Real Estate Capital, Inc.

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Key Highlights

Suboptimal Maintenance of Real Estate Leases Commonly Yields Foregone Value

Similar to optimizing many other functional areas of the MSO ecosystem, real estate requires sufficient resource allocation and technical expertise. When overlooked and not given sufficient resources, this can result in on-going missed value.

Common areas of foregone value:

- Incorrect and unaudited common area maintenance reconciliations leading to recurring tenant overpayments
- Missed opportunities for incremental landlord investment – through rent abatement or tenant improvement allowance – as a reward for long-term, stable tenants and / or in exchange for opportunistic lease extensions
- Missed windows for exercising lease options for renewal on comparable, pre-existing terms

Third-party lease administrators can be helpful in improving real estate lease maintenance across these areas. In general, third-party lease administration starts to become worth considering when a portfolio is greater than 10 locations.

How Much Leverage Do You Have in Landlord Negotiations, Included In Distressed Healthcare Operations?

Landlords are often receptive to working out reasonable deals to help preserve long-term, stable tenants. A reliably filled space is extremely valuable to a landlord. Landlord contribution of rent abatement and / or tenant improvement allowance may be feasible to negotiate for.

Key variables driving negotiations with landlords:

- How much time does the landlord have left on their debt financing? This will contribute to how much flexibility they are likely to have.
- What percentage of the building is your space? Are you a small tenant on the periphery or a large anchor tenant that would represent a meaningful loss for the landlord, and carry a significant interim cost to the landlord until the space is re-occupied?
- Does the tenant's operating business have a credible pathway to turnaround or would the landlord's offering of interim concessions simply be delaying the inevitable and throwing good money after bad?

Thoughtful, Holistic Healthcare Real Estate Analytics Should Be Embedded Into MSO Business Planning Around New Site Selection

When performed correctly, holistic site selection analytics can be a valuable predictive tool for understanding expected patient volume and vetting business feasibility, especially for more retail-oriented healthcare businesses.

Components of Holistic Site Selection Analytics

- **Trade Area Profile:** Develop target trade area profile designed to cater to your patients, as well as to your providers & staff. Vet specific sites in the context of this broader target trade area profile, taking into account location convenience and surrounding area amenities.
- **Psychographic Profile:** Analyze psychographic profiles to understand if market buying patterns are aligned and correlate positively with success for your particular healthcare business. For example, a pediatrics MSO would be interested in different psychographic profile attributes than a senior care MSO.
- **Competitive Landscape:** Evaluate competitive landscape density and relative market saturation.
- **Consumer-Facing Presentation:** Real estate can serve as anything from a subtle or overt value add billboard to a subtle or overt deterrence. What does your physical site communicate to your target consumer audience? Does your real estate site selection reinforce your brand and value proposition?

Healthcare Real Estate Outlook Remains Positive

Positive outlook on healthcare real estate ownership over the coming decade driven by:

- Reliable demand for healthcare services
- Growth in senior population expected to require incremental healthcare services
- Despite adoption of homecare and telehealth, in-office care remains the predominant channel for care delivery with expected "staying power"

In the current market environment, expect:

- De novo costs driven higher by supply chain cost inflation. As such, purchasing existing sites can be more attractive on a relative basis.
- That being said, acquisition valuations are likely to be depressed near-term due to higher debt costs, which may drive down transaction volume due to resulting bid-ask spreads.

Background

My company is Echo Real Estate Capital. We were formed in 2016 and we are based here in Chicago. We have an acquisitions and development platform. Within healthcare real estate, we primarily focus on three different types of deals. The first being traditional value add deals, where there is an asset and, for some reason, value is not being maximized. That could be because they don't have a great leasing team in place. It could be because the current owner doesn't have the financing to make capital improvements to a building. They are having a hard time attracting tenants for that reason, because the asset needs a new roof and a new parking lot. Or maybe the current owner is a group of physicians, and they're not really paying attention to the asset, because they're so focused on their operations that the last 15 to 20% of the building is just sort of sitting there because no one is actively working on it. Or maybe we have a tenant that's leading us to a deal, and they want us to acquire a building because they're going to occupy some vacancy in it. That's what we would call value-add deals. The second type of healthcare real estate would be just ground-up new construction. We speculatively take land positions, or we will work in partnership with larger private physician groups or health systems to identify sites and needs for their space programming. We then work with them to create a medical office building, either single or multi-tenant, for their expansion needs or consolidation needs, whichever the case is. Then the third thing that we do is sort of programmatic, what we call de novo rollouts typically for private equity backed healthcare provider groups. These can be groups like autism, therapy, urgent care, dental, dermatology, behavioral health, addiction treatment. These are more programmatic, smaller but volume engagements with a tenant. As their development partner, we help them expand and scale.

