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Financing Walkable Urbane Projects

by Christopher B. Leinberger

Over the past decade, much has been learned from urban designers and developers such as J.C. Nichols (Country Club Plaza in Kansas City), George Merrick (Coral Gables, Florida), and the Rockefeller family (Rockefeller Center). They have become role models to be emulated in the revival of downtowns, suburban town centers, new urbanist projects, transit-oriented developments, and lifestyle centers throughout the United States. While attention has focused primarily on the urban design lessons they have taught us, there are financing lessons they can teach us as well.

The most important financing lesson is to recognize that real estate has always been a long-term asset class. The U.S. Internal Revenue Service dictates that structures are depreciated over 39 years. The U.S. National Park Service, the agency that designates historic tax credits, considers buildings historic if they are more than 50 years old. One reason downtowns lately are reviving so quickly is the positive market response to the rehabilitation of historic structures—buildings whose quality of construction could never be matched today. However, over the past half-century real estate has changed. Today, most real estate projects have a seven- to ten-year life as a Class A property—the result of a reduction in the construction quality of projects and the building of commoditized, single-purpose product.

To build projects like Country Club Plaza or Rockefeller Center—mixed-use projects erected in walkable environments—something in short supply today was undoubtedly employed: patient equity. Patient equity is the capital committed to a development or redevelopment budget that does not have a defined payback. To many today it is an oxymoron—since equity is the most expensive and, therefore, most impatient of all capital. However, patient equity in the past was generally required to move a project forward, but also used because of the pride taken in building something that J.C. Nichols called of “enduring value.”

Proper financial structuring in the early stages of a project’s life entails lining up the required equity and debt. Not planning for an essential source of equity could result in minimizing a project’s financial performance or even financial disaster. If patient equity is a requirement, not providing enough of it can jeopardize the project and the developer’s financial future.

It is important to distinguish between the two forms of real estate development. Revitalizing a downtown, developing a new urbanist project, or building a mixed-

use lifestyle center requires creating a walkable urbane place where most or possibly all of life's daily needs (shopping, recreation, school, restaurants, employment, etc.) are reachable on foot or by mass transit. The preconditions for a walkable urbane place include:

- significant residential uses within walking distance of local-serving retail and a park;
- a continuously pedestrian-friendly and safe walk;
- an average net residential density of at least eight dwelling units per acre (20 per ha) to support local-serving retail and transit (planned or currently available); and
- being within walking distance of work for at least one household member or within walking distance of transit that links the household to employment. Walkable urbanity is in contrast to conventional suburban development, which is exclusively based upon car transportation, separation of uses, and low density.

The purpose of developing walkable urbane places is to allow for walking to be the preferred method for the majority of trips from a residence, though there are multiple transportation options available, including the car. The resulting density for walkable places is a floor/area ratio (FAR) of more than 1.0 in a suburban town center or new urbanist suburban project, 3.0 to 4.0 in a mid-sized downtown, and as high as 40.0 in downtowns like Manhattan, London, or Shanghai. In sharp contrast, the FAR of conventional suburban development is between 0.05 and 0.30.

Generally, walkable urbane places have higher construction and land costs as well as higher financial risks, which translates into higher financing costs, than conventional suburban development. There are a number of reasons for this, some structural and others temporary, including lack of investor experience with walkable urbane projects; prices that may be higher than comparables in the market; need for a critical mass of mixed-use product to ensure success, which might not be in place yet; a larger number of units or square footage delivered per phase than conventional development; intensified NIMBY opposition; and increased entitlement risk.

The net result is that it is significantly more difficult to finance walkable urbane projects.

But patient equity pays for these increased costs and mitigates the risks. Patient capital is additive; it is layered on top of a conventional development budget, as shown in Figure 1.

