



The Role of Public REITs in Financialization and Industry Restructuring

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ABSTRACT

Real Estate Investment Trusts (REITs) are important but little studied financial actors that control over \$3.5 trillion in gross assets and over 500,000 properties in the U.S. Yet they have been largely ignored because tax rules define them as ‘passive investors.’ The evidence in this report shows that they are actually financial actors that aggressively buy up property assets and manage them to extract wealth at taxpayers’ expense. This study identifies the powerful impact that REITs, as owners of the real estate that houses productive enterprises, have had on operating companies and on the US economy more generally. It draws on case study evidence from markets where REITs have a major presence – nursing homes, hospitals, and hotels. The tax

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treatment of REITs has facilitated a growing and worrying influence on health care markets in particular at taxpayer expense.

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Table of Contents

Executive Summary.....	4
Part I: Introduction.....	8
Evolution of REITs in the US Economy	10
Characteristics of REITs	14
Part II: REITs in Healthcare: Handmaidens of For-profit and Private Equity Owned Operators.....	16
Trends in REIT Ownership in Healthcare.....	16
The Business Model and Financial Logic for REITs in Healthcare	19
REITs and Private Equity in Skilled Nursing Facilities	20
The Risks of REIT Ownership of Nursing Homes	23
Case Study: HCP, Carlyle Partners, and HCR ManorCare.....	24
Case Study: Health Care REIT, Formation Capital, and Genesis Healthcare.....	31
Conclusions: The Outcomes of REITs and Private Equity in Nursing Homes.....	33
REITs and Private Equity in Hospital Systems	35
Medical Properties Trust.....	35
Case Study: MPT and Steward Health Systems.....	38
Case Study: MPT and Prospect Medical Holdings	42
Case Study: MPT and LifePoint Health.....	44
Conclusions: REITs and Private Equity in Hospital Systems.....	46
Part III: REITs in the Hotel Industry	48
Trends in REIT Ownership of Hotels	49
Changing Legal Regulations and Hotel REIT Structures	51
The Business Model: How REITs Make Money.....	53
Do Hotel REITs Influence Hotel Operations and Employment?.....	58
Conclusions: Hotel REITs	61
Conclusions	61
References	65
Appendix A: US Hotel REITs by Market Capitalization, 2022	80

Executive Summary

Real Estate Investment Trusts (REITs) are important financial actors that control over \$3.5 trillion in gross assets and over 500,000 properties in the U.S. Yet they have been largely ignored because tax rules define them as ‘passive investors.’ They exist as tax “pass through” entities and pay no corporate taxes if they invest at least 75 percent of their assets in real estate, derive 75 percent of their gross income from real property, and pay out at least 90 percent of taxable income (excluding capital gains) as shareholder dividends each year.

The evidence in this report paints a very different picture of REITs: They are actually financial actors that aggressively buy up property assets and manage them to extract wealth at taxpayers’ expense. They do not simply wait patiently to buy real estate through market transactions, sit back passively, and collect the rent. The case studies in this report suggest that their tax-exempt status should be revisited.

We identify three important ways in which REITs have had a powerful impact on the US economy in general and on productive enterprises more specifically – whether intended or not. We draw on cases from markets where REITs have a major presence – nursing homes, hospitals, and hotels.

First, because REITs were designed to facilitate retail investing in the real estate market, they have become an important mechanism for expanding the financialization of the US economy. That is, they increase the power of finance capital by expanding its reach into larger swaths of the productive economy. They have expanded the pool of capital available for transactions that monetize real property and turn it into tradable assets – financial widgets with little or no connection to the real purpose of the productive enterprises that occupy the properties they own.

Second, REITs have played a major role in industry restructuring and consolidation. They have done so by promoting REITs as a separate asset class – one that should be legally separate from the commercial enterprises that produce goods and services on real estate property. By separating ownership of real property (property company or PropCo) from the enterprises operating on that property (operating company or OpCo), investors may more precisely calculate the returns to capital based on the risk-reward features of the asset class – in this OpCo/PropCo model, real estate assets versus the goods or services produced on the property. And the stock market values these assets differently.