My background really comes on the retail side, both in retail landlord and tenant rep brokerage, as well as development. I've worked with a number of national retailers in a previous life on the brokerage side - household names like Verizon Wireless, Dollar General, McDonald's, Sonic. There are some larger junior anchor department stores that I represented over my career. I also worked at family office development firms, but they were primarily retail development firms, doing power center and grocery anchor development primarily here in Chicago.

And now with Echo Real Estate Capital. Again, while Echo is based here in Chicago, we have a national reach, and are currently working on assets from Arizona to Boston, and everywhere in between. We've carved out a niche for ourselves in that we will pursue opportunities in markets that are perhaps under the radar of larger groups. As examples, we've transacted and acquired medical office buildings in Topeka, Kansas, or Akron, Ohio, Rowlett, Texas, smaller towns in Indiana. That's a niche where we've found opportunities where others are maybe not necessarily looking, either because of geography or size of the deal.

Most outsiders mistakenly view real estate as a commodity. I think once you get closer to real estate, you realize that it's a business. It has many different tentacles, many different ways to create value. Converting something that was used for one purpose to another purpose. Attracting users that would otherwise have left the site vacant. It's beyond optimizing lease agreements, but really thinking about every asset as many streams of what's possible and then executing on it. With that context in mind, what makes Echo special versus other real estate brokerages and developers out there?

I think our shared experience. Myself and my other two partners, we have run the gamut of every functional job within real estate. That is a big family tree of job functions between brokerage, development, leasing, construction, property management, asset management. We, the three of us, have touched all of those areas, and we bring that background. Sometimes when you work for an acquisitions firm or a development firm, you come to a company or a transaction only from one lens. I would say maybe that lens is from a banking background, or a financing background. In that case, the firm may not have the practical boots in on the ground leasing. I've gotten my hands dirty on leasing assignments, negotiating with tenants, and attracting users. How are we going to position this space and who are we going to target? It's ground level functional experience. On the other side, other groups come to a development background from an architecture and engineering lens, and they really don't have the financing experience. Well, we have acquired and financed many hundreds of millions of dollars of projects. So between practical and high level, I think we cover a lot of the spectrum of real estate. I want to go back to something that you mentioned about how to look at real estate as something more than just the space that you occupy, in our case for your healthcare practice.

We have found a lot of the tenants that we work with in the buildings that we own, or the tenants that we're trying to attract to our buildings, utilize the physical space that they occupy almost as a strategic tool. I'm speaking in the context of referral relationships both up and down the acuity scale. I'll give you an example of a portfolio that we own in Indiana. We're actually closing today on our fourth asset in this market. We'll own about 150,000 square feet. It's four buildings. We happen to be positioned halfway between two different hospital campuses in the market. There are buildings on each of the hospital campuses, outpatient buildings, for clinical uses. What we have learned, and this is transferable to other markets that we've worked in, is that having a physical location in what these providers deem as being a neutral location - that is to say it's not on one hospital campus or the other - allows them to have a referral network beyond just one of the systems. It's not like they have to pick one team or the other. In turn, our buildings have both of the health systems in this market represented. So just by virtue of occupying, in what again I'm going to call a neutral territory, the tenants expanded their ability to create referral partnerships across both health systems. We've seen that in other markets too. I'm speaking more about it because, again, we're closing on it today.

You brought up the point about using real estate, and there's many tentacles and facets to it. That's sort of a strategic and business development component to it. There's obviously the revenue and money side of it. Can you turn your real estate that you either own or occupy into either a profit center or a way for you to grow revenue? There's lots of ways to do that too. That's more of a nuanced kind of technical side of the real estate, but certainly there's a strategic component too.