Figure 1: Comparison of Conventional Suburban Financing with Walkable Urbane Project Financing Structure

	Conventional Project		Walkable Urbane Project	
Conventional equity	\$200,000	20%	\$200,000	16.6%
Debt	\$800,000	80%	\$800,000	66.7%
Patient equity	\$0	0%	\$200,000	16.6%
Total	\$1,000,000	100%	\$1,200,000	100.0%

A development budget consists of equity and debt. Conventional equity expects a 20 to 30 percent internal rate of return (IRR), has ownership of the project, provides the construction guarantee, and generally is 20 percent plus or minus of the total development budget. When patient equity is added to the mix, the conventional equity takes on a different role with a different return. When patient equity is provided, the conventional equity is referred to as “first tranche” equity or mezzanine debt. In exchange for having additional (patient) equity in the project—which is behind the first-tranche equity in cash flow priority—and no financial guarantees of the construction loan (which the patient equity provides), the first-tranche equity or mezzanine debt will receive a lower rate of return and no ownership. Instead, it will receive 100 percent of the after-debt-service cash flow until both the negotiated cumulative or noncumulative rate of return is achieved and the principle is returned. Currently, first-tranche equity or mezzanine debt receives between 10 and 12 percent priority return.

With the retirement of the first-tranche equity, 100 percent of the after-debt-service cash flow of the project is available for the patient equity providers. It can be expected that first-tranche equity is retired between three and seven years of the project’s life, so the patient equity providers have to wait until then for financial returns.

The conventional debt provided for a project with patient equity will probably stay about the same in absolute dollar terms, but will be a proportionally smaller piece of the total development budget, as shown in Figure 1. This could result in a potentially major benefit. If the debt-to-value ratio drops from the conventional 80 percent to, say, 66 percent as shown in the above example, there is the possibility that the bank will not require as much of a construction loan guarantee or any at all, i.e., it becomes a nonrecourse loan. This is due to there being significant equity (patient equity plus first-tranche equity or mezzanine debt) in front of the debt on the project. While there is no established market for pricing the value of providing a construction guarantee, it is certainly worth at least 25 percent of the ownership in the project and sometimes more. This is a considerable financial benefit to the developer if a construction guarantee is not

required or even if the guarantee required can be negotiated to “burn off” faster than normal.

So why would a patient equity provider trade off a lower-risk, short-term return for a higher-risk, mid- to long-term return? Because there could be significantly higher cash flows as the project matures. Unlike conventional development where cash flows have been hybridized to be loaded at the front end—the result of lower construction costs for simple commoditized product—it appears that cash flows from walkable places get better over time. Value spirals upward as the critical mass of a walkable place is achieved and enhanced. As more development takes place within walking distance, there are more people on the street and therefore rents and sales prices go up, resulting in land and building values rising, which leads to increased cash flows and so it continues upward as more development is added to the area. However, it generally takes time to achieve critical mass or expand the walkable district, hence the time lag in cash flow generation.

During the late 1980s, Mobil Land, the real estate subsidiary of Mobil Oil, owned the master-planned community of Reston, Virginia, located on the Dulles Tollroad in the Washington, D.C., metropolitan area. At the intersection of Reston Parkway and the tollroad, a roughly 200-acre (81-ha) greenfield site had been planned for a town center for the master-planned community growing rapidly around it. The form that the town center took was unlike anything developed in the postwar era of the United States. It is composed of a Main Street with sidewalks and parallel parking on both sides of it; buildings come right up to the sidewalks, with hidden decked parking supporting the 770,000 square feet (71,628 sq m) of office, hotel, and retail space developed in the first phase.

When it opened in 1992, it immediately became a “place,” achieving critical mass and becoming a favorite destination for Fairfax County residents as well as tenants. The second phase of 900,000 square feet (83,721 sq m) of office space added in 1997 increased the town center’s walkability. However, it was with the addition of thousands of condominium and rental apartments, as well as additional office and retail space, during the late 1990s and early part of the 2000s, that confirmed Reston Town Center’s role as a major regional-serving, walkable urbane place—what the current owner refers to as “a downtown for the 21st century.”

Though an analysis of the entire investment over the life of the development has not been undertaken, the current rental rates and sales prices shown in Figure 2 demonstrate the premium that walkable urbane places command.

Figure 2: Comparison of Reston Town Center Rents and Sales Prices with the General Reston Area and the Dulles Corridor in Dollars per Square Feet; Second-Quarter 2006

	Office		Condominium	Retail
	Rents/SF	Vacancy	Rents/SF	Rents/SF
Reston Town Center	\$40–\$45 (gross)	0%	\$550–\$575	\$50–\$60 (triple net)
General Reston area	Mid \$30s	3%	\$340–\$475	\$35–\$40
Dulles corridor	High \$20s	12%	No product	Mid \$30s

Reston Town Center is the only walkable place in the surrounding market. The general Reston area and the Dulles corridor are composed of single-purpose product and require a car for all transportation needs. Taking the midpoints of the rental and sales price ranges in Figure 2 shows a nearly 50 percent price premium for Reston Town Center over the rest of the market.

