

# Medical Office Building Appraisal

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There are numerous and significant differences between medical office buildings and standard office buildings that must be considered, researched, and addressed by appraisers. Overlooking these differences can lead to a faulty appraisal. In addition, hospital proximity and the financial condition of any adjoining hospital must be examined in detail. While largely unknown, the effects of the proposed political transformation of the health care industry are also significant.

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**E**ven when equipped with a complete understanding of how to appraise a standard office building, to appraise a medical office building an appraiser must thoroughly understand the many characteristics that make us appraisal unique.

Not only do the physical, financial, and external influences of medical office buildings (MOB•) differ significantly from standard office buildings, but the recent proposed changes in the medical and political arenas add to the complexity of these appraisal assignments. All of these factors combined make appraising medical office buildings a specialty within the appraisal profession.

There are three main topics that relate to the appraisal of MOBs 1) the unique characteristics that differentiate them from standard office buildings; 2) the effects of hospitals and hospital proximity on MOBs, and 3) the current medical

and political climate, which may alter some of the fundamental aspects of MOB appraisals.

## UNIQUE CHARACTERISTICS OF MOBS

There are many unique characteristics that differentiate a MOB from a standard office building. From an investor's perspective, a well-positioned and well-managed MOB represents a relatively secure investment opportunity, as there is always a demand for medical care. Of course, values of investment-grade properties vary, but within the Los Angeles area recent transactions of investment-grade MOB, have ranged from \$120 per square foot to \$220 per square foot. This is significantly higher than standard office space, which often sells for less than \$100 per square foot. Recent sales indicate sale prices ranging from approximately \$2 million to over \$12 million.

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### Medical office income and expenses

As is generally known within the commercial real estate industry, MOBS lease at higher rates than standard office buildings. A sample of various rental surveys conducted by the author in the course of appraising such buildings indicates that MOBS lease for approximately 20% to 100% higher than surrounding standard office space.

Not only are rental rates generally higher, but a MOB has substantially higher expenses than a typical office building. For this reason, standard office expense comparables or office expense publications are not appropriate for use in a MOB appraisal. Some expense publications do include special studies of medical buildings; however, close examination of these surveys often indicates that the data are too diverse to be of real value. The only acceptable source for a MOB expense analysis is expense comparables of similar medical buildings in the vicinity of the subject property.

Table 1 sets forth the averages of seven operating expense comparable properties from the Los Angeles and Orange County, areas and compares them with standard office operating costs. For this analysis, all expenses have been divided into seven main categories for uniform comparison. Overall, MOB expenses are nearly 17% higher than typical office building expenses. The greatest variance occurs within the categories of management, which is approximately 25% higher, and utilities,

which are nearly 20% higher than a standard office building. The combined higher rental rates and operating expenses generally result in a higher net operating income (*NOI*) per square foot compared with a standard office building.

Tenant improvement allowances also tend to be considerably higher than standard office buildings. According to a study of five recently constructed medical office buildings in the southern California area, construction costs of new standard tenant improvements are from \$20 to \$25 per square foot, but range from \$35 to \$45 per square foot for a medical office building. This is primarily caused by the doctors' demands for extensive plumbing, numerous restrooms, examination rooms, and cabinets. It is not uncommon for medical buildings to include lead-shielded floors, walls, and ceilings to enclose magnetic scanning and x-ray equipment.

Not only are operating expenses and tenant improvements higher for MOBS, but construction costs are also considerably higher. Table 2 shows MOB construction costs versus standard office building construction costs, using standard base construction costs from Marshall & Swift<sup>1</sup>. This analysis clearly quantifies the expected result: MOB construction costs range from approximately 8% to 43% higher than a standard office building.

### Homogeneous tenant mix

A strong core of doctors situated in one location will attract other doctors because of the advantages of close medical associations and the efficiency of inter-office referrals.

**TABLE 1 Medical Office Building Expense Analysis**

	Medical Office Average	Standard Office Average	Percentage Difference
Taxes	per Assessments		
Insurance	\$0.31	\$0.33	-6.06%
Management	\$1.46	\$1.17	24.79%
Maintenance	\$2.27	\$2.10	8.10%
Security	\$0.16	\$0.15	6.67%
Utilities	\$2.45	\$2.05	19.51%
Reserves	\$0.37	\$0.20	85.00%
<b>Total</b>	<b>\$7.02</b>	<b>\$6.00</b>	<b>17.00%</b>

1. Base costs are construction costs prior to adjustments such as for size perimeter, indirect costs, trend multipliers, and current and local costs.