Let's break down real estate into two categories. One is search and find. The other is optimize. On search and find, what do most provider groups, large, medium and small, get wrong? I've had the privilege of looking at some of your analytics. What do most groups not include in their analysis when they're selecting sites? Then when they optimize, let's have the same question about optimizing existing portfolios.

On the site selection side, I'll speak a little bit to my retail background, because it has now transferred to the healthcare setting. On the surface, everyone can look at the easy three or four demographics such as population, household income and payer mix. We're getting layers deeper. As you go into additional layers in dividing up a trade area, it's more than just how many cars per day are traveling on this road, and what is the distance as the crow flies to a hospital campus? We look at things like other daily needs of the traffic drivers in a given trade area. That can be in healthcare, for example, having other amenities in a trade area like grocery stores, shopping centers, restaurants. Having those amenities in a trade area, from a site selection standpoint can enhance a provider's ability to maximize their real estate. Because it's more convenient not only for their patients, but also for the other providers in the practice. If they can run errands at lunch and things, that's a big factor. You can sometimes face challenges if your physical location is too remote, tucked behind an office park, or in some nondescript quasi flex building that doesn't have great signage and it doesn't have great visibility to the street.

We like to encourage our providers to think of their visibility and presence in a given commercial corridor, it's almost like their billboard too.

Healthcare is not necessarily an impulse purchase. You're not driving down the street and saying, "Gosh, I'm going to go have my knee looked at today. Let's pull over. I just saw a sign." It doesn't really work like that. You would do that for a cup of coffee, but not to have your knee looked at. But real estate can serve as a valuable forward facing billboard in healthcare too if you are paying attention to this level of detail in the site selection process – and, as a part of that, your sign, the cleanliness of your parking lot, your landscaping, your snow plowing. There's all kinds of things that make your physical location attractive. There's a statistic that we say, that 80% of the healthcare decisions are made by a female head of household. So is a mom with a stroller, if their son or daughter has an upper respiratory infection, are they going to take that child to this location? Well if it's clean and neat, and has a nice looking sign. It's well lit, and the landscaping looks nice, they're more inclined to do so.

The next layer deeper on the site selection, to us, are called psychographics. For those that aren't familiar, again back to the retail, they divide demographically based on things like blue collar, white collar, workforce, income, household expenditures, age. What are average age, number of households with children, et cetera? You can create these psychographic profiles, and we subscribe to that. Obviously, you could have different psychographics that you're targeting. If it's a pediatric urgent care you might be interested in what's the household income, or household expenditure for households with children? Or, if it's something more senior focused, what's the average age and demographic of a given population, if it's a more mature market, and they have less households with children and more of an aging population? You can parcel up a given population, and put them in these psychographic categories.

The other thing that we can do with our demographics is we have a metric where we can predict - statistically speaking within 93% accuracy, and it's been tested over hundreds of urgent care facilities - the number of patients per day that a practice can expect to receive if they're within a certain geographic range of a given latitude and longitude.

If they have a freestanding building. If they have a great sign. If they're at a signalized intersection, which is to say there's a stoplight there instead of being mid-block on a given commercial corridor. If you take that with the demographic information, the number of households with children, the average expenditure for healthcare, you put that all into the soup and it spits out, "Okay, you can expect to see 45 patients per day at this urgent care," or 62 patients per day at this urgent care. Then what you can do is, given the average reimbursement rate for a given trade area, a physician at this point can have a better prediction of what their top line revenue is going to be for a given location. Why is that important? Because a doctor needs to know, "Okay, if my staff is going to cost this much. My real estate, my rent and my real estate taxes, and the maintenance on a building is going to cost this much. After all of these expenses are covered, what is my profitability for this given location?" To quantify it on the revenue side for a physician, we're able to do that with predictive analytics.

The point to really drive is how many new site selections involve that level of analysis, versus how many should. I think there's a wide gap between those two.

What I didn't touch on was competitor data too. If we can extend the predictive analytics to how many physicians per capita are in a given trade area? If we add another urgent care in this example to a given trade area, you're now taking the same population, and you're adding one or two providers. Now the pie is being chopped up even more. When you're adding competition in this case, what does that do? How do we differentiate ourselves from the competitors? Do we have a better sign? Do we have an easier parking lot to get in and out of? Are we closer to the grocery store? Are we at the signalized intersection, so you can turn right in and get out turning left as well, whereas our competitor is mid-block? So eventually, we're going to start stealing patients from a competitor just by virtue of us being easier to get in and out of our site. All of that goes into site selection for us on the new build.