Thus, REITs have grown and expanded their reach by separating real estate assets from productive assets. They have dominated M&A activity in real estate markets, due to their tax-exempt status, which allows them to pay higher premiums for properties than non-REIT property owners. As REITs buy up local property and consolidate it into national or global property corporations, they also facilitate the consolidation of the operating companies that become their

tenants. That is, they facilitate industry consolidation both at the property level and at the commercial enterprise level. This is evident in the three sectors analyzed in this study. In healthcare, private equity firms have partnered with healthcare REITs to separate assets into property and operating entities, with REITs financing the expansion and consolidation of the PE-owned nursing homes and hospitals into mega-chains with enhanced local, regional, or national market power. The anti-competitive implications of these developments in healthcare have become a major focus of scholarly research and a major concern for political leaders and anti-trust regulators. A similar pattern of concentrated ownership is evident in the hotel sector, where REITs have dominated M&A activity and fostered industry consolidation – both at the level of the hotel real estate and also at the level of the brands and operating companies that manage the property assets.

A third effect of REITs occurs at the level of operating companies and the outcomes for the companies, employees, and consumers. By law, REITs must act as passive investors to retain their tax-exempt status, which means that they cannot interfere with the management or operating decisions of their tenants. This has led to the OpCo/PropCo model described above, which separates property and operations ownership into separate legal entities – entities that by law must maintain arms-length relations. *But this separation poses major problems from the standpoint of effective business management and service delivery.* That is because productive operations depend importantly on the quality and maintenance of the underlying property. The quality of patient care depends on how well facilities are maintained; hotel revenues depend on customer satisfaction with both services and facilities. In other words, the separation of property ownership from operations is driven entirely by the financial logic of maximizing returns for investors – NOT the business logic of providing high quality integrated services. The legal requirement for an arms-length relationship between property and operating companies is in conflict with the needs of the business, and ironically, the ability of real estate owners to make sure that operations on their properties are managed effectively.

To overcome this dilemma, REITs have developed work arounds to allow them to influence or partner with the companies that manage their properties – strategies that are at odds with the original conditions for their tax exempt status. They have successfully lobbied for legal changes that have freed up REITs to behave more and more like publicly-traded corporations, but without paying the corporate taxes that their counterparts pay. These work arounds vary based on different risk-reward assumptions across industries.

Beyond that, the cases in this report show how REITs achieve their financial goals through work arounds that directly or indirectly shape the decisions or business strategies of their tenants -- and in turn, outcomes for consumers, patients, and employees. However, they bear no legal liability for what happens to the operating company or any of these stakeholders. While these REIT strategies may be technically legal, they undercut the original intent of the laws.

In healthcare, REITs use sale-lease back agreements with healthcare operating companies in which the companies are tenants and the REITs are landlords. These agreements assume that government reimbursement systems provide long term predictable funding mechanisms. The tenants bear all of the profit-loss risks, as well as the costs and risks of property maintenance. Thus, healthcare REITs are viewed as safe investments that yield reliable dividends, almost as safe as bonds. They bear little risk if an operating company fails; and in that event, their properties may be repurposed for a new tenant. Healthcare operating companies in nursing homes and hospitals, however, bear substantial risk of financial failure due to ongoing cost increases and uncertain and unpredictable funding.

Healthcare REITs have teamed up with private equity firms to strip property assets from healthcare providers. Our case studies show how private equity firms have bought out nursing homes and hospitals using extensive debt, and then have sold the underlying property to a REIT, in what is known as a 'sale-leaseback.' The PE firms have taken the proceeds from the property sales to pay dividends to themselves and their investors, rather than using them to improve healthcare services for patients. The REITs have received inflated rents from healthcare providers, while the healthcare providers have become tenants of the property they formerly owned. Now they are burdened with 'triple net' leases in which they pay rent subject to annual escalator clauses (and continue to pay the costs of property maintenance and improvements, taxes, and insurance).