**TABLE 2 Base Cost Analysis Medical Office Space versus Standard Office Space**

Class	Type	Standard Office Base Cost per Square Foot	Medical Office Base Cost per Square Foot	Difference	Percentage Difference
A	Excellent	\$120.03	\$131.80	\$11.77	9.8%
	Good	\$ 96.51	\$106.49	\$ 9.98	10.3%
	Average	\$ 72.69	\$ 81.82	\$ 9.13	12.6%
	Low Cost	\$ 58.59	\$ 63.14	\$ 4.55	7.8%
B	Excellent	\$115.52	\$127.26	\$11.74	10.2%
	Good	\$ 92.75	\$102.68	\$ 9.93	10.7%
	Average	\$ 69.16	\$ 78.62	\$ 9.46	13.7%
	Low Cost	\$ 55.53	\$ 60.52	\$ 4.99	9.0%
C	Excellent	\$ 97.54	\$108.55	\$11.01	11.3%
	Good	\$ 68.90	\$ 82.40	\$13.50	19.6%
	Average	\$ 49.52	\$ 62.86	\$13.34	26.9%
	Low Cost	\$ 33.72	\$ 48.12	\$14.40	42.7%
D	Excellent	\$ 86.64	\$ 94.47	\$ 7.83	9.0%
	Good	\$ 62.30	\$ 75.77	\$13.47	21.6%
	Average	\$ 44.66	\$ 57.06	\$12.40	27.8%
	Low Cost	\$ 31.64	\$ 44.68	\$13.04	41.2%
			Range	7.8%	42.7%
			Mean		17.8%
			Median		25.2%

source: Marshall & Swift Cost Services, 1992 Base Costs. Used by permission.

Office buildings that contain both medical office uses and standard office uses tend to perform poorly.

For example, in a recent appraisal of a MOB located in Santa Monica, a broker stated that a prospective tenant was lost to a competing building that was entirely occupied with tenants practicing in the medical field. The broker indicated that the doctor was willing to pay \$0.05 per square foot per month more in rent and take \$5.00 per square foot less in tenant improvements to be located in the 100% medical building rather than the mixed-use building.

**Doctors as tenants**

The dynamics of the physician population are also affecting the market for medical space. Physicians are forming larger medical group practices because of such factors as higher operational costs, increased competition, and the advent of the Health Maintenance Organizations (HMOs), resulting in a shift in demand away from small 1,000-square-foot spaces toward large 2,000- to 8,000-square-foot office areas. Many of these groups are even purchasing their own buildings. Increased physician competition is making doctors increasingly cost conscious, resulting in lower space requirements per physician.

**Full service gross versus net leases**

Some doctors choose not to be represented by a broker. As a result, some MOB managers market medical space, using net prices with the goal of making their buildings appear more attractive than buildings that are leasing on a full-service gross basis, hoping that doctors do not understand the difference.

**Usable versus rentable square feet**

In the 1970s and 1980s, several groups of doctors throughout southern California actually began to measure their medical suites, and were somewhat concerned that their leases stated rentable size, which was of course larger than the suites' actual usable size.

To avoid misunderstandings, many medical building owners and managers began writing leases based on usable rather than rentable square footage. Today the trend is in the opposite direction, with rentable square footage being the predominate standard. As a result of these practices, it is essential that an appraiser pay close attention to this issue when conducting rental surveys to ensure that all data are compared on a uniform basis of either rentable or usable areas. As with the appraisal of any office property, it is important to obtain building efficiency ratios

during the rental survey, so that an accurate comparison can be made between the subject property and rental co comparables

### **Nonmarket lease transactions**

Hospitals, commonly faced with decreased revenue per patient, are seeking to increase patient volume, resulting in increased competition between hospitals. Doctors, who are typically the decision-makers in patients' hospital selection, are hospitals' primary customers. One technique employed by hospitals to attract physicians is to provide competitively priced high-quality MOB space. Hospitals thus often become a significant force in the supply and pricing of MOB space.

