White Paper

An Economic Analysis of Sale Leasebacks in Healthcare

BJM Solutions, LLC
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Executive Summary

Recent political and media attacks on sale leasebacks in healthcare are based on a fundamental misunderstanding of the business model, the economic value it brings to hospital operator relationships, patients, communities, and the economics of the hospital real estate market. The erroneous conflation of the hospital private equity business model and sale leasebacks with REITs is due to the failure to distinguish between operators and landlords. Private equity firms in hospitals control the day-to-day operations of the hospitals they own or lease. Private equity owners of hospitals make a profit when hospital revenues exceed hospital costs, including rent or interest payments related to the real estate. REITs can be landlords to both public and private hospitals and make a profit when lease revenues from for-profit and not-for-profit tenants exceed capital and management costs.

This White Paper demonstrates to lawmakers, regulators, the financial media, and policymakers at the federal, State, and local levels that their attribution of the financial problems facing the nation's hospital industry is not due to the actions of hospital REITs but is primarily the result of financially devastating reimbursement policies. Like REITs operating in other industries in the U.S. and global economy, hospital REITs provide needed capital to owners of property. Efforts to restrict the actions of healthcare REITs in hospital finance are likely to worsen the financial health of hospitals.

Very few hospital systems have the financial resources to purchase real estate outright. The vast majority of hospital operators have some sort of debt. For example, HCA had $37 billion in long-term debt with $59 billion in property, plant and equipment ("PP&E") as of March 31, 2024. Not-for-profit hospitals are the primary utilizers of municipal financing that could be directed to other valuable uses such as infrastructure and education.

Tenant challenges are primarily the result of inadequate reimbursement. The fundamental challenge hospital REITs face is the financial viability of certain tenants. The problems of financially stressed tenants are the result of numerous factors, but near the top of that list is the problem facing nearly all safety-net hospitals – inadequate reimbursement due to a patient mix that is too heavily dependent on Medicaid, Medicare, and uncompensated care patients.

Hospital closures are the result of operating challenges, not financing structure. There are several examples of hospital failures over the past few years that had nothing to do with sale leaseback strategies. For example, when Trinity Regional Hospital Sachse in Dallas, Texas filed for bankruptcy in 2023 – defaulting on $70 million in municipal bonds approximately two years after opening – the primary causes were operating challenges such as struggling to recruit physicians and unsustainable contracts. By the time of the filing, interest payments represented more than 50% of gross revenue.

*Hospital REITs provide cost-efficient capital to finance critical community infrastructure***.** Through an accepted and established business model, REITs pay hospital operators the full value of their land and buildings, supplying permanent capital to hospital systems. This capital is available to the operator to increase and improve patient services, expand its outreach to additional patients, develop new facilities, recruit staff and physicians, invest in innovative technologies and equipment, and permanently repay expensive debt and implement steps to improve operations. Hospitals by their nature require costly real estate that must be funded with expensive capital. A sale and leaseback strategy allows hospital operators to redirect the cost of owning real estate to their primary mission of healing patients.

The White Paper starts with an overview of the hospital real estate market. Section II discusses political attacks from lawmakers who mistakenly conflate REITs like Medical Properties

Trust with private equity firms. Section III provides developments in the economy that are moving in favor of MPT and the hospital REIT market in general. Section IV discusses the reimbursement problem facing the nation's safety-net hospitals as the reason for their financial troubles. The final section provides concluding thoughts on MPT and the hospital REIT market.

About the Author

Fred McKinney received his Ph.D. In economics from Yale University in 1983 where his dissertation, "Market Determinants of Access and Quality of Physicians' Services" was an early contribution to the literature on the growing importance of third-party health insurance's impact on healthcare markets. Dr. McKinney has served as a full-time faculty member at Brandeis University's Heller School for Advanced Studies in Social Policy Analysis (1983-1987), the University of Connecticut's School of Business (1987-2001), Dartmouth College's Tuck School of Business (2015-2018), and Quinnipiac University's School of Business (2018-2021). In addition, Dr. McKinney served as CEO of the Greater New England Minority Supplier Development Council (2001-2015). Dr. McKinney has served on over a dozen boards of directors for-profit and not-for-profit organizations, including Yale New Haven Health System's Bridgeport Hospital. Dr. McKinney has published over 100 articles and editorials on social policy analysis. Dr. McKinney spent one year working at the White House Council of Economic Advisers (1978-1979). Dr. McKinney is a co-founder of BJM Solutions, LLC (formed 1999). BJM has consulted dozens of large Fortune 500 companies, federal, state, and local government organizations, and large non-profit organizations. Dr. McKinney writes a bi-monthly column for Hearst Newspapers. In 2024, Dr. McKinney was a consultant on supplier diversity issues for the Conference Board, a business organization representing the largest American companies.

I. Overview of the Hospital Real Estate Market

There are over 6,200 hospitals operating in the United States. Figure 1 shows that most hospitals in the country (58%) are public not-for-profit institutions.

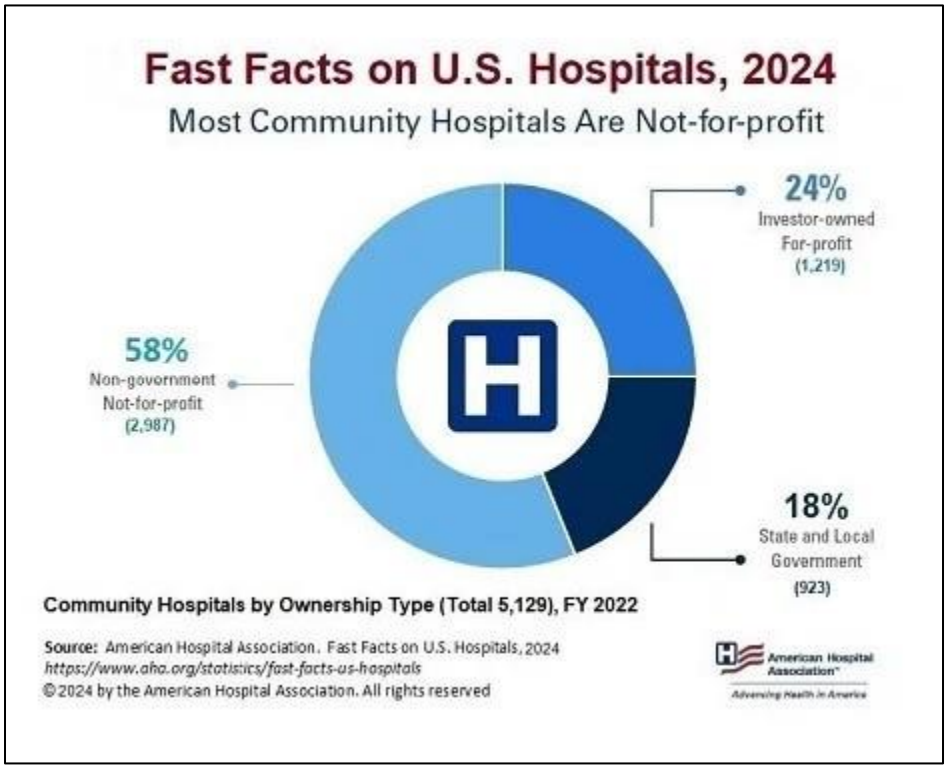

Figure 1: Fast Facts on U.S. Hospitals

This fact is consistent with the history of how, why, and where the first hospitals were built and operated in the United States. The early 19th century hospitals were little more than places for the poor to receive healthcare and other social services. The first hospitals had extremely high mortality rates – patients checked in but rarely checked out. Higher income Americans received their healthcare, even surgery, in their homes.[1] The focus of these early institutions on the needs of poor patients is why most of the early institutions were sponsored by religious institutions,

[1] History of Hospitals • Nursing, History, and Health Care • Penn Nursing (upenn.edu)

funded by public subscriptions, bequests, and philanthropic donations. These early institutions were places of last resort for most of their patients.

The development of the science of medicine led to the development of the practice of medicine and the expanded role of university-trained physicians. By 1925, American hospitals along with the development of Blue Cross community insurance had begun the path of acute care services focused on curing patients and not just keeping patients comfortable in their last days.

Two major developments changed American hospitals to become what they are today: the Hill-Burton Act of 1947 that led to construction of hundreds of hospitals nationally and the establishment of Medicare and Medicaid in 1965. These two federal acts provided much of the hospital infrastructure we still use today, and Medicare and Medicaid made the Federal government the largest single payer of healthcare services in the country.