While REITs appear to be passive investors in these cases, a deeper analysis shows how they have made it possible for private equity firms to extract wealth through excessive debt financing; and how they have undermined healthcare providers' financial stability through charging excessive rents with unsustainable escalator clauses in long-term renewable leases. Our case analyses illustrate how this happens. They include examples in skilled nursing: Healthcare Properties (HCP) (a healthcare REIT) and HCR ManorCare (owned by PE firm Carlyle Partners); and Health Care REIT and Genesis (owned by Formation Capital). In hospitals, they include Medical Properties Trust (a healthcare REIT) and its involvement with Cerberus-owned Steward Health, Leonard Green-owned Prospect Medical Holdings, and LifePoint Healthcare, owned by PE firm Apollo.

In hotels, by contrast, REITs bear most of the risk of profit and loss, as they lease their properties to taxable REIT subsidiaries, which in turn contract with hotel operator -- paying them a fee for managing the properties and reimbursing them for labor and other expenses. Hotel REITs hide behind the complexity of contracting relationships to argue that they maintain arms-length relations with operators. But their financial concerns over risk management lead them to promote strategies to 'actively manage' their assets and drive down hotel operating costs, which became particularly evident during the COVID pandemic.

Notably, if operating companies or their stakeholders suffer negative consequences due to REIT ownership strategies, the REITs bear no liability or responsibility for these outcomes.

In sum, this report suggests that scholars and policy makers need to take a much closer look at REIT activities. Their profits and executive compensation have been extraordinary in recent years, with little discomfort caused by the COVID pandemic. Their financial transactions offer little or no transparency, and taxpayers deserve a clear assessment of how much they are subsidizing yet another asset class that may be contributing to greater inequality in the US economy.

Part I: Introduction

Real Estate Investment Trusts (REITs) are important financial actors who have mainly flown under the radar because their activities are viewed as benign. However, they control over \$3.5 trillion in gross assets and over 500,000 properties in the U.S., according to Nareit, the National Association of Real Estate Investment Trusts. Public and privately held REITs own, operate, develop, or manage income-producing real estate in many sectors of the economy. Publicly-traded REITs alone owned roughly \$2.5 trillion in assets in 2022, and had an equity market capitalization of over \$1.35 trillion (Nareit 2022a).

REITs have been overlooked in part because tax rules define them as ‘passive investors,’ as authorized in the 1960 Real Estate Investment Trust Act. The key provisions require REITs to invest at least 75 percent of their assets in real estate, derive 75 percent of their gross income from real property, and pay out at least 90 percent of taxable income (excluding capital gains) as shareholder dividends each year. Under these conditions, they exist as tax “pass through” entities, pay no corporate taxes, and only investors pay taxes on their dividends.

This paints a picture of REITs as organizations that wait patiently to buy real estate through market transactions, sit back passively, and simply collect the rent.

While this may be true of some REITs, the evidence in this report paints a very different picture: REITs are aggressive financial actors that buy up property assets and manage them to extract wealth at taxpayers’ expense. REITs contribute to the ‘financialization’ of the US economy – that is, they increase the power of finance capital by expanding its reach into larger swaths of the productive economy. They have expanded the pool of capital available for transactions that monetize real property and turn it into tradable assets – financial widgets with little or no connection to the real purpose of the productive enterprises that occupy the properties they own. Before the 1980s, healthcare, hospitality, retail, manufacturing, and companies in other industries owned their own property, which they used to hedge against downturns in the economy.

They had sound economic reasons for maintaining property ownership. But REITs opened up the real estate industry to retail investors. As a result, REITs have access to larger pools of other peoples’ money to play with. The larger they grow, the more money they can make, and the higher their executive compensation – all without paying corporate taxes. In the meantime, their shareholders focus on increasing dividends they receive, oblivious to how REIT strategies to extract wealth may negatively affect the productive enterprises that rent their properties. This separation of real property from real productive enterprises – referred to as the OpCo/PropCo model – often undermines the stability of the operating companies and makes them more vulnerable than other companies to financial distress or bankruptcy -- as is well documented following the Great Recession of 2008 and the current COVID Pandemic.