Now you asked me also about acquiring existing. A lot of the same variables apply to existing real estate from a site selection standpoint, and certainly for us when we're looking at medical office buildings. The trick with buying existing buildings, and certainly in the context of smaller provider groups and de novo rollouts, it's great if you can acquire an existing facility. We always use the example of a closed bank branch as being a type of a structure that is convertible to a free-standing urgent care, for example.

There's things you can do with the drive-through canopy. They're typically free-standing buildings. They're typically between 3,000 and 4,000 square feet. They're typically well located at a corner, at a light, by a grocery store. If you can mix an existing asset into the equation, it is very much easier than building new construction. It can be less expensive. You're inheriting some improvements. You've got four walls and a roof already. You're ahead of the game, and so you eliminate a lot of variables when you're buying existing. When possible, we would love to be able to acquire versus building new, just from a cost standpoint.

If you were to walk into an average provider group, every one of them has a portfolio of real estate other than maybe the group that's purely virtual and everyone's working from home. But other than that, everyone leases or owns something. Some lease and own a lot and are continuing to lease and own and develop more. What does your consulting hat direct you to do, and think about these assets both in terms of happy, performing well, but could do better? What would the real estate function offer a group like that? Alternatively, think about a group that's in dire straits, heavily distressed, and in need of any lifelines that can be created? So A versus B.

What I would do is separate it into two different categories on the onset. Are you leasing space in a multi-tenant building? Let's start there. The first thing I would do if I was putting a consulting hat on is to dive into your lease agreement. Really understand what kind of rights and remedies you have as a tenant, to better your position. What does that mean? The first thing I would look at is, how is the landlord treating the expenses for the property, and what is your lease structure? In other words, on what we call a triple net lease, the tenant is paying an estimated payment monthly in addition to their rent, to help cover the real estate taxes, the maintenance on the building, the landscaping, snowplow, et cetera.

But there are a million different ways that a landlord can either make the tenant's life difficult, or overcharge, essentially is where I'm going. Short-changing your tenants.

There is a process at the end of a calendar year. It typically happens in January after the books are closed out at the end of the year. Where a landlord is supposed to reconcile the money they collected from the tenants for these expenses to operate the building, and the money they had to spend to actually plow the snow, and cut the grass, and fix the HVAC, and change the light bulbs, et cetera. There can be a discrepancy between those two numbers. Sometimes, the landlords don't do either an accurate or a good job of reconciling the money they collected and the money they spent. It's typically in the lease, that the tenant has the right to audit the landlord, audit their reconciliation, and say, "I don't think so, Mr. Landlord. This expense that you charged me for in my lease, it explicitly states that is a landlord expense, and I am not to reimburse for XYZ." If you don't have your eye on that ball, the landlord is just going to take advantage of you. Now, we don't do that to our tenants. We operate in transparency. We show our tenants our reconciliations. If they ask, they have the ability to see our paid invoices from our vendors, so they know every dollar's accounted for on our end.

Let's put odds on this. You're not involved. You're now just being introduced. The provider group has 50 different leased locations, so you can imagine most of those are independent leases. What percentage of those leases are going to have some kind of underpayment by the landlord? How often?

You could have it be 75%, 80%. It really depends on the sophistication of the landlord. To audit the landlord's CAM reconciliation is a way. You do a couple things. You put the landlord on notice that you're not messing around. You have your eye on things, and you're not going to let them overcharge you. That's the first thing. The second thing, you're kind of setting the tone with these landlords that, come renewal time, which we'll get to that in a second, that I better not mess around with this tenant. I don't want to lose them, so I'm not going to be cute when I'm negotiating this renewal with them. Because they've had their eye on the ball the whole time.

Plenty of benefits. Let's put a dollar number on it. If I'm spending, let's assume it's a big number. Big location, heavy rent, urban area, a million dollars a year on rent, what savings are available?