Public dollars flowing into hospitals from Medicare, Medicaid and other private insurance companies and the very nature of hospital services created inflationary pressures that made healthcare cost a major political and economic issue. On the one hand, medical science and hospital care had improved dramatically, but the cost of care in hospitals had skyrocketed, but reimbursement levels had not kept pace with rising cost. In 1983, Congress responded by imposing price controls in the form of diagnostic related groups (DRGs) to replace retrospective reimbursement with prospective reimbursement.[2] The theory was that if hospitals knew what they

[2] The author worked with one of the architects of the DRG system, Dr. Stuart Altman, who was the Dean of the Heller School at Brandeis when the author was on the Heller faculty. Before coming to Heller, Altman served as chairman of the congressionally legislated Prospective Payment Assessment Committee.

would be paid in advance for a particular service, they would more efficiently produce those services and costs would be controlled.

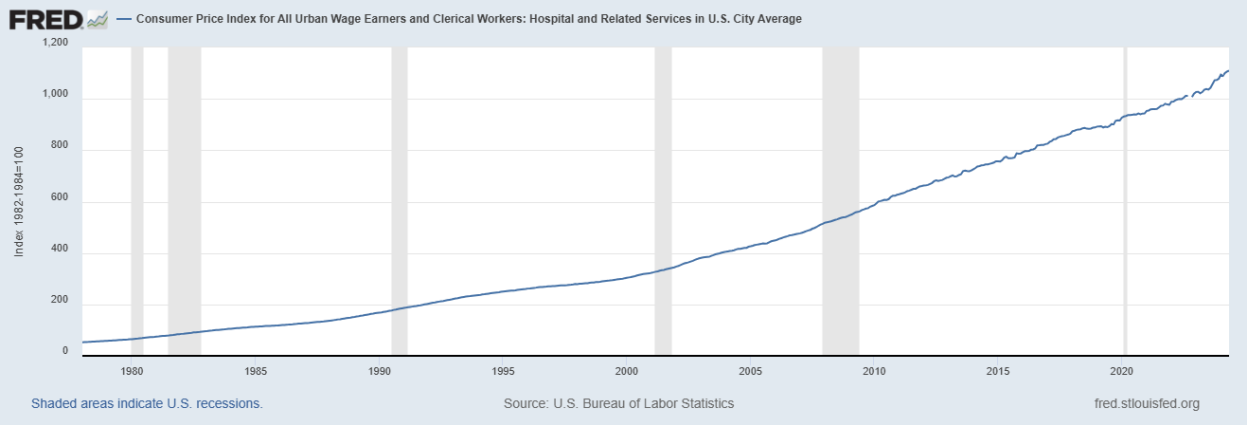

Figure 2: Consumer Price Index for All Urban Wage Earners: Hospitals and Related Services, U.S. City Average

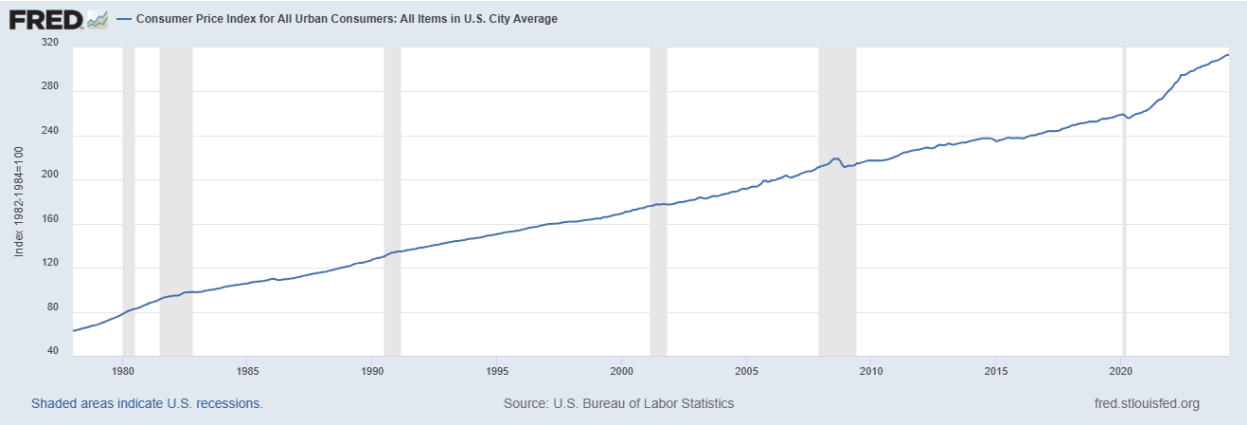

Figure 3: Consumer Price Index for All Urban Wage Earners, All Items, U.S. City Average, 1978-2024

The two figures above show that since 1978, hospital prices have increased by a factor of 11 while all other goods and services have increased by a factor of 3. In other words, hospital prices have increased more than three times the prices of all other goods and services since 1978. It was this reality that DRGs and prospective payment was designed to change. The results have been mixed.

Hospital Real Estate

The cost of hospital real estate is a function of land acquisition costs and construction costs. A recent study of land cost in downtown Washington D.C. indicated that one acre of land costs over $4 million.[3] The cost of hospital construction is also significant. In a study of the cost of building hospitals in major cities, the cost per square foot of hospital construction in Los Angeles ranges from $640 per square foot to $970 per square foot.[4] To build a new hospital in an urban market today could easily cost a quarter of a billion dollars. While these are some of the most expensive examples, regardless of where, hospitals are expensive institutions to build, and this does not include all the specialized technology and supporting infrastructure required to efficiently and effectively manage these institutions.

The expense of building hospital infrastructure is one of the primary reasons, the physical plant of American hospitals is as old as they are. Some of these institutions date back to the founding of America. Benjamin Franklin founded Pennsylvania Hospital in 1751 and New York Hospital was founded in 1771 and is now Weill Cornell Medical Center. Bridgeport Hospital (a hospital I proudly served on the board for 10 years) in Bridgeport, Connecticut was started by Dr. George Lewis, a Columbia University Medical School graduate, in 1883. Dr. Lewis had just returned from fighting in the Civil War. Dr. Lewis convinced his aunt to donate an acre of land

[3] Washington, DC Land for Sale - 253 Properties - LandSearch
[4] Hospital construction costs in 12 large U.S. cities (beckershospitalreview.com)

and $13,500. Shortly after incorporation, circus entrepreneur P.T. Barnum, a Bridgeport native, became the chairperson of the board for Bridgeport Hospital.

This is a commonly told origin story of hospitals across America. Similar to Bridgeport Hospital, hundreds of independent community not-for-profit institutions combined with other independent hospitals to become part of large hospital systems.[5] The rationale for these hospital conglomerations was to use the buying power of larger systems to reduce the cost of capital for those large systems. In 2021, three quarters of all acute care hospitals and 93% of all hospital beds were in affiliated groups of hospitals.[6]

A next phase of hospital conglomeration might involve the merging of these large hospital systems. For now, however, the stand-alone public and private hospital is a thing of the past, primarily due to the reimbursement policies and the cost of building new hospital infrastructure.

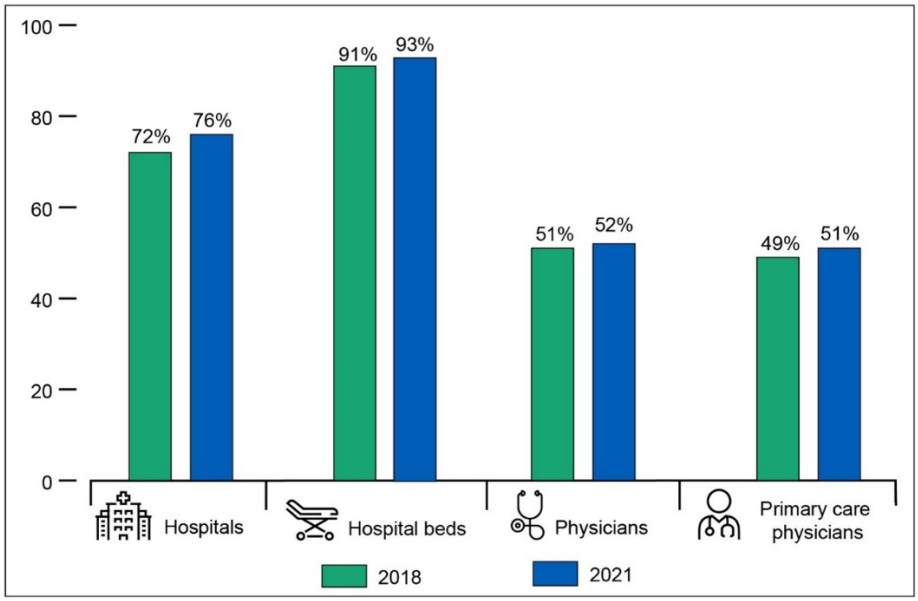

Figure 4: Share of Hospital Assets in Hospital Systems, 2018-2021

[5] Bridgeport Hospital is now an affiliate of Yale New Haven Health System

[6] Consolidation And Mergers Among Health Systems In 2021: New Data From The AHRQ Compendium | Health Affairs

Hospital infrastructure has been continually updated and improved, but many of the nation's hospitals are operating on the same land and some of the same buildings that are decades old. This economic reality that hospital real estate is an extremely scarce and expensive resource that hospital operators can use to generate cash is the opportunity created for REITs.