To illustrate this process, we examine cases in three markets where REITs have a major presence – nursing homes, hospitals, and hotels. In these sectors, REITs have played a leading role in facilitating mergers and acquisitions (M&As) that drive industry consolidation and enhance their market power. In healthcare, activist REITs have teamed up with private equity firms to strip property assets from healthcare providers. Private equity (PE) firms buy out a nursing home or hospital using extensive debt, and then sell the underlying property to a REIT, in what is known as a ‘sale-leaseback.’ The PE firm pockets the proceeds to pay out investor dividends, rather than using them to improve healthcare services for patients. The REIT receives inflated rents from the healthcare provider, with annual escalator clauses in long-term leases on property the provider used to own. The healthcare provider’s net revenues fall, making it more financially fragile than it was in the past. In hotels, by contrast, REITs use a completely different mechanism to extract value, due to differences in industry characteristics. They use an elaborate series of contracting relationships with separate legal corporations to manage their hotel properties in order to maintain the legal fiction that they are passive and have no influence over operating decisions. But these contracts are fraught with conflicts of interest, and evidence suggests that hotel REITs engage in various legal work arounds to make sure they are able to influence hotel operations in order to extract the profit margins they seek.

We focus on these three sectors because they provide leading examples of REIT activity. In addition, both healthcare and hotels are subject to a similar carve out provision in federal regulations. Despite similar IRS regulatory frameworks, however, they offer a ‘most diverse’ comparison. Health care and hotels are radically different in key ways: their sources of financing (3rd party payment systems with heavy government subsidies in healthcare versus consumer-driven revenues in hotels); government regulation (high in healthcare, low in hotels); and exposure to the business cycle and financial crises (low in healthcare, high in hotels). These differences allow us to examine how REITs use very different business models in distinct market contexts to influence the operation of their portfolio properties and to extract enormous wealth. The case evidence raises the question of whether REITs should retain their tax-exempt status or whether their activist behavior goes far beyond the original intent of the law. Are REITs passive investors or asset managers extracting wealth at taxpayer expense?

In this paper we consider three central research questions. What is the business model of REITs? That is what kinds of investments do they make and why, and how do they make money? Second, to what extent are they growing and why? Third, are they passive investors or active asset managers shaping the behavior and outcomes of the operating companies that rent their properties?

Evolution of REITs in the US Economy

The original intent of the REIT law was to create opportunities for individuals to invest in commercial real estate – a kind of mutual fund for commercial real estate. REIT investments may be attractive because individuals can invest in real estate without the liquidity constraints or substantial capital commitments that real estate investments generally require. Individuals access REITs either directly through the stock market or through 401(k), IRAs, pension plans, or other investment funds. REITs have delivered high dividends and serve as a source of portfolio diversification; and they offer both equity and bond-like benefits to investors through long-term capital and reliable dividends (Feldman, Schmidt et al. 2013). Roughly 145 million Americans, or 44 percent of US households held REIT investments in 2020 either directly or indirectly as part of their retirement savings, according to Nareit (2020).

The IRS has additional rules that apply to REITs, beyond the three core requirements (the 75 percent assets in real estate, 75 percent gross income from real property, and 90 percent dividend payout rules). No more than 5 percent of their gross income can come from sources other than real estate. They also must be managed by a board of directors, have fully transferable shares, have a minimum of 100 shareholders after one year of operation, and have no more than 50 percent of shares held by five or fewer people (Cornell LLI 2022; DiLallo 2022).

REIT regulations have become far more favorable to the real estate industry due to their ongoing lobbying efforts, which have yielded changes that allow REITs to attract more investors and operate more like corporate property owners while still retaining their tax-exempt status. Amendments to the 1960 law occurred under Presidents Ford, Reagan, Clinton, Bush, Obama, and Trump. In other words, political leaders in both parties supported legal changes to facilitate the monetization of property assets as part of broader deregulatory changes that were occurring in these decades – changes that supported the overall expansion of finance capital into productive industries and heightened the financialization of the overall US economy.¹