Oh, it could be tens of thousands of dollars easy just for the one lease. So $20,000 times 10 leases is $200,000. Let's assume I have 50 leases, so that's five times 200 thousand dollars, is a million dollars of value created just through this exercise alone. By auditing the CAM reconciliation, that would be the term that you would ask for with your landlord. I'll get to owned in a minute. In a leased scenario, tenants have a relationship with their landlord. It comes to a head, in a good or a bad way, come renewal time. Your lease is coming due. You've been in the space for four years on a five year lease, or seven years on a 10 year lease, or eight. You're looking around the corner as a practice, and you say, "You know what? I've got a lot of gas left in the tank. This location is great. My patients know I'm here. I want to stick around. I want to commit to additional term on my lease." Well what can you do with your landlord to create a partnership with this landlord? The landlord's going to be getting rent from you for X number of years more. Maybe it's a five year renewal, or a 10 year renewal. What are the things, the concessions you can get from a landlord to entice you to sign a longer term lease, if you're talking about a five versus a 10? The landlord should be giving you a tenant improvement allowance. You might even use the fact that you're distressed to get some consideration. "Help me. Otherwise I'm gone, and you're left with an empty lot." Because the alternative for the landlord is, they don't help you out, they don't provide an allowance for you to spruce up your space,

clean up your lobby, carpet and paint allowance sort of thing. You continue to struggle as a practice, and then you end up having to close the location. Now, the landlord has an even bigger problem.

So they would rather spend money on the front-end to keep you and keep you healthy, than to have a brand new space to lease. Because that check is going to be even bigger, to retrofit the space and pay a bigger brokerage commission to the next tenant.

You can go to your landlord at any time and say, "I would like to commit for some additional term on my lease." Let's say you're six years into a 10 year lease. "I'd like to talk about an early renewal, Mr. Landlord. I'd be interested in knowing how incentivized are you to have this conversation, if we're going to commit for additional term?" Essentially you're asking, "What can you do for me?" That could be dollars. It could be free rent. Maybe the landlord is not going to write you a check, but they could abate your rent maybe the first month of the year for the next four years, so four months free essentially. There's a dollar value equated with that. It gives operationally you as a practice, a rent break for the remainder of your term. There's all kinds of ways you can negotiate.

Now let's say you're a practice group. You own your real estate, and it's a multi-tenant building. That is to say, you're in an orthopedic group and you occupy 60% of the building for your orthopedic practice. You're also a partner in the physical therapy practice. Now that's up to 75%, but 25% of this building is space that, "Oh, you know, it used to be occupied by an ENT doctor, but he retired. It's just sitting there. We've got a sign on the window, but nobody's really looking at it."

That is, you're leaving money on the table if you are not proactively marketing that space with a broker in this market who specializes in medical real estate.

A broker who has their ear to the ground on tenants and movement and practices expanding and growing, who has relationships with other brokers that are with tenants that are actively looking.

It's foolish to not engage with third party help. Now you're going to have to pay a commission to do that, but it would be foolish not to do that, because it's just sitting there. You're not maximizing the value of the real estate in a multi-tenant setting. Why is that important? Well, let's say you own your building. You occupy, as we talked about, between the orthopedic practice and the physical therapy practice, 75% of the building. Maybe you're nearing retirement age. You're going to sell your practice, the operations that is, but you want to hold onto the real estate as an income vehicle for your retirement. Well, if you've got leases in place, not only with your practices that you are selling, but also leases in place on the other 25% of the building. You've sold your operations, and you're just playing landlord now. Well don't you want the rest of your building full, if you're going to engineer this financial instrument for your retirement? The wrong time to be doing that is when you're thinking about hanging it up. Be proactive on the front-end, so those pieces are in place when you're ready for the capital then on your practice.

As for general trends in the space, what are you seeing happening at a macro level? Obviously, the cost of everything has gone up exponentially. The cost of debt versus cap rates has become a source of major concern for real estate owners and developers - they all use leverage. But, what else? Beyond the current environment that we're in, which won't last forever, what else is happening in healthcare real estate that's worth highlighting?