II. Hospitals Need Access to a Wide Array of Capital Solutions

Changes in the Macroeconomic and Hospital Industry Environment

On Wednesday, March 20th, 2024, the Federal Reserve ("Fed") Chairman Jerome Powell held a press conference to announce that interest rates would remain unchanged within the 5.25% to 5.5% range. Chairman Powell stated they want to see further reductions in inflation, but that there could be as many as three interest rate cuts this calendar year. The Fed's inflation target is 2%. The February Consumer Price Index (CPI) came in at 3.2 year-over-year and the core CPI was 3.8% year over year. While higher than the 2% target, the rate is a reduction from the 6% CPI reported in February 2023 or the 5.7% core CPI in all of 2022. Clearly, the Fed's interest rate policy has made gains in the war on inflation.

The higher interest environment began in March of 2022. The Federal Funds figure below documents the appearance of a peak in interest rates (Figure 5). For interest sensitive industries like REITs, this is the good news for which they have been waiting. Higher interest rates increase the cost of capital and slow down economic activity. The news and the expectations for future rate reductions have led to stock markets reaching all-time highs (Figure 6).

Improved economic conditions are also reflected in unemployment rates. Unemployment rates are an important indicator for hospital REITs because as unemployment rates decline, more

people are eligible for employer sponsored healthcare insurance plans. These plans pay more than public sector plans or for care provided to uninsured patients. As a result, we expect hospital financials to improve with the economy (Figure 7).

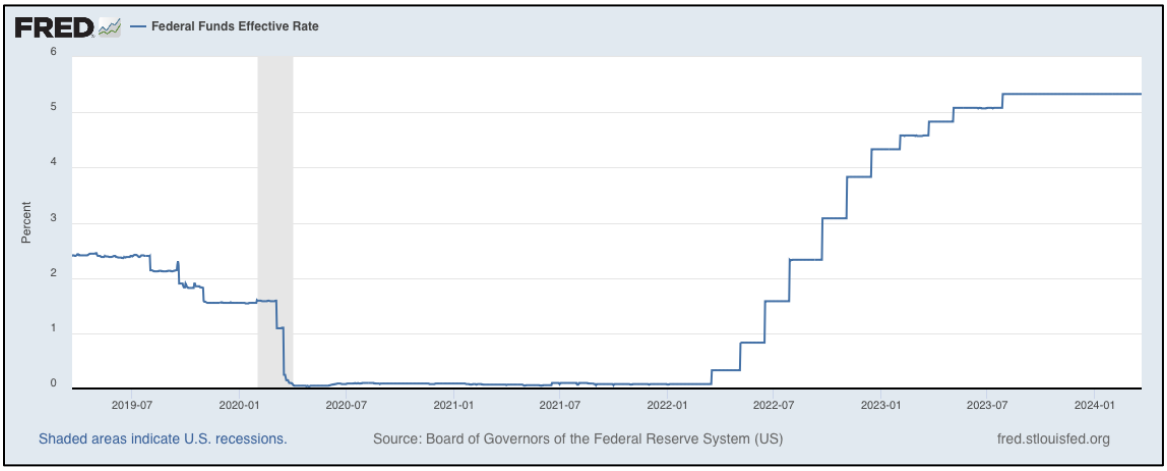

Figure 5: Federal Funds Rate, 2018-2024

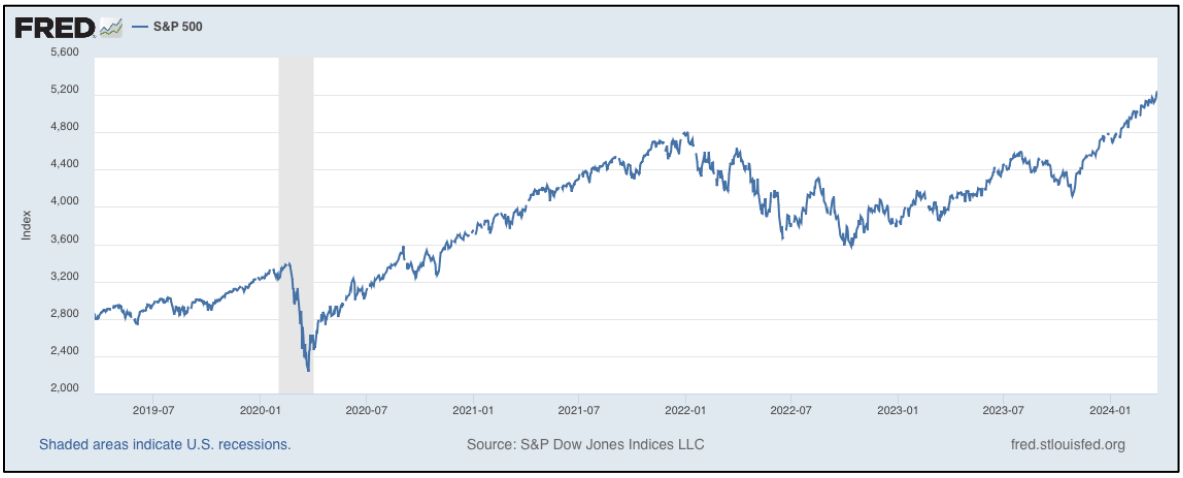

Figure 6: S&P 500 Five-Year Returns

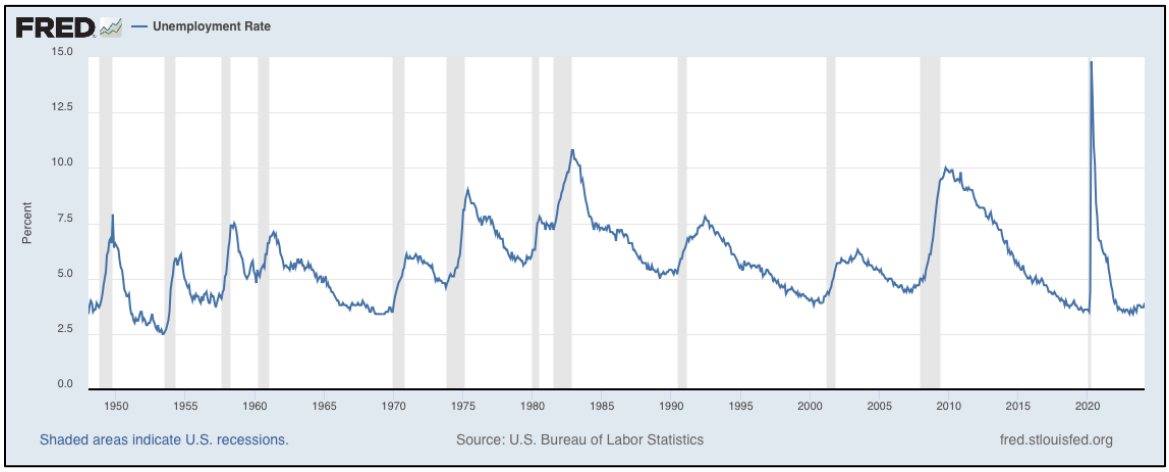

Figure 7: Unemployment Rate, 1978-2024

The dramatic spike in unemployment rates during the pandemic is what led to the Fed's decline in interest rates and the biggest fiscal policy injection in the U.S. economy in history. Figure 7 above shows that not only are we returning to normal, but the labor market is also better than it has ever been. Workers are finding it easier to find work, and wages are also rising (Figure 8).