Particularly important was the Tax Reform Act of 1986, which allowed REITs to provide services and manage their real estate portfolios -- essentially functioning as businesses with employees. They were not simply investment vehicles (Katz 2022). REITs were also allowed to limit their liability by establishing wholly owned subsidiaries, referred to as qualified REIT subsidiaries (QRS), which for tax purposes are considered to be part of the REIT as a single corporate taxpayer. Amendments in 1993 made it easier for pension plans to invest in REITs. Then in 1999, the industry succeeded in getting major reforms passed under the REIT Modernization Act (RMA) that allowed REITs to form taxable REIT subsidiaries (TRS) designated to offer services to REIT hotel tenants and others, without jeopardizing REITs' tax status. Prior to the RMA, REITs were required to lease their assets to third party lessees; but

¹ See Katz (2022) for a detailed review of precursors to modern REITs, the history of REIT legislation, and the legal standards and tests used to determine whether REITs qualify for tax exempt status.

after passage of the RMA, REITs could capture more of the rents -- the 'leakage' that had gone to the third-party lessees now went to their own subsidiaries (Beals and Singh 2002: 15).

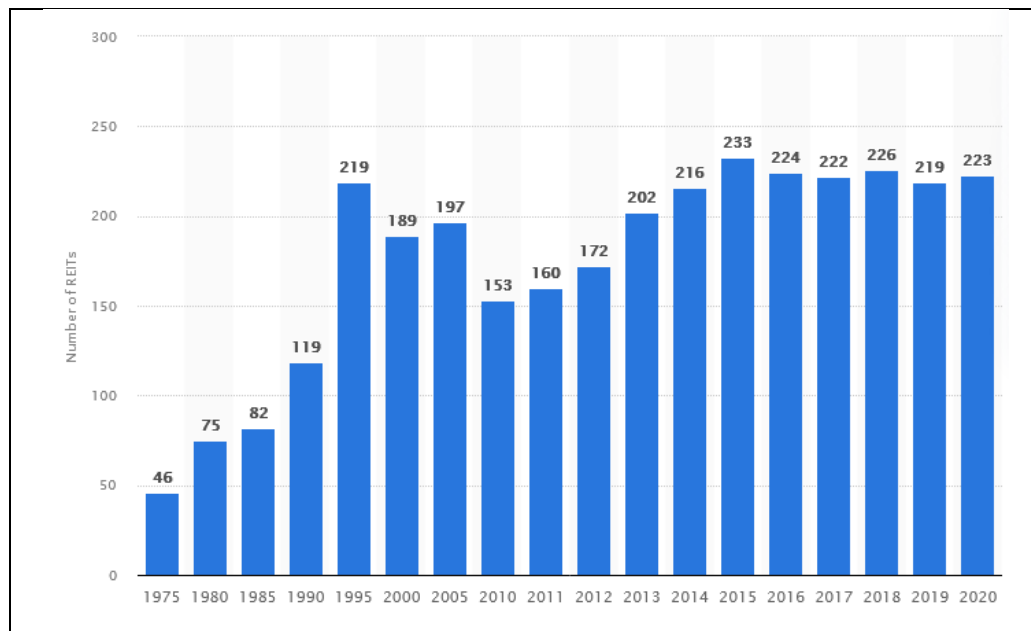
In July 2008, the REIT Investment and Diversification Act (RIDEA) made it easier for REITs to buy and sell assets, increasing the size of taxable hotel and other REIT subsidiaries. It also allowed health care REITs to use taxable REIT subsidiaries, consistent with what hotel REITs had been able to do (Edwards and Bernstein 2008). In 2015, the Protecting Americans from Tax Hikes (PATH) Act included a number of favorable REIT-specific tax provisions that made it easier for them to access foreign capital for US real estate investment (McGuire Woods 2015). And in 2017, REITs also benefitted from the Trump administration's Tax Cuts and Jobs Act (TCJA), which allows individuals to deduct up to 20 percent of ordinary REIT dividends from their taxes. REIT investors in the top income tax bracket, with a 39.6 percent marginal tax rate, realized an after-tax savings of 25.5 percent in 2018 (Inland 2018).