I can take this in a couple different directions. The first thing I would say is we're in for a period of another 12 to 18 months of lower transaction volume. That is driven by macroeconomic factors, primarily interest rates. The cost of money is going to reduce the value of assets. We sold assets last year at cap rates. We sold a building, it was a four tenant medical building in Texas, last year. It was about a 15,000 square foot building. It was a mile from a regional hospital campus. It was on what we would call medical row, amongst retail and grocery stores and other medical practices. We sold that building, it was 100% occupied. We extended all the leases in the building, created the value. We sold that for a 5.65 cap. In other words, the buyer on the other end was getting a yield of 5.65%. That building today, we couldn't sell it for more than a 7.25 cap rate, 180 basis point difference. Lower price, higher yield for the buyer. This is driven because the buyer's cost of funds with their bank now is significantly higher because of the interest rate environment. Transaction volumes is going to be down.

New construction starts are going to go down, again because the cost of construction has increased. We used to be able to peg, a new class A off-campus medical office building could be built for somewhere between $350 and $400 a square foot. Now you're looking at, the range is $425 to $500 a square foot, depending on the level of acuity. If you're talking about a surgery center, it's even higher. That is due to cost of materials, cost of labor, cost of construction in general is up. If new construction starts are going to be suppressed, because of the cost of construction, it makes existing assets more attractive to own and to acquire, because new product is not being built.

The funny thing about real estate - there's often, not always, an offset. Ownership less available, rental market strengthens. It's just interesting. You're saying de novo projects more unattainable, existing real estate more attractive.

Then the last thing I would say, macro trends, there's still health systems and larger provider groups that are expanding and looking to grow their footprint. But it's a challenging environment for everybody, because the cost to occupy new space sometimes is prohibitive from an operational context. So you have to find creative ways to grow your practices. It could mean partnering with a developer. It could mean buying existing. Yeah. I mean there's different financing vehicles. There's not just banks, other things like that.

Do you think about some of the following headwinds and tailwinds? So a tailwind for everyone, macro demographics. Aging population, and a wave of patients and all their respective needs. Potential headwind, potential tailwind, migration. If you're on the wrong end of that, headwind, the right end, massive tailwind. Other potential headwinds, transition to home care and virtual care. Do you think about any of those trends and/or others impacting your business?

I do, especially demographically speaking. The "silver tsunami" in the aging population is absolutely a reason we feel healthcare real estate is going to be resilient - the aging baby boomer population, and the percentage of the population that's going to be over 70, over 80 in the next 10 years. That is a reason healthcare real estate is more resilient than and less cyclically susceptible than hospitality, or certainly general office, certainly retail. The most attractive real estate asset classes now are multi-family apartments. Everybody has to have a place to live. That's not going anywhere. Second would be industrial real estate. That's born out of the rise of e-commerce, the dependency on e-commerce coming out of the pandemic, and the emphasis on reshoring and bringing manufacturing back to the United States. In macroeconomics, industrial is very, very active right now. The third I would say is healthcare. In our opinion, and it's largely shared, telemedicine and virtual care is a component of care, but you still need to have a physical location for a provider group. I can't have my shoulder looked at by my primary care physician, I'm using an example, on an iPhone. The provider still has to complete some level of in-person evaluation. "Where does it hurt? Can you move your arm," and that thing. It's a complement to primary care, or checkups or follow-ups or clinical whatever. Reimbursement rates, when they get figured out, and I believe they sort of have. You would know more than me on telehealth versus in-person visits, the parity there. But occupying physical real estate, especially for aging populations where technology is not as easy to work with, I don't see that ever being replaced.

So for us, healthcare real estate is still going to be a resilient asset class, that we want to work in and own for the next 10 years.

With that, comes the implied consolidation strategy that a lot of platforms are faced with. In distressed situations, in terms of working out the lease exits, what's your experience with that? What's the current climate like from a landlord's perspective, facing all the headwinds of the economy against the needs of the platform?

