with non-GHS space, the internal availability of capital, the variety of available locations, and numerous other factors are a part of the decision-making process. Figure 5 above shows the potential for cost savings.

Conclusion

In an industry that is constantly and rapidly changing, hospitals need to be able to adapt and innovate to stay relevant and profitable. An effective real estate strategy that aligns with a health system's overall strategy can be a market differentiator within the competitive health care landscape.

Working with a trusted advisor on a Real Estate Optimization Study is a key first step for an organization to gain a thorough understanding of their existing portfolio, establish a baseline for performance metrics that can be used on a forward basis, and begin to formulate strategic alternatives to support larger system initiatives. This can result in unifying hospital leadership on strategic decisions around their current real estate, as well as help define strategies to make smart decisions on new real estate endeavors. When choosing an advisor, it is important to ensure that the advisor is objective and independent, placing the organization's goals and mission before their own financial interests or other objectives (e.g. does your advisor work with your competition?). Additionally, an experienced advisor will craft an individualized plan to fit an organization's needs, budget, and timeline.

An effective real estate strategy will reduce costs and create value across an organization's real estate portfolio by utilizing well-founded strategies that help fulfill the organization's ultimate mission of delivering quality health care to the community in a cost-efficient manner. Any meaningful strategy must define risks and opportunities, determine how to align assets with demographic and market trends, and help clients capitalize on emerging/underserved markets.[7] With the right optimization strategies and future development platform and decision making in place, health systems can use their real estate portfolios to outpace their competition and achieve tangible financial, operational, and strategic benefits. ◆

Endnotes

1 Scott Evans, Adam Luttrell, and Kevin Baker, "Healthcare Real Estate Strategies" (July 2, 2016), at page 1, available at http://www.realtytrustgroup.com/publication/healthcare-real-estate-strategies/.

2 A recent Revista survey named Kaiser Foundation Hospitals the largest health care real estate owner in the country, with a portfolio of properties valued at nearly $35.9 billion based 2016 year-end data. Survey available at http://wolfmediausa.com/2017/09/25/cover-story-top-50-owners-of-medical-real-estate/.

3 Scott Evans and Adam Luttrell, "Healthcare Real Estate Optimization" (October 4, 2014), available at http://www.realtytrustgroup.com/publication/healthcare-real-estate-optimization/.

4 *See* Joe Krumdieck, "Administrative Consolidation Solutions in Healthcare" (May 2, 2018), at page 1, available at http://www.realtytrustgroup.com/publication/administrative-consolidation-solutions-in-healthcare/ ("All too often, service lines are relegated to the most readily available vacant space, which results in administrative programs becoming increasingly fragmented and inefficient").

5 Examples of health systems that have realized significant gains from selling their property include: Catholic Health Initiatives who sold over $850 million worth of property in 2016-17 in two separate transactions; Memorial Hermann Health System in Houston, TX who in the last few years sold a 1.2 million square feet portfolio for over $225 million; the for-profit Community Health Systems who in the last few years completed a $163 million sale involving over 750,000 square feet of property; and North Cypress Medical Center in Houston, TX who recently sold a $137 million portfolio.

6 Scott Evans, "2018 Monetization Trends in Health System and Physician-Owned Real Estate" (August 17, 2018), at page 2, available at http://www.realtytrustgroup.com/publication/2018-monetization-trends-in-health-system-and-physician-owned-real-estate/.

7 Jake Hannay, "Unlocking Value Through Healthcare Real Estate Analytics" (September 14, 2016), at page 5), available at http://www.realtytrustgroup.com/publication/unlocking-value-through-healthcare-real-estate-analytics/.