Figure 8: U.S. Hourly Earnings of All Employees

These macroeconomic metrics all suggest improving financial market, labor market and hospital industry conditions will have a positive impact on Hospital REITs' business moving forward.

Hospital Industry Analysis and Overview

Hospital Market Size: "*The U.S. hospital facilities market size is anticipated to reach USD 2540.4 billion by 2030 and is anticipated to grow at a compounded annualized growth rate (CAGR) of 7.7% from 2023 to 2030, according to the report. Technological advancements, such as telehealth, mobile apps, artificial intelligence, and wearable devices, are boosting market growth. Furthermore, the demand and supply gap in the U.S. healthcare system is increasing rapidly. This can mainly be attributed to the growing number of patients and the limited resources available to provide necessary care*" (Research and Markets "U.S. Hospitals Facilities Market," 2023).

Optimism for Hospital REITs: The last sentence in this recent report above on the hospital industry is the primary reason for optimism in the hospital REIT market. Unlike commercial real estate that is suffering from reductions in the demand by corporations to work in office buildings, hospital demand is growing with changing demographics and the high costs of building new hospital bed capacity. These market dynamics of growing demand and stable supply drive up rents.

Population Pyramids Suggest Increasing Hospital Utilization: Population pyramids are a way to show the distribution of a population by age cohort and gender. They were called pyramids because when the first U.S. population pyramid was drawn, it had the distinct form of a pyramid with younger aged groups outnumbering successive older groups. The U.S. population pyramid for 2020 shows that demographic changes favor hospitals (Figure 9). The median age in the U.S. is now 39 years, the oldest average age in the history of the country. Over 34% of the U.S. population in 2020 is over the age of 50. The bulk of inpatient hospital patients is between the ages

of 60 and 80[7]. The large cohorts of baby boomers and millennials are entering the period when they are prime hospital bed consumers. Demographics, as indicated in the population pyramid below, will drive the demand for hospital beds and the higher costing surgical services associated with an aging population (Figure 9). The demographics, the supply conditions, and continued income growth support the forecast of hospital spending increasing from $1.41 trillion in 2022 to the projected $2.56 trillion in 6 years.

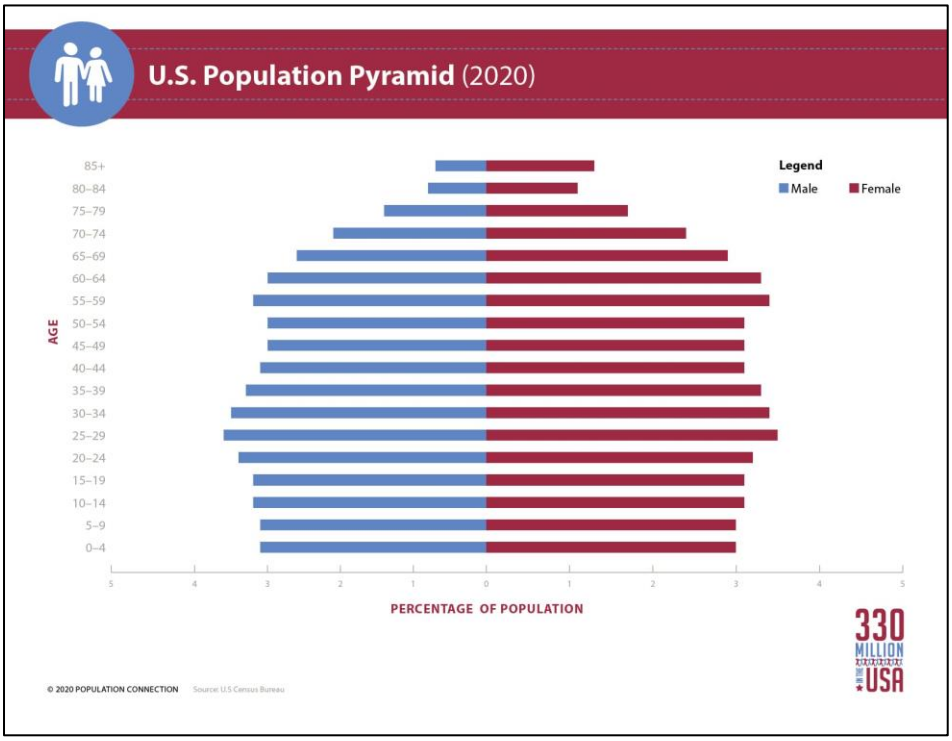

Figure 9: U.S. Population Pyramid 2023

III. The Hospital REIT Business Model

The REIT industry in the United States encompasses over 190 REITs with a total market cap of $1.3 trillion dollars according to Invesco Real Estate. The industry owns $4.5 trillion in real

[7] Acute Healthcare Resource Utilization by Age: A Cohort Study" Tillman, Bourke et al., May 19th, 2021

estate and is the largest REIT market in the world.[8] It is estimated that over 170 million Americans own REIT stocks directly or indirectly through mutual funds.[9] REITs did not formally exist until Congress established provisions in the 1960 Real Estate Investment Trust Act. The growth in the industry and the widespread ownership of REITs in the United States and globally show that REITs are a financial innovation that created the opportunity for small investors to invest in real estate in ways that were impossible before REITs. It is likely that few of the 170 million Americans who today own office buildings, factories, malls, timberlands, or hospitals would own any of these critical assets without the financial innovation REITs represent. Figure 10 below is an overview of the real estate investment trust process.

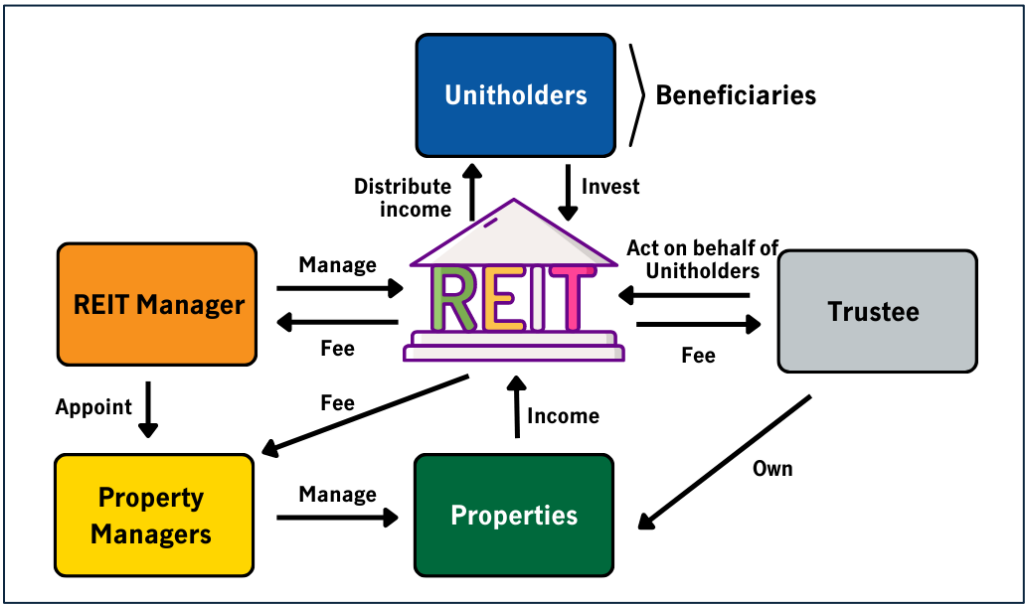

Figure 10: Overview of Real Estate Investment Trust Flowchart

[8] Invesco Real Estate | Invesco US
[9] History of REITs & Real Estate Investing

Companies whose core businesses were not real estate were able to finance that real estate in ways that contributed to their primary non-real estate business objectives. The alternative for a developer or property owner to engage in a REIT transaction is a traditional bank loan. Banks use loan to value calculations that limit the amount of the loan and also have numerous operational covenants that further tie the hands of borrowers. A REIT transaction can finance 100% of the value of the property, providing the lessee more capital and having fewer covenants than bank loans. REITS give lessees more flexibility and more capital.

Overview of Sale Leasebacks: In a sale leaseback transaction, a REIT purchases the physical plant and land of facilities with cash and debt, and then lease those properties back to the seller in long-term lease agreements. The seller of the property receives a significant amount of cash that they can use as they see fit, and the REIT receives an asset that generates revenue over the life of the lease and could be sold back to the operator or another buyer in the future. All REITs must be held by a minimum of 100 shareholders, cannot be closely held, and cannot be owned by financial institution or an insurance company, which makes it legally impossible for private equity companies to own and control REITs.