A lot of variables with that. I think when we last spoke, we sort of chatted, and the answer to this similar question was, every deal is different. Some of the big variables affecting the conversation with a landlord are going to be, what is their situation with their given lender? Do they have time on their loan to figure things out. If a problem is around the corner, do they have time on their loan? Do they have a lender that's willing to work with them to help solve the problem and stabilize the asset? Another variable - is the given practice that you may be referring to a big or small component to whatever building they occupy? If it's a small component of a building, that is to say they occupy less than 20% of the building, the landlord may be less inclined to work out an agreement. You're a smaller piece of the pie. They've got their anchor tenant in the building. Sort of small potatoes. If I get some space freed up in the building, maybe my anchor tenant can expand and take it. Or maybe you are the anchor tenant in the building. You're the 80% of a building. If this tenant leaves, you're in a lot of trouble as a landlord with your lender. Your income's going to go down. You're not going to make your debt service coverage ratios and your loan covenants. The whole thing sort of starts to crumble. What types of things can a landlord work out with you? Well again, it goes back to what they have the ability to do in their loan. Do they have an ability to offer concessions, such as rent abatement, to help ease the pain operationally with whatever practice you're working with? In exchange for that, these landlords, they're not just going to give you things for free. Sometimes, they're going to ask for additional term on your lease. Or they're going to ask you as a tenant, "If I'm giving you a rent abatement for a period of time, you're going to have to catch me up on the rent that you owe me that I abated for this period of three months," or four or six or whatever. "We're going to add that on to your lease. Over the next 18 months, we're going to chip away at the balance that you owe me." There's lots of different ways you can structure them. It really is deal-by-deal dependent. What type of position is the landlord in? How willing are they to make a deal or not, by virtue of the assets and their loan and the occupancy of a given location? Hard to generalize. Hard to say, "Yeah, all landlords are going to be willing to work with you." We're staring at an economic troubling time. Hard to say. Just it's really deal-by-deal dependent.

But that initial analysis percentage of total real estate, total building in a multi-site is a helpful one. Are we an anchor or are we peripheral?

The landlord's going to want to know. In the given example, if you're in a restructuring mode with a given practice. If I'm a landlord and a practice is struggling. "Gosh. We really need some free rent, otherwise we're going to have to close the doors." Sometimes the landlord may look at you and say, "It's not worth

saving." That's trouble too for the practice or the given tenant. The landlord needs to know that you're going to be there in the long term. Otherwise, "Why am I giving you more time to work it out? I better just rip the bandaid off and get this practice out, and start fresh with somebody else." It's a delicate balance.

You've talked about a bunch of opportunities – CAM reconciliation, TIA trades for term extensions, rent rate trades for term extension, etc. across your portfolio. So, there are clearly a lot of moving parts. It sounds like one of those things, that if you work these moving parts, you'll find opportunities somewhere within the portfolio. But you don't necessarily know which lever and which site will yield results. Can you talk about resources to manage a decent sized portfolio? What do you typically see as best practice internally, technology that's relevant to managing these types of situations across the portfolio? How does a company work with a firm like yours? I think there's always this dynamic of, what am I willing to invest and pay for? I see this in particular in real estate. Massive portfolios, complicated & tedious work to find the value in the real estate, and then a service fee of $10,000. There's just sort of a mismatch of resources and investment relative to the opportunity and the need.

The function that we're describing here is called lease administration. It is typically a third party service. You can contract with professional real estate services organizations, big and small. But typically larger, that all they do is have staff that audit and essentially mind the store on a portfolio of leases. And look for ways to engage with the landlord to help out their tenant, their client, and help create some value. We have a lot of instances where tenants just miss their renewal notice date. That is to say, they've got an option in their lease to extend their lease for five more years at a given rental rate, and it locks them in for five years. All they have to do is send a notice to the landlord, email or sometimes written notice. It locks in their rate, and they can put it on the shelf and forget about it. You would not believe the number of tenants that just miss that date. On a portfolio of 50 locations, that happens a lot. Where nobody's keeping their eye on the ball, they miss their notice date, and now the landlord has leverage. "Now your option has just expired, because you didn't give me notice. We're going to renegotiate your rent. Instead of $18 that you were going to pay in your option, I want $22 a square foot. If you don't like it, you can leave." That's a tough position to be in. The investment on the front-end in a lease administration consulting function and help can save you trouble down the road, because you're not going to miss renewal dates. Lease administration, they abstract every lease. They put reminders and calendar dates so that those critical dates, is what they're called in a lease, are not missed. You don't lose opportunities to take advantage of the option you negotiated for in your lease.

At what size do you think a company should have an internal real estate lease department, or do you always recommend working with a third-party lease administration?