In addition, many MOBS are leased by doctors who are also joint partners or owners of the same building. An appraiser must always address and research these factors to avoid using distorted medical rental comparables where there is not a true arm's-length transaction.

The Americans with Disabilities Act (ADA) sets forth regulations requiring building owners to make buildings more accessible to physically disabled persons. MOBS are often in compliance with the ADA because, by their very nature, they must accommodate these individuals, and often have construction codes that meet or exceed ADA requirements. An appraiser must be particularly sensitive to the requirements of the ADA, as compliance or noncompliance has an added impact on the value of a MOB.

### **Elevators**

Elevators are a subtle but important factor in the utility of a MOB, as elevators must be larger than typical elevators to accommodate numerous patients who are unable to use stairs. A higher concentration also is needed because of inter-floor traffic (e.g.- patients between doctors' offices, pharmacies, and laboratories; persons traveling with data between offices to laboratories and imaging suites; the continuous flow of patients throughout the day).<sup>2</sup>

Elevator availability is measured in terms of elevators per 1,000 square feet.

In other words, a 100,000-square-foot building with four elevators has a ratio of 0.04. Better MOBS have an elevator ratio of 0.05 or higher.<sup>3</sup>

### **Parking ratios**

A typical MOB has approximately four to five parking spaces per 1,000 square feet of net leasable area. A desirable level may be even 6:1,000 or more. The determining factor for the amount of parking provided is usually local building codes; nevertheless, developers should not be governed solely by minimum requirements in the provision of parking, and appraisers should not necessarily assume that parking code compliance means that there is adequate parking. If necessary, an appraiser should inspect the parking adequacy during peak hours, to ensure that the MOB accommodates parking nerds. Parking issues, along with the availability of mass transit, should be addressed for the subject property the rental comparables, and the improved market data.

### **Retail tenants**

Retail tenants often enhance MOBS. Strong ground-floor tenants in an area of high pedestrian traffic will produce substantially higher effective rents than the medical office space on the upper floors. A strong tenant such as a pharmacy may produce as much as triple the amount paid by typical medical tenants. A well designed building will arrange its parking so that the patients pass through the retail areas on at least two occasions on every visit.

As a practical matter, when an appraiser provides a fee quote, he or she should be aware that the job may include separate rental surveys for retail space, and should charge accordingly,

### **Capitalization rates, discount rates, and absorption**

Capitalization and discount rates are often similar for medical and standard office buildings; however, these rates must always be derived from comparable medical market data rather than from published surveys of standard offices. Further, MOBS often differ significantly from standard office buildings in their absorption rates, which should only be derived from studies of new medical office construction or re-leasing activity within an existing MOB.

*One technique employed by hospitals to attract physicians is to provide competitively priced high quality MOB space.*

2. Arthur E Gimmy, "The Doctor's Office – An Intimate Examination," *The Appraisal Journal* (October 1975): 527-539

3. Gimmy, 52N

## THE IMPACT OF HOSPITALS ON MEDICAL OFFICE BUILDINGS

A proper analysis of hospital activity is absolutely critical when appraising a MOB. A hospital and its surrounding MOBS are inherently interdependent, and the economic health of a MOB depends directly on a hospital's financial viability. Clearly, a MOB located adjacent to a financially healthy hospital would be expected to perform better than a MOB that is adjacent to a hospital experiencing financial difficulties. This is an increasingly important factor today, as many hospitals are consolidating under current cost reduction programs.

## Hospital proximity and vacancy

Hospital proximity has a direct impact on the financial viability of a MOB. As shown in Table 3, a recent survey by the author indicated that of a random sampling of nearly 1.8 million square feet of medical office space, approximately 147,000 square feet, or 8.6%, was vacant. Of more importance, however, is the dramatic difference between the vacancy rates of MOBS located near hospitals and MOBS not located near hospitals. MOBS located in proximity to hospitals have a vacancy rate of 1.7%, while MOBS not located close to a hospital have a vacancy rate of 34.6%. Clearly, this study indicates that proximity to a hospital has a significant impact on the occupancy rate of a MOB.