These legal changes paid off. After very slow growth in the 1960s through 1980s, REITs expanded rapidly in the 1990s (Nareit 2022b). First, traditional sources of financing real estate -- including banks, insurance companies, and savings and loans dried up -- leaving a vacuum that REITs began to occupy. In that decade, institutional investors saw REITs as a highly liquid vehicle, compared to owning mortgages, to diversify and invest in real estate. And the national recession had shut down funding sources, making real estate cheap. REITs represented an insignificant source of equity financing in 1990, but 39 percent of the total by 2001 (Beals and Singh 2002). The total number of REITs in the US grew from 46 in 1975 to 119 in 1990 to 223 in 2020.

Figure 1.1 shows the explosive growth in the number of REITs in the early 1990s, which then stabilized over the next two decades -- with the exception of a significant drop (and recovery) due to the 2008 financial crisis.² Growth in capital invested in REITs continued to occur, however, as existing REITs grew larger through M&A activity.

² International REITs expanded in the 2000s, primarily in Europe, and after 2010, primarily in Asia, with modest growth in South America as well (Nareit 2022b).

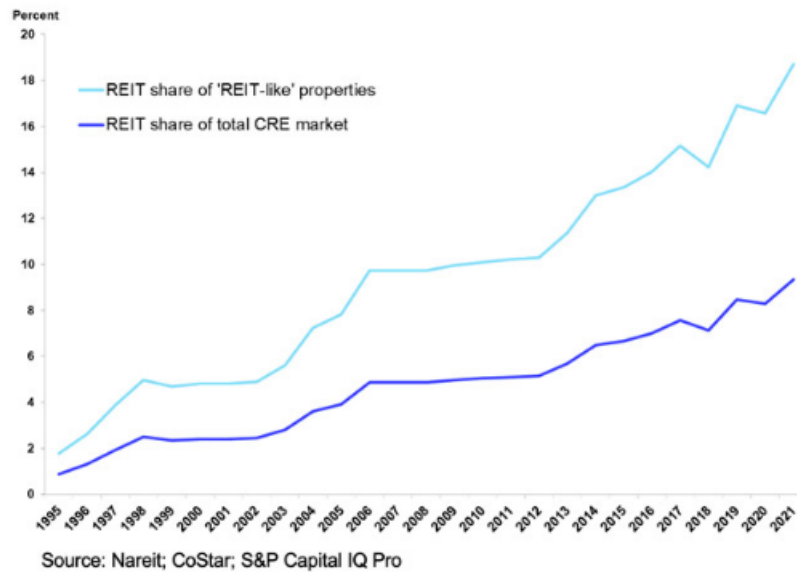
Figure 1.1
Number of real estate investment trusts (REITs) in the United States from 1975 to 2020



Source: Statista. 2022. <https://www.statista.com/statistics/916661/reits-usa-number/>

Note that REITs as a share of the total US commercial real estate (CRE) market grew in three bursts of economy-wide growth: In the late 1990s, the bubble years of the early and mid-2000s, and from 2012 on – reflecting the economy’s overall business cycle (Figure 1.2). REITs recovered nicely from the Great Recession and accelerated their growth thereafter from 2012 to 2021 due in large part to the extremely low interest rates. REITs represented 2 percent of the CRE market in 1995 and 9.4 percent in 2021 (Q2). According to the industry’s advocacy association (Nareit), however, REITs tend to invest only in ‘institutional-quality’ properties that are newer and higher quality than many other privately-owned properties. These ‘REIT-like’ properties are estimated at 50 percent of the total CRE market, and the REIT share of these properties is 18.7 percent. The total value of the US CRE market in 2021 was estimated at \$20.7 trillion, with \$2.3 trillion in healthcare and \$1.6 trillion in hospitality (Nareit 2021a).