If a company can take that person and maximize the utility of an in-house person. Let's say they have 10 locations. In addition to that, they're helping manage property management, asset management. 10 or so locations I would say is probably a break point. Once you get higher than 10, depending on if it's again single tenant or multi-tenant, managing a portfolio in-house, you get larger than that. Geography also plays a role in it. Are these physical locations, where you can get to them easily travel-wise? It's tough when this function gets left to a practice manager. In addition to the HR stuff, and in addition to reimbursement, contracting, credentialing, all the things that an office manager might oversee. Then in addition, you've got real estate too, a lot of times the real estate is just the thing that gets shoved off to the side. Because it's not the immediate, "Oh my gosh. I have to pay attention to it today." That's when you get in trouble. If you've got one or two locations, an office manager can probably handle that. When you get up to, like I said, 10 or so, that job in itself, you might be better off outsourcing it so that nothing is missed, and you don't create a bigger problem for yourself.

A quick question about utilization of emerging marketing tactics. Especially now that, as you mentioned, physical real estate is more expensive than it's been in a long time.

So it is increasingly important that real estate is utilized to its fullest capacity in terms of volume and getting patients in there.

Are you hearing from your healthcare deals, and not marketing the deal itself, but marketing the practice once it's open, of emerging technologies such as geofencing or Google My Business? To make sure that new location, day one of operations that it's populated in folks' GPS and Google Maps, more so than just a banner outside that says, "Now open."

Yeah, absolutely. I think in a digital and technology focused age that we live in, sticking a coming soon banner out, as you described it, you're not even scratching the surface, I think absolutely. A lot of the groups that we work with that are private equity backed, have that engine they can turn on with the digital marketing and things. For us, we're building three practices out right now in one of our buildings. I would be shocked if the practice isn't trying to advertise the fact that they are expanding and can take on more patients as a result. It's an autism therapy clinic in a multi-tenant building. They added another 3,000 or 4,000 square feet to their space. They were at capacity. Now,

whoever was on their waiting list, or they want to try to grow their waiting list again, they're also now offering instead of just young children care, all the way up through early teens and teenagers. If they aren't doing what you do with them, I think they're setting themselves up for failure. Our involvement sort of stops at, "Hey, let's get you guys a great sign on your façade." Then when you take it over, and the things that you're able to do, absolutely I think it's critical. No question.

Do you think the real estate activity or energy in the independent practice market will be higher or lower than in the hospital owned medical practice market?

I think it's market-by-market dependent. What I mean by that is, we as of yesterday now, own just one medical office building in Illinois, even though we're based in Chicago. Why is that? In Illinois, Chicago MSA, there's probably 22 to 25 health systems. That is a very hard landscape to navigate if you're a private practice physician. You don't know whose name is going to be on the hospital down the street in a few years, because of M&A activity. The referral relationships that you establish when you move to a given location may change, because that hospital could be acquired. Then those doctors are now affiliated with this orthopedic practice, and they're not sending you patients anymore.

A lot of times in a market like Illinois, smaller private practice groups are paralyzed. They can't expand anywhere, because they don't know the health system landscape. It's not a stable one. There's a lot of consolidation left to take place. Now conversely, in a market like Indianapolis, there are four dominant health systems. You've got Franciscan on the south side. You've got IU Methodist downtown. You've got Community on the northeast side, and you've got St. Vincent's near North Central. Everybody has their geographic fiefdom, and they know whose sandbox is where. So private practices have freedom of movement, because they know these hospitals aren't changing.

One is not going to buy the other. Everyone knows where everybody plays, and where their referral relationships are going to come from. So it allows for freedom of movement for private practices. The buildings that we own on the south side, Franciscan is the dominant system on the south side, and they've got a 500 bed hospital there. But Community has a smaller sort of satellite hospital there too. For years, IU has been trying to get into this market. We've heard rumblings of they're trying to plant a flag somewhere.

It just hasn't happened, because Franciscan and Community are the dominant players. All the private practice groups that have locations on the north side of Indianapolis, they all look to add one on the south side to grow their patient base, and they know they're not going to be stepping on anybody else's toes. It's a great question, but it's market-by-market dependent, and I think it starts at the health system.