The REIT business model is fairly simple: REITs accumulate cash from shareholders and borrow money to purchase or build real estate that they then lease to tenant relationships. REITs earn profits when their lease revenues exceed operating expenses, management costs, and their cost of capital. REITs then distribute 90% of their profits to shareholders, and shareholders pay taxes on their dividend income. REITs operate this accepted and established model across the entire American industrial landscape. REITs service manufacturing, retail, commercial office space, education, federal, State and local government facilities (including those that house federal contractors who handle our most sensitive national security activities), warehousing and

distribution, medical offices, and hospitals. REITs own over $1.5 trillion in real estate assets in the United States over 575,000 properties, and 15 million acres of timberland.[10] Most American consumers are completely unaware that when they visit almost any mall, any office park, any casino, many government buildings like post offices, that they might be entering and shopping and doing business in a facility owned by a REIT.

The economic advantages of sale-leasebacks are well documented as:

- The ability to convert an illiquid asset into working capital for the seller;
- Seller can generate 100 % of the value of the real estate compared to a lower value typically given by a bank because of loan-to-value ratios and rules;
- Eliminate some of the risks associated with changing interest rates when the seller might need to refinance;
- Fewer covenants associated with traditional bank or bond financing, giving the seller more operational control;
- Seller gets a long-term partner that can assist in future financing and access to more favorable capital markets;
- Rent payments do not change based on day-to-day operations; and
- Rent expense is a small portion of a tenant's net revenue and remains generally fixed on an inflation-adjusted basis.

[10] NAREIT. "What's a REIT (Real Estate Investment Trust)?" *NAREIT* 2019, www.reit.com/what-reit.

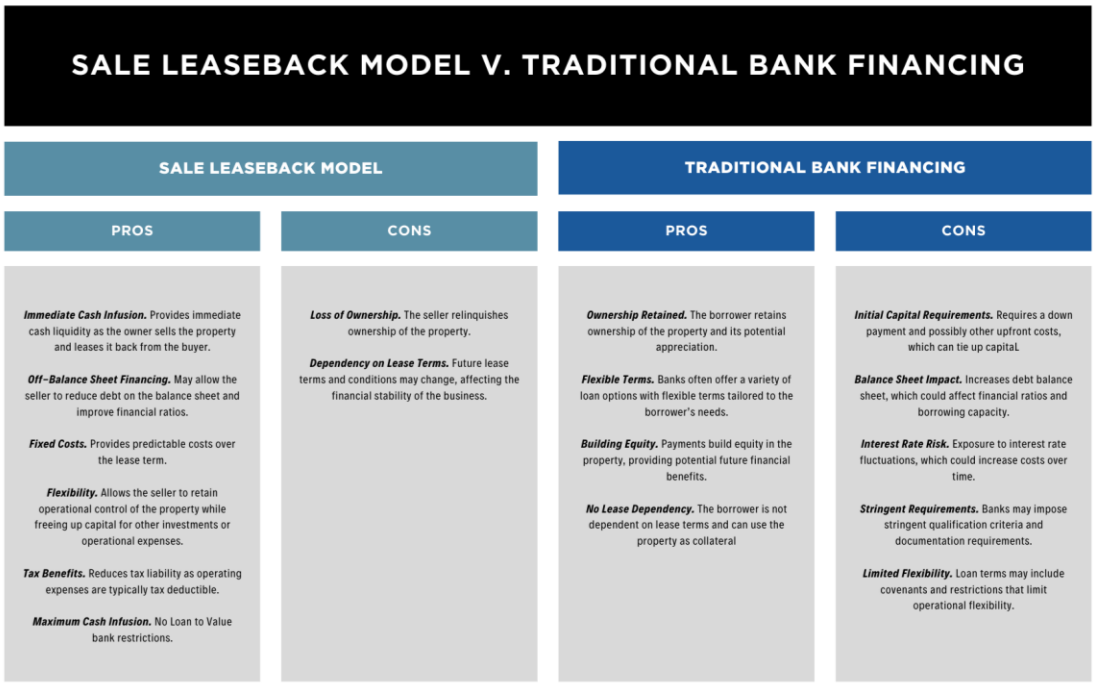

Figure 11: Pros and Cons of Sale Leaseback Compared to Traditional Bank Financing

The figure above shows a comparison of benefits and costs for sale leaseback financings and traditional bank financing. Sale leaseback transactions are an alternative to traditional bank financing. Hospitals will continue to use both types of financing to meet their capital and cash needs, but the growth of REITs indicate hospital executives may be getting more comfortable with this newer form of financing.

Advantages of REITs in healthcare: The advantages of this model for hospital operators are significant. Most hospitals in America are old. Over 80% of hospitals in America are public not-for-profit anchor institutions built following World War II after passage of the Hill-Burton Act (1946).[11] Not-for-profit hospitals were often started with philanthropic donations from community

[11] Jarvis, Claire. "America's Aging Hospitals Aren't Ready for the Technology Revolution." *Undark Magazine*, 19 Dec. 2019, undark.org/2019/12/19/aging-hospitals-technology-revolution/.

leaders. Those donations came in the form of land and buildings. Much of America's hospital real estate stock has been fully depreciated and is wholly owned by the not-for-profit hospital corporation. Both for-profit and not-for-profit hospitals generally operate in older buildings with increasing upkeep costs, and they need major infrastructure and technology investments. REITs provide hospitals with large amounts of immediate capital in exchange for affordable future lease payments. Without access to this capital, the cost of the physical facility would certainly exceed what can be funded with cash from short-term operations and would require debt financing from lenders and/or cash from donors, other investors or even taxpayers.

Much is at Stake: Hospitals in many communities are anchor institutions with a far-reaching impact on their surrounding communities. It is not uncommon for hospitals to be the largest private employers in the towns and cities where they operate. In 2023, almost 6 million people were employed in hospitals. Hospitals are the largest single employers in 14 States and are second or third in 20 other States.[12] Maintaining their physical plant is an important factor in the continuation of this economic function. The service REITs provide to hospitals allows them to continue to invest in technology and employ their highly skilled workforces by unlocking the value of their physical assets and monetizing it to reinvest in hospital operations.

Hospital REITs are not Hospital Operators: REITs do not exercise operational control over the business of the tenant. If the relationship/tenant cannot "afford" to pay the lease payments, the lease agreement dictates the steps needed to end the relationship between the REIT and the tenant, like any other lease agreement between a landlord and a tenant.

[12] Leins, Casey. "These Are the Largest Employers in Every State." *US News & World Report*, U.S. News & World Report, 2018, www.usnews.com/news/best-states/articles/2018-12-21/walmart-health-companies-and-universities-are-top-state-employers-study-finds.

The lease agreement with the hospital operator does not give operational control or decision making to the REIT. Hospital operators are not restricted in what they do with the cash generated from the sale of the hospital's real estate. Many operators use the unlocked value in their real estate to upgrade technology, build new facilities, or pay down other debts.

Assessing the Fair Value of Hospital Real Estate: Several factors determine the "right" price of hospital real estate including, the physical attributes of the property, the hospital's current and future referral relationship mix which is a key determinant of the hospital's revenue stream, and the management of the hospital. REITs must also assess local market conditions and the current and future supply of hospital resources in the market where the transaction is scheduled to take place.

Regulatory Considerations: REITs must also consider State and local regulatory requirements. For example, when purchasing new hospitals or major equipment, hospital operators must secure Certificate of Need (CON) approvals from relevant State agencies. CONs were put in place to control the amount of hospital infrastructure because it was believed that new hospitals and expensive innovative technologies would lead to greater payments from public and private insurers, adding to hospital expenditures without providing sufficient community benefits. This regulatory environment has the impact, like many regulations of this type, of restricting market competition, innovation, and providing competitive protection for existing market suppliers.