Figure 1.2
REIT Share of the CRE Market: 1995-2021

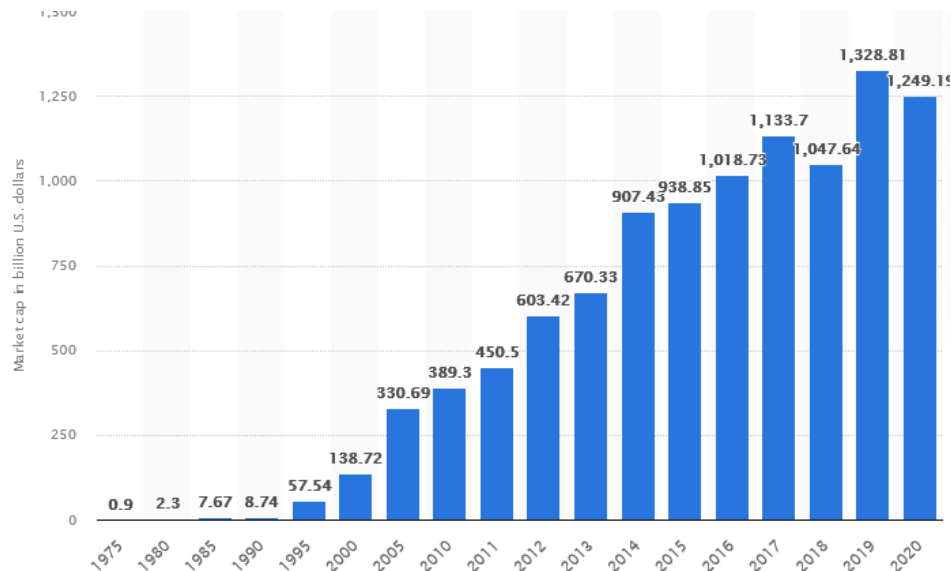


The stock market value of publicly-traded REITs also increased exponentially from the 1990s on – with no deceleration during or after the Great Recession (Figure 1.3). Their market capitalization was insignificant until 1990, but \$138 billion in 2000 and \$1.25 trillion in 2020 (Figure 1.3). There was a total of 221 publicly traded REITs in that year – reflecting the fact that growth in scale and scope occurred through M&A activity, not the founding of new REITs per se.³

Industry analysts argue that REITs have grown because they are attractive to individual as well as institutional investors: Compared to other stocks, they pay above-average dividends, allow investors to diversify away from the stock market, and shield investors from ‘double taxation’ because the REIT does not pay federal corporate income tax. They are considered stable long-term investments. Publicly-traded REITs also offer greater liquidity compared to owning real estate directly, are lower cost compared to buying commercial real estate directly, and are highly transparent. They can also operate in virtually any city or state. The downsides to REIT investments include the restrictions on income sources; higher tax liabilities because REITs pay ‘nonqualified dividends;’ and they involve risks such as sensitivity to interest rate changes, property-specific risks, and the risk of extensive use of debt (DiLallo 2022).

³ Note that most publicly traded REITs also have private, nontraded ownership units (operating units) that are similar to shares of common stock, but market capitalization data excludes these units (Krewson-Kelly and Thomas 2016:88-91). Also not included in these charts are public, non-traded and privately-held REITs.

Figure 1.3
Market capitalization of REITs in the US (1975 – 2020) (\$ billions)



Source: Statista 2022a. <https://www.statista.com/statistics/916665/market-cap-reits-usa/>