**TABLE 3 Medical Office Vacancy and Hospital Proximity**

Number	Location	Size (in square feet)	Vacancy (in square feet)	Percentage Vacant	Rental Rate	Expenses per Year	Increases	Year Built	Hospital Proximity
1	Torrance	35,050	0	0.00%	\$2.37 R	\$8.00	CPI	1976	Yes
2	Torrance	51,713	1,085	2.10%	\$2.46 R	\$9.00	CPI	1970	Yes
3	Torrance	61,835	8,212	13.28%	\$2.46 R	\$9.00	CPI	1973	Yes
4	Torrance	31,000	1,022	3.30%	\$2.35 R	\$8.00	CPI	1981	Yes
5	Torrance	41,422	2,437	5.88%	\$2.15 R	\$7.50	CPI	1981	Yes
6	Torrance	40,769	1,564	3.84%	\$2.15 R	\$7.50	CPI	1981	Yes
7	South Bay	60,404	21,596	35.75%	\$2.15 R	\$7.50	CPI	1985	No
8	South Bay	51,999	29,047	55.86%	\$2.15 R	\$7.50	CPI	1983	No
9	South Bay	35,115	974	2.77%	\$2.00 U	\$8.00	CPI	1966	Yes
11	South Bay	45,661	25,352	55.52%	\$2.14 R	\$7.37	CPI	1990	No
12	South Bay	18,000	2,200	12.22%	\$2.00 R	\$4.80	CPI	1989	No
14	South Bay	79,000	0	0.00%	\$2.35 R	\$8.00	CPI	1973	Yes
15	South Bay	52,057	0	0.00%	\$2.30 R	\$7.00	CPI	1990	Yes
16	Redondo Beach	46,000	0	0.00%	\$2.50 R	\$8.00	CPI	1990	Yes
17	Rolling Hills Estates	31,000	8,000	25.81%	\$2.00 R	\$6.65	CPI	1968	No
18	San Pedro	10,500	525	5.00%	\$2.00 R	\$8.50	10%	1984	Yes
19	Long Beach	17,000	0	0.00%	\$2.20 R	\$8.00	CPI	1986	Yes
20	Los Angeles	91,430	1,800	1.97%	\$2.17 R	\$8.25	CPI	1980	Yes
21	Los Angeles	73,414	0	0.00%	\$1.95 R	\$9.00	CPI	1989	Yes
22	Los Angeles	153,000	38,250	25.00%	\$2.75 R	\$9.00	CPI	1967	No
23	Los Angeles	331,038	0	0.00%	\$3.50 R	\$8.00	Flat	1978	Yes
24	Los Angeles	72,861	0	0.00%	\$2.45 R	\$8.19	CPI	1986	Yes
25	Los Angeles	54,300	0	0.00%	\$1.75 R	\$7.00	CPI	1987	Yes
26	Los Angeles	100,000	5,000	5.00%	\$1.95 R	\$8.00	CPI	1977	Yes
27	Harbor City	32,740	0	0.00%	\$2.35 R	\$9.43	CPI	1982	Yes
28	Inglewood	102,572	0	0.00%	\$2.00 R	\$8.00	CPI	1973	Yes

R = Rentable square feet

U = Usable square feet

	Total Square Feet	Vacant Square Feet	Percentage Vacant
Overall vacancy	1,719,880	147,064	8.6%
Vacancy—not by hospital	360,064	124,445	34.6%
Vacancy—near hospital	1,359,816	22,619	1.7%

This situation may be explained by a number of factors, including a doctor's travel time. To illustrate, assume that a doctor's income is \$150 per hour. A savings of only 30 minutes per day in travel time can result in an annual income potential of as much as \$18,000. Clearly, a doctor's incentive to locate close to a hospital is high.