Most hospitals operate in specific geographic markets. And most of these markets are characterized by oligopolistic conditions, where the actions of one hospital affect the outcomes of other hospitals in that local market.[13] If CONs make it difficult for new hospitals to be built, then

[13] The author was on the Board of the largest healthcare system in his State for over a decade. At every Board meeting, we had time set aside to discuss developments of our neighboring hospital who was our greatest competitive threat.

the value of existing hospital capacity increases. One factor over which a REIT has no control is the increasing consolidation of hospital operators, a market phenomenon which has accelerated since the late 1990's and which many contend has accelerated significantly because of the changes in health care delivery prompted by the Affordable Care Act.[14]

REITs Provide a Vital Source of Capital for Hospitals and Opportunities for Retail Investment: Ultimately, REITs allow for retail investors to invest in America's hospital infrastructure, which would otherwise be nearly impossible Hospital real estate is a class of assets that should continue to be available to retail investors. Hospital REITs, provide an important intermediation between those retail investors and hospitals. Without this intermediation, there would be less capital available for all hospitals. This important fact is something hospital regulators and politicians need to consider carefully.

REITs and Private Equity

Private Equity in Healthcare: Private equity-sponsored companies currently operate 460 hospitals in the U.S., about 7.5% of all U.S. hospitals. These companies include; Apollo Global Management (Lifepoint Health, ScionHealth), Equity Group Investments (Ardent Health Services), One Equity Partners (Ernest Health), GoldenTree Asset Management, Davidson Kempner (Quorum Health), Surgery Partners (Bain Capital), and Webster Equity Partners (Oceans Healthcare).[15] Texas has the most private equity owned hospitals (97) and New Mexico has the highest percentage of private equity owned hospitals (38%).

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[14] See Levinson et al., Ten Things to Know About Consolidation in Health Care Provider Markets, Kaiser Family Foundation, April 19, 2024; and Christopher Pope, How the Affordable Care Act Fuels Health Care Market Consolidation, The Heritage Foundation, August 1, 2014.

[15] "PESP Private Equity Hospital Tracker." Private Equity Stakeholder Project PESP, pestakeholder.org/private-equity-hospital-tracker/#:~:text=Approximately%20460%20US%20hospitals%20are. Accessed 25 Apr. 2024.

The Private Equity Business Model Is NOT the REIT Business Model: Private Equity (PE) firms have a business model that is different from REITs in general. Some private equity firms in hospitals and in other industries attempt to extract value from assets through consolidation, poorly defined synergies, using debt to fund returns to PE shareholders, and reducing operating costs. It is the actions of some bad actors that give PE firms a bad reputation broadly when they take over hospitals. Struggling not-for-profit hospitals are more vulnerable to considering PE firms as saviors than "profitable" not-for-profits. The combination of sophisticated PE firms and struggling not-for-profits has accelerated the decline in some of these institutions. Historically, when PE firms acquire struggling firms, regardless of the industry, they often take steps to reduce costs and re-organize operations, changes the previous owners failed to make. While it appears the PE firms are the source of the problems, the underlying management and financial problems facing many of their acquisitions often started long before PE firms became owners. This is not to excuse or justify the actions of PE firms, but it is important to recognize that many of their acquisitions were struggling prior to their sale.

REITs Association with Private Equity: The fact that hospital REITs such as MPT owns hospital real estate operated by PE-sponsored entities is not grounds for government at all levels to target the REIT business model. Over 70% of MPT's tenants are not PE-owned hospitals, and most of those hospitals have used the proceeds from the sale of their real estate to MPT in ways that promote the strategic interest of their institutions, patients, and communities. It is unfortunate that REITs have been wrongly painted with the brush that colors PE firms. This is flawed logic and can only lead to flawed policy.

"Health over Wealth Act": Senator Ed Markey (D-MA) plans to introduce legislation that would effectively restrict MPT and other hospital REITs from owning hospital assets. The so-

called "Health over Wealth Act" confuses PE firms with hospital REITs, and incorrectly concludes that REIT business models, such as the sale-leaseback transaction, only exist as a tool for PE firms to exploit.[16] If this legislation ever became law, all hospitals would be cut off from a proven and efficient form of financing their operations. As discussed, through sale/leaseback transactions, hospital REITs provide more capital to hospitals than hospitals could ever get from traditional bank financing. Traditional bank financing with strict loan/ value ratios would limit how much capital the hospital could unlock from its real estate. Hospital REITs can provide 100% of the value of the real estate back to hospital operators. If hospital REITs are restricted from providing this source of long-term financial stability to all types of operators, more hospitals might be driven into bankruptcy or forced to raise expensive debt capital from institutions with interests that are both purely financial and very short-term. Both parties, the operator and REIT are engaging in a transaction that provides long-term benefits to both parties. The complaint in both not-for-profit and for-profit sale-leaseback transactions is that the communities, patients, and physicians are harmed when PE firms are involved as owners. It is argued that PE firms put their financial interests ahead of the interest of the community the hospitals serve. But it is illogical to blame the REIT for this problem.

REITs Are Not Private Equity: REITs do not operate as intentional conspiratorial handmaidens of private equity. The conflation of private equity with REITs such as MPT is sowing confusion as demonstrated most clearly in a letter sent from Senators Sheldon Whitehouse (D-RI) and Charles Grassley (R-IA) to leaders of Apollo Global Management, Leonard Green & Partners

[16] "The Health over Wealth Act | U.S. Senator Ed Markey of Massachusetts." *www.markey.senate.gov*, 3 Apr 2024, www.markey.senate.gov/healthoverwealth.

(Prospect Medical Holdings), and MPT in 2022 asking each company to explain their roles as private equity firms. MPT's inclusion in this inquiry demonstrates the confusion over differences between private equity firms and hospital REITs and the immediate need to set the record straight on MPT, its business model, the diversity of its portfolio, and the role it plays in providing hospitals nationwide and globally with critical capital to maintain high-quality healthcare.

The Value of REITs: While there are legitimate questions about private equity, hospital REITs such as Medical Properties Trust (MPT) provide significant value to troubled institutions. Hospital REITs buy the real estate of hospitals and then lease the facilities and land back to the hospital in long-term leasing arrangements. Hospitals get hundreds of millions in cash, which they can use (and in some cases must use) to improve the facilities, hire needed staff, and improve operations and quality. In other cases, the proceeds are used to repay debt or to fund returns to equity investors. Regardless of how the money is deployed, the REITs get a long-term lease with the hospital operator, but do not operate the hospital. Lease payments to MPT average 6.4% of hospital revenues. Many corporations outside of health care now have REITs as their landlords for buildings they once owned.

IV. The Real Problem Facing America's Urban and Rural Hospitals

Confusing Cause and Effect: It is easy for people to be confused about matters of cause and effect. It is only through understanding how things work that we can distinguish between the two. For example, to an outside observer looking at a gas-powered car, it would be easy to conclude that the wheels are the source of mobility. Their movement is readily visible, and as they move, the car moves. We know, however, that the engine is the source of the power, and the movement of the wheels is the result. Cause and effect.

Misguided Federal and State Efforts: Congress along with several States, including Connecticut, Rhode Island, Massachusetts, and Pennsylvania are considering legislation that would restrict the activities of private equity companies and Real Estate Investment Trusts (REITs) in the hospital industry. The motivation for this legislation includes growing worries about the financial health of hospitals, particularly safety-net hospitals serving low-income and rural communities. These safety-net institutions are experiencing reductions in both access and patient care quality while generating huge dividend payments to private equity company owners. Several for-profit hospital chains in these States have shut down or threatened to shut down while the private equity firms have made millions. However, this begs the question about the cause of the hospitals' faltering economic conditions.

In Connecticut, Prospect Medical Holdings operates the three financially troubled Eastern Connecticut Health Network (ECHN) hospitals in Rockville, Waterbury, and Manchester. Steward is in bankruptcy. ECHN and Steward were both previously sponsored by private equity companies, and both hospital systems sold their real estate to a hospital REIT.

The experiences of ECHN and Steward are not unique. While the aforementioned hospitals are still open, between 2010 and 2021, 140 non-MPT rural hospitals throughout the United States closed their doors. And hospitals in cities including Chicago, San Antonio, Seattle, and Los Angeles have gone out of business. The financial stress in rural and inner-city hospitals is clearly unrelated to REITs.

The Truth Behind Private Equity Acquisitions: The growth of private equity acquisitions and sale leasebacks are the result of the poor economics facing safety-net hospitals — not the other way around. There are more than 6,000 acute care hospitals in the United States. They are in rural

areas, urban areas, suburban areas, Native American reservations, and military facilities. Hospitals can be for-profit organizations or not-for-profit organizations. They may be secular or religious in their origins. Hospitals are challenging organizations to manage. Their fortunes depend on third-party reimbursement, a complex regulatory infrastructure, uncertain demand, rapid advances in technology, a plethora of licensed professionals, and deep ties with public and private sector leaders. Not all hospitals survive these challenges.