In Albuquerque, New Mexico, the Historic District Improvement Company (HDIC) developed the Century Theatre Block as a catalyst to help revitalize downtown. When it opened in November 2001, it consisted of a 47,000-square-foot (4,372-sq-m), 14-screen movie theater; 25,000 square feet (2,325 sq m) of retail; and 25,000 square feet (2,325 sq m) of office space in a mixed-use, walkable form. Initially, HDIC proposed the project as a joint venture with a major international development firm, which produced financial projections. The projections assumed conventional suburban construction quality and tenant improvements as well as suburban rental rates.

It became obvious to HDIC that the quality of the development as proposed would not be sufficient to catalyze the revitalization of downtown and the joint venture was dissolved. HDIC became the sole developer and built a project that had a 40 percent higher construction and tenant improvement budget than the conventional budget. This required additional equity: patient equity. The development budget became 5 percent conventional equity, 67 percent debt, and 27 percent patient equity. The patient equity included HDIC cash, land, structured parking, and developer fees. It achieved developer nirvana: the construction loan was nonrecourse due to the high proportion of equity.

The resulting comparative cash flows between the conventional joint venture development and the final project are shown in Figure 3. (Only the nontheater cash flows are shown since the theater construction costs and lease were the same under both scenarios.)

The early actual returns from the final project were, in fact, lower than the conventional projections; however, cash flows have recently surpassed those projections and seem set to significantly surpass them in the future, pointing to the pent-up demand for higher-quality walkable product. Most of the early cash flow went toward repaying the principal and interest of the conventional equity providers, who should be completely paid off by 2007. Nearly 100 percent of the cash flow will then accrue to HDIC, which will see the mid- to long-term cash flow the project is forecasting.

Going public as a real estate investment trust (REIT) in 1993 as a spin-off of Trammell Crow Residential, AvalonBay has always concentrated on building and owning rental apartment projects in markets with high barriers to entry. Many times that has involved developing and owning in walkable urbane districts, such as downtown Stamford, Connecticut, and San Francisco, or transit-oriented Ballston, an Arlington, Virginia, neighborhood on the Metro subway line in the Washington, D.C., area. As a result, over half of AvalonBay's portfolio is in walkable urbane locations. AvalonBay, consistently one of the nation's more profitable apartment REITs, achieved this long-term financial performance while providing short-term, high shareholder returns.

There are many sources of patient equity, including land/buildings, developer fees, parking improvements, off-site improvements, professional fees, and, always preferred, cash. The providers of patient equity are broad based and include land/building owners, the project's developer, investment allocated to venture capital by institutions, REITs with strong current cash flow, individual investors, nonprofit organizations—especially if long term-oriented investment might fit the nonprofit's philanthropic mission—and state and local governments.

The amount of patient equity that should be invested in a project will naturally vary from project to project. However, experience seems to indicate that somewhere in the range of 10 to 30 percent of the development budget should be patient equity. The increased patient equity in a walkable urbane project is used to heighten construction quality and pay for the additional time to obtain entitlements and other issues mentioned above. The patient equity lowers the inherent risk of developing walkable, mixed-use projects and places. Having the project less leveraged may result in less of a need or no need for a construction loan guarantee, allowing the patient equity providers to own more of the project. The developer of a project with patient equity has a much better chance to maintain ownership and not have to sell the project to cash out the conventional equity provider, as is often the case.

Most walkable urbane projects today probably use more patient equity upfront than their developers recognize, since it seems to be a requirement for mixed-use, walkable developments. However, investing patient equity was not what most developers set out to do; since projects required it, it was put into the deal incrementally. It is time to recognize that patient equity is a necessity and should

be planned for upfront. The need for this type of equity to create the walkable places the market is demanding also creates cash flow potential for years to come. As such, we might just see real estate become a long-term asset class once again.

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