### Hospital beds and adjoining MOBS

While a direct correlation between the size of a hospital and the number of surrounding MOBS may be expected, this is not necessarily the case. Table 4 illustrates the results of a study conducted to determine whether there is a correlation between total medical office space and the size of adjoining hospitals. The survey of nine randomly selected hospitals found a range of square-feet-per-bed ratios from 41 to 1,010. As this information suggests, there is not necessarily a correlation between licensed hospital beds and the total amount of adjoining medical space. The lack of correlation is a result of the wide variety of hospitals' specialties, agendas, physician requirements, and profit status, which have an impact on the demand for surrounding MOB space. This means that each hospital must be studied individually,

### Sources and uses of hospital financial statements

While hospitals often have a public relations department that provides financial statements, an excellent source for hospital financial data is state agencies, which monitor and regulate

hospitals and publish detailed hospital financial information as well as a glossary of terms that is often used in hospital operations. In California this information is published by the Office of Statewide Planning and Development,

Appraisers must have access to these financial statements and be familiar with the various financial terms when investigating the financial status of a hospital that adjoins the MOB being appraised. For example, a frequently used term in a hospital financial analysis is the cost-to-charge ratio. It is the quotient of cost (total operating expenses minus other operating revenue) divided by charges (gross patient revenue) expressed as a decimal, in other words, a cost-to-charge ratio of 0.50 means that the hospital incurred 50 cents of cost for every dollar of charges. This ratio is a quick reference in determining the financial status of a hospital,

Table 5 shows an overview of hospital statistics in California and illustrates the usefulness of state-published data. For example, note that Orange County has the lowest occupancy rates for both available and licensed beds, while San Diego County has the highest occupancy rates. Investor-owned hospitals operate at approximately 42.2% occupancy, while county / city-owned hospitals operate at 73.3% occupancy. However, investor-owned hospitals operate on the lowest cost-to-charge ratio of 0.45 and county / city-controlled hospitals operate on the highest cost-to-charge ratio of 0.70. All of this information is important when evaluating the health of a hospital and an adjoining MOB; this is only a small fraction of what is available for review in state published reports.

**TABLE 4 Medical Space and Hospital Beds**

Number	Hospital Location	Total Hospital Beds	Total Adjoining MOB Square Feet	Square Feet per Bed Ratio
1	Inglewood	365	149,278	409
2	Torrance	345	348,592	1,010
3	Torrance	216	131,057	607
4	San Diego	258	10,500	41
5	San Pedro	380	243,070	640
6	Los Angeles	1,120	331,038	296
7	Los Angeles	386	100,000	259
8	Los Angeles	259	32,740	126
9	Harbor City	403	102,572	255

SOURCE: Orell Anderson, unpublished medical office building study, November 1993

**TABLE 5: Quarterly Aggregate Hospital Data for California : Four Quarters Ending 3/31 /93**

Capacity and Utilization									
County	Number of Hospitals	Licensed Beds	Available Beds	Patient Days	Inpatient Discharges	Occupancy (Licensed Beds)	Occupancy (Available Beds)	Outpatient Visits	
Los Angeles	154	33,322	30,204	6,038,659	952,654	50.00%	55.10%	8,195,217	
Orange	44	7,974	7,413	1,193,264	223,998	42.10%	45.20%	1,969,326	
Riverside	21	3,454	3,181	595,346	113,257	50.00%	54.50%	1,329,784	
San Bernardino	21	3,428	3,285	685,682	126,255	54.80%	57.20%	1,289,193	
San Diego	35	7,114	6,657	1,476,019	228,795	56.00%	60.70%	2,426,193	
Ventura	12	1,730	1,631	336,935	53,709	53.40%	56.60%	696,791	
<b>Total</b>	<b>287</b>	<b>57,022</b>	<b>52,372</b>	<b>10,326,405</b>	<b>1,698,968</b>			<b>15,906,504</b>	
<b>Mean average</b>		<b>9,504</b>	<b>8,729</b>	<b>1,721,068</b>	<b>283,161</b>	<b>51.20%</b>	<b>54.88%</b>	<b>2,651,084</b>	
<b>Statewide</b>	<b>547</b>	<b>94,123</b>	<b>84,985</b>	<b>17,460,524</b>	<b>2,827,994</b>	<b>51.30%</b>	<b>56.90%</b>	<b>32,598,842</b>	
<b>Type of Control</b>									
Nonprofit		54,429	48,812	10,649,026	1,770,483	53.90%	60.20%	20,618,434	
Investor		22,534	21,634	3,252,049	517,283	40.60%	42.20%	3,679,572	
County/city		9,990	8,107	2,162,735	320,056	59.40%	73.30%	5,070,794	
District		7,170	6,432	1,396,714	220,172	53.50%	59.60%	3,230,042	
<b>Statewide</b>	<b>547</b>	<b>94,123</b>	<b>84,985</b>	<b>17,460,524</b>	<b>2,827,994</b>	<b>51.30%</b>	<b>56.90%</b>	<b>32,598,842</b>	
<b>Mean average</b>		<b>23,531</b>	<b>21,245</b>	<b>4,365,131</b>	<b>706,999</b>			<b>8,149,711</b>	

source: California Office of Statewide Health Planning and Development, March 31, 1993.