Low Medicare and Medicaid Reimbursement Rates: On average, if a hospital receives a dollar for a service from a private health insurance company, they will receive $0.60 from Medicare, $0.40 from Medicaid, and $0 from uninsured low-income relationships for that same service. Uncompensated care can represent 20% of the care delivered in these "safety-net" institutions, not because that is the market they are strategically pursuing, but because of where the hospitals are located. A recent study by the Congressional Budget Office confirms the substantial reimbursement differentials. National studies estimate that commercial insurers pay twice the prices paid by Medicare.[17]

Reimbursement Rates and Uninsured Patients Drive Hospital Closures: Urban and rural hospitals are closing and have been closing in communities because of their patient-mix. Without substantial philanthropic contributions, safety-net hospitals cannot cover their operational deficits, eventually leading to bankruptcy. Sale-leaseback funding has proven to be a successful long-term solution for operators that maintain or grow their profitability over time, manage their revenue cycle competently and grow their operations at a sensible pace. Sale leaseback transactions benefit both the buyer and the seller, otherwise they would not happen. In the absence of the advantages

[17] The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services (cbo.gov)

that many not-for-profit entities enjoy, such as charitable contributions and low borrowing costs, sale-leaseback transactions are their best option. This ability is not an obligation, but it is one of the advantages of REIT financing over traditional financing.

The Problem Is Reimbursement – Not REITs: There is no question that America's safety-net hospitals are in trouble. But it is important to understand this trouble started before private equity companies and hospital REITs entered the market. Congress, State legislators and others need to evaluate the legal environment for private equity in hospital acquisitions. However, there is no question that the financial problems facing safety-net hospitals are not the result of sale leaseback transactions. The problem is reimbursement. If we want urban and rural safety-net hospitals to survive and continue to provide services to low-income and undocumented residents, we need to pay hospitals appropriately for their services. Attributing blame to hospital REITs for the problems of safety-net hospitals is illogical, lacks an understanding of hospital economics, and is wrong. Any legislation in this area must discern the difference between cause and effect. If it does not, the legislation will make things worse.

The Solution Includes Reimbursement Reform and Supporting REITs: If we want to fix the financial problems facing America's urban and rural hospitals, government at all levels need to pay hospitals a fair price for the services they provide their patients.

V. Case Study – MPT

Basic Facts about MPT Business Model in the U.S.

As of March 31st, 2024:

- MPT owns 213 properties in 31 States

- The average number of licensed beds in MPT general acute facilities is 154 with a maximum of 744
- MPT owns 24 Behavioral Health facilities, 43 Freestanding ER/Urgent Care Facilities, 96 General Acute Care Hospitals, 31 Inpatient Rehabilitation Hospitals, and 19 Long-Term Acute Care Hospitals

As September 30th, 2023:

- 68% of MPT facilities are owned by for-profit enterprises
- 84% of MPT rent payments are paid by for-profit enterprises
- 29% of MPT rent payments are paid by operators owned by Private Equity
- 19% of MPT relationships are at least 1 month in arrears paying their rent with none over 5 months in arrears.
- The annual average rent as percentage of operator annual revenue is 6.4%
- The annual average rent as a percentage of Gross Book Value is 8.4%

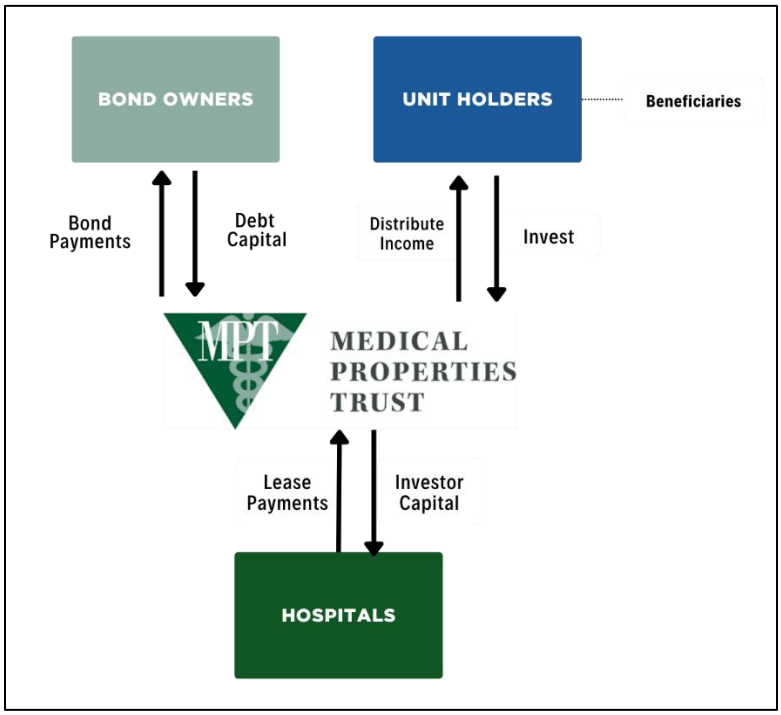


Figure 12: MPT Flow of Funds Model

MPT Investment Philosophy: MPT's business model is to acquire hospital and other healthcare real estate from the prior owners and lease the property back to the prior or a new operator. MPT's investment philosophy is:

- Meet the demand from hospital operators for licensed real estate appropriate for the highest acuity healthcare services;
- Agnostic as to the operator;
- As with any other landlord, if the tenant cannot pay rent, a new tenant is found;
- Rent payments do not change based on day-to-day operations; and
- Rent expense is a small portion of tenant's net revenue and remains generally fixed on an inflation-adjusted basis.

MPT Underwriting Process is Thorough and Diligent: The foundation of MPT's business model is built upon a best-in-class underwriting process designed to minimize risk and select properties with stable patient census and revenues. MPT carefully considers the physical quality of the property, the demographics of the market, the competitive landscape of the hospital and the operator, and the financial strength of the operator in its decision to acquire a property. MPT has developed market leading expertise in this critical underwriting skill. Without the alignment of these important determinants of the long-term financial health of an operator, MPT will not commit scarce capital to acquire hospital properties.

Overall High Performance of MPT's Portfolio: Over 70% of MPT's assets and liabilities are performing as planned, including its nearly 24,000 total beds in Europe. The troubled tenants, Steward (19% of assets) and Prospect Medical Holdings (6%), while in arrears, are working through their financial problems. We believe, MPT will be able to extricate itself from troubled tenants at the majority of the involved hospitals, either through re-tenanting, outright sale or by these institutions being successful in raising the necessary capital to become current with all their obligations, including rent owed to MPT.

Prime Healthcare – Demonstrating how sale leasebacks create value for hospitals

- MPT's first large general acute tenant
- Represented 31% of revenue in 2011
- One of best covering tenants at 5.2x TTM EBITDARM when MPT first started publishing tenant-specific coverages in 1Q22
    - Despite many years of rent escalations, coverage grew well beyond underwriting
- MPT capital – in both Sale-Leaseback and mortgage form - allowed Prime to reinvest in its own operations and the growth thereof

- Prime achieved financial strength that allowed them to issue a large amount of secured debt at a very attractive rate in late 2020
    - Prepaid $280mm in MPT mortgages in late-2020
    - Repurchased 11 facilities from MPT in 2022 for $360mm and another $100mm in 2023
    - Purchased 5 hospitals from MPT for $350mm in 2024 and will likely repurchase the remaining properties for $238mm
- **Bottom line is that MPT's model worked very well for both MPT and Prime. Profits to MPT and financial flexibility and predictability for Prime.**

VI. Conclusion

Recent political and media attacks on sale leasebacks in healthcare are based on a fundamental misunderstanding of the business model, the economic value it brings to hospital operator relationships, patients, communities, and the economics of the hospital real estate market. The erroneous conflation of the hospital private equity business model and sale leasebacks with REITs is due to the failure to distinguish between operators and landlords. Private equity firms in hospitals control the day-to-day operations of the hospitals they own or lease. Private equity owners of hospitals make a profit when hospital revenues exceed hospital costs, including rent or interest payments related to the real estate. REITs can be landlords to both public and private hospitals and make a profit when lease revenues from for-profit and not-for-profit tenants exceed capital and management costs.

This White Paper demonstrates to lawmakers, regulators, the financial media, and policymakers at the federal, State, and local levels that their attribution of the financial problems facing the nation's hospital industry is not due to the actions of hospital REITs but is primarily the result of financially devastating reimbursement policies. Like REITs operating in other industries in the U.S. and global economy, hospital REITs provide needed capital to owners of property.