In addition to the general statistics, most states also publish a complete year end financial income and expense analysis for all hospitals in that state. In California this is called the *Disclosure Report Facsimile*, and includes 20 to 25 pages of information that directly relate to each specific hospital,

Because the financial viability of a MOB is directly linked to hospital proximity and the financial status of adjoining hospitals, the scope of any MOB appraisal must include a thorough analysis of these factors.

### **POLITICAL ISSUES**

Details of a national health plan are beginning to unfold. Some proposals promise the American people that the 37 million uninsured Americans will be insured, and that current expense levels for 220 million insured Americans will remain unchanged. This is to be accomplished by an increase in the tax on cigarettes of \$0.70 to \$0.80 per pack, and a reduction in the cost of Medicare and Medicaid. This plan has been heavily criticized, as the nation's wealthy cannot finance free health care for the poor, and there is not enough untaxed revenue to generate the shortfall. That leaves primarily the middle class to finance the plan.

Many doctors and health officials are concerned about the government's intervention in the health industry. For example, in 1965 the government projected the cost of Medicare in 1990 to be \$8 billion. In reality, it cost \$70 billion, a mis-projection of 775%.

At this point, there are only questions and speculation, with few answers. Some of the questions that affect MOB appraisal are:

- Will doctors make less money and pay lower rental rates?
- Will there be fewer doctors, who will occupy less medical office space?
- Will HMOs grow and dominate hospitals, and will MOB demand decline as a result?
- Will one-doctor practices, termed boutiques, disappear from MOBBS?
- Will doctors walk from existing leases?

As a result of these issues, many doctors are reluctant to expand their practices. To help appraisers understand doctors' attitudes and the possible impact on medical office space, several doctors from the UCLA Medical Center were interviewed by the author in preparing this article. From their perspective, some of the proposed health plans will push doctors into primary care practices and away from specialization. This will be accomplished by increasing the fees of family practitioners, general surgeons, and internists to make them commensurate with existing specialist practices. The government also wants to mandate the total number of positions available for specialists within the general makeup of the medical community.

These doctors also indicated that there was a dramatic increase in the applications for family practice internships at the medical school, which are up 50% from a year ago. In the area of specialized internships at UCLA, there has been a decline in applications from 23 in 1993 to 10 in 1994.

In addition, the doctors interviewed stated that the government may be enacting economic sanctions that dictate the reimbursements they will give to the school for specialized internships, such as nuclear medicine and radiology. They anticipate that by 1995 the state and federal government will mandate the number of specialized internships available at all medical schools. Finally, these doctors agreed that HMOs will continue to grow and make typical medical practices, or medical boutiques, less common. As HMOs are self-contained, reliance on hospital proximity may decline. Further, the demand for medical space suited for small practices and near hospitals is difficult to predict.

### **CONCLUSION**

There are numerous and significant differences between medical office space and standard office space, which must be considered, researched, and addressed in a MOB appraisal. These issues include rental rates, expenses, tenant mix, construction costs, tenant improvement allowance, and building features such as elevators and parking. Data concerning these characteristics must be collected from similar medical office

buildings, because there are frequently differences between a MOB and a standard office building. Using standard office data in a medical office building appraisal can negatively affect the reliability of the appraisal. In addition, hospital proximity and the financial condition of any adjoining hospital must be examined in detail, as proximity or lack of proximity is often a significant factor.

At this point, the effects of the proposed health care changes are clearly unknown,

however, some speculate that only the strongest medical office buildings will remain financially viable. Many anticipate declines in demand for typical medical office space, and an increase in demand for buildings designed for HMO use.

By application of the principles provided here, appraisers will be better able to provide the real estate community with a solid analysis of issues unique to this specialty within the appraisal profession. ■