Efforts to restrict the actions of healthcare REITs in hospital finance are likely to worsen the financial health of hospitals.

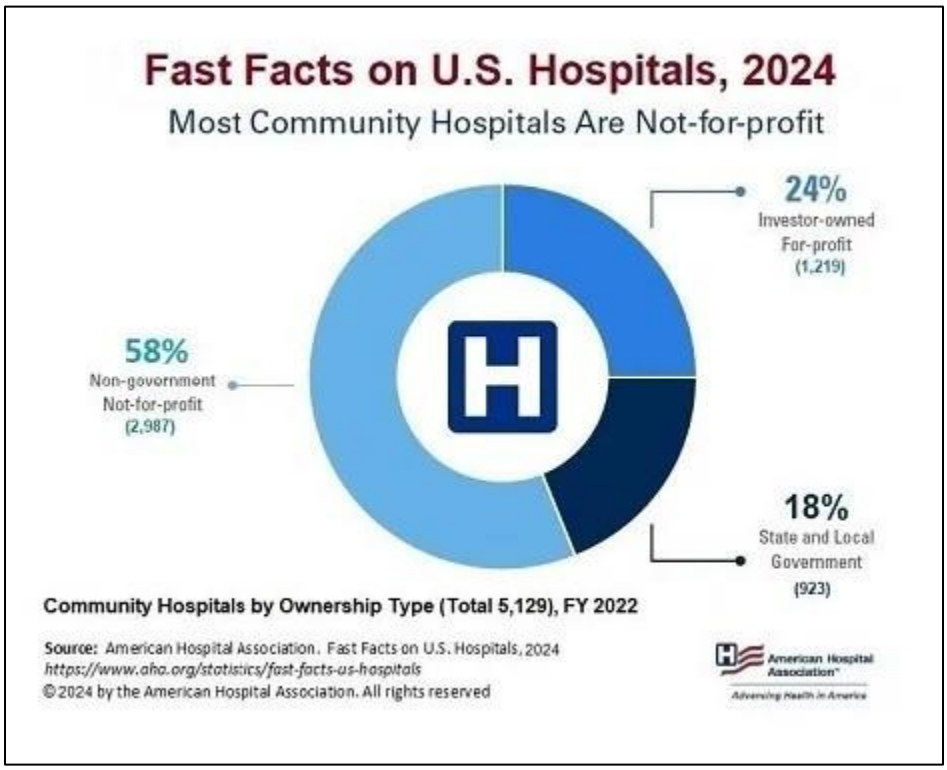
Hospital closures are the result of operating challenges, not financing structure. There are several examples of hospital failures over the past few years that had nothing to do with sale leaseback strategies. *Hospital REITs provide cost-efficient capital to finance critical community infrastructure***.** Through an accepted and established business model, REITs pay hospital operators the full value of their land and buildings, supplying permanent capital to hospital systems. This capital is available to the operator to increase and improve patient services, expand its outreach to additional patients, develop new facilities, recruit staff and physicians, invest in innovative technologies and equipment, and permanently repay expensive debt and implement steps to improve operations. Hospitals by their nature require costly real estate that must be funded with expensive capital. A sale and leaseback strategy allows hospital operators to redirect the cost of owning real estate to their primary mission of healing patients.

We also conclude based on the size of the hospital market (one million beds), the hospital sale/leaseback market is still in its early stage of development and is likely to grow significantly in coming years. Companies like MPT are in a great position to take advantage of these market conditions. Investors should take note the durability of the sale leaseback business model – even in the most challenging high interest rate environment in more than four decades. Policymakers at all levels of government should disavow linking medical REITs with private equity and preserve the ability of hospitals in all parts of the U.S. to have access to the sale-leaseback model as a potential ready source of capital depending upon the market conditions in which they operate. In fact, there is a strong case for government promoting the expansion of sale leaseback financing in hospital real estate markets. Hospitals are ultimately in the business of providing health care to

consumers. They are not in the real estate business and a focus on core competencies would improve the quality of care and lower the cost major payors like commercial insurers, Medicare and Medicaid pay for these essential services. Economic theory and modern business practices inform us that ultimately, consumers and payors should not care whether the facilities services are rendered are owned or are leased from a hospital REIT.

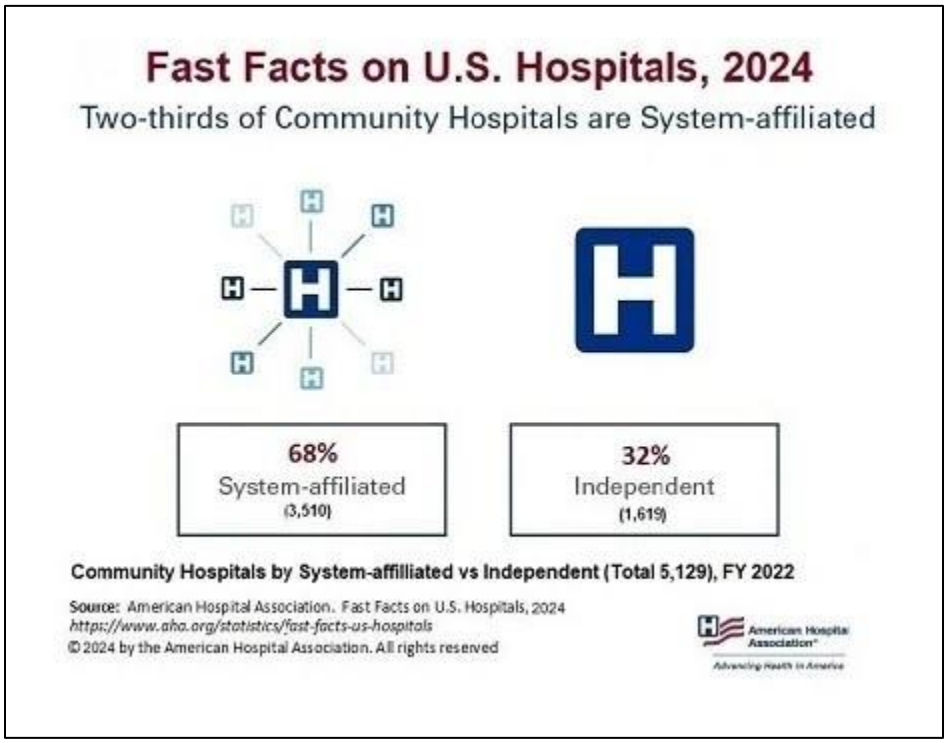
Appendix: Hospital Industry Overview

The hospital industry is the industry that key economic characteristics will strongly influence MPT's performance and their opportunity to grow. This section uses figures to highlight some of the major factors influencing the industry:



Appendix Figure 1: Hospitals by Legal Status[18]

[18] https://www.aha.org/statistics/fast-facts-us-hospitals



Appendix Figure 2: Hospitals by Affiliation[19]

[19] https://www.aha.org/statistics/fast-facts-us-hospitals

Appendix Figure 3: Hospitals by Location[20]

Appendix Table 1: National Hospital Revenue Payer Mix (2023)

(Source: Medicare Cost Reports)[21]

Payer	Total Net Revenue	Average % of Payer Mix
Medicare	$178 Billion	18.9%
Medicaid	$141 Billion	13.5%
Private/Self/Other	$759 Billion	68.9%
Total	$1,078 Billion	-

[20] https://www.aha.org/statistics/fast-facts-us-hospitals

[21] https://www.definitivehc.com/resources/healthcare-insights/breaking-down-us-hospital-payor-mixes

Appendix Table 2: Average National Cost of Producing One Hospital Beds[22]

Year	Cost per Square Foot
2019	$363
2020	$371
2021	$382
2022	$400
2023	$420

Appendix Table 3: Estimated Cost of Hospital Construction in Major Markets

City	Cost of Hospital Construction per Square Foot
Los Angeles	$640 to $970
San Francisco	$580 to $935
Washington, D.C.	$510 to $885
New York City	$510 to $885
Honolulu	$505 to $855
Chicago	$385 to $810
Denver	$600 to $800
Portland	$600 to $800
Seattle	$530 to $745
Boston	$465 to $735
Phoenix	$460 to $650
Las Vegas	$495 to $590

[22] https://www.bdcnetwork.com/healthcare-construction-costs-2023