Characteristics of REITs

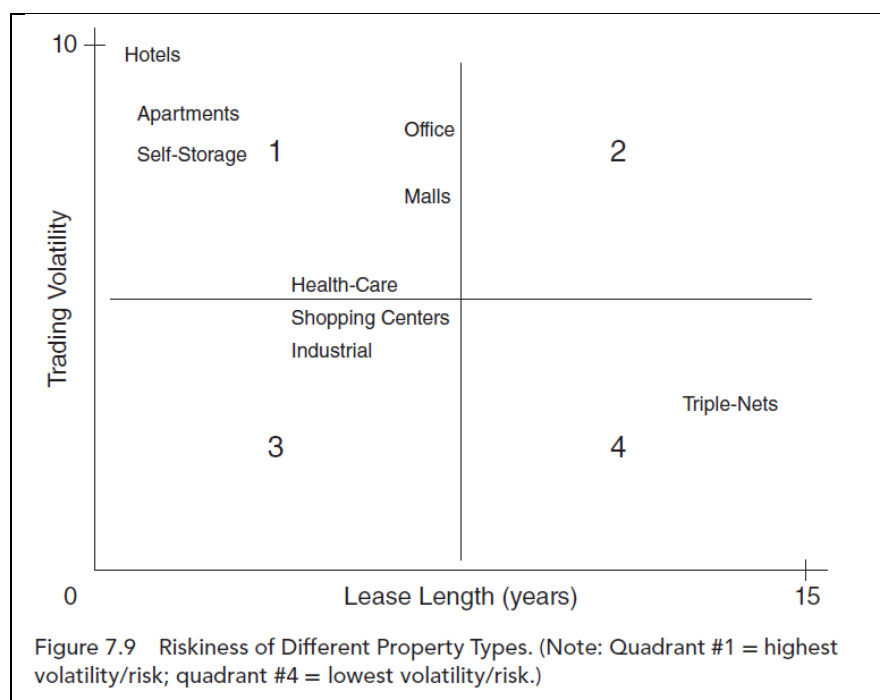
There are two types of REITs: *Equity REITs* own and operate properties while *mortgage REITs* invest in mortgages. They have basic characteristics in common as required by law, but their specific ways of making money differ. Mortgage (mREITs) operate primarily in the housing market; equity REITs are most common (roughly 82 percent of the total, Krewson-Kelly and Thomas 2016:6). Until about 2010, REITs were primarily located in traditional commercial real estate – warehouses, apartments, shopping centers, office buildings – but since then ‘nontraditional REITs’, including those in healthcare and hotels have emerged. Most REITs specialize in a single industry, with less than 20 of the over 220 publicly-traded REITs diversified across industries (Krewson-Kelly and Thomas 2016:182). Within industries, however, REITs diversify across different brands or operating companies.

For equity REITs in healthcare and hotels, triple net leases are common, in which the company leasing the property (the lessee) is responsible for three types of property related expenses: Maintenance (utilities, water, trash service, landscaping, etc.); taxes; and insurance (Borchersen-Keto 2015). Triple net leases benefit landlords because they offer a steady, bond-like cash flow; and they are less volatile and tend to perform better than other lease arrangements when economic conditions are uncertain, as in the Great Recession, when healthcare REITs were the least negatively affected of all sectors (Krewson-Kelly and Thomas 2016: 59). REITs using triple

net leases also tend to grow via acquisitions, which requires them to maintain a low cost of capital. In the very low interest rate environment since the Great Recession, competition for triple-lease properties accelerated (Krewson-Kelly and Thomas 2016: 59). Interest rates have only recently begun to rise as the U.S. Federal Reserve Bank has tightened monetary policy to fight inflation.

An important difference across sectors that shapes risk and volatility is the typical length of lease terms, which can vary from a month or less (hotels) to 5-10 years or more (healthcare). As shown in Figure 1.4, hotel REITs with short term leases have the highest risk and volatility, while healthcare REITs with longer leases are lower; and triple-net leases characteristic of healthcare have among the lowest.

Figure 1.4
Risk Factors Affecting Different Types of REIT Properties



Source: Krewson-Kelly and Thomas (2016:124).

As we discuss in the sections below, the level of risk and volatility that REITs face have important implications for their relations with operating companies.

Part II: REITs in Healthcare: Handmaidens of For-profit and Private Equity Owned Operators

Trends in REIT Ownership in Healthcare

The growth of REITs in healthcare can be traced to the 1980s and 1990s, when government cutbacks in reimbursements and rising healthcare costs led some healthcare systems to sell their real estate in order to generate cash. REITs could sell shares on the public market to finance the purchase, then pass on lease payments as dividends to investors. The first REIT specializing in healthcare was 'Health Care REIT, Inc,' founded in 1970. But healthcare REITs were slow to take hold because of the perceived difficulty in managing the facilities. Then in 1985, National Medical Enterprises (NME) established a REIT called 'Health Care Property Investors,' which raised capital on the stock market and bought the property of several NME nursing homes. NME claimed this move improved its financials, but not all nursing home owners were convinced of the benefits of sale-leaseback agreements at this time. Other owners, including Manor Care, Inc., decided against selling property to a REIT, in Manor Care's case because it would have exposed it to significant tax liabilities (Abramowitz 1986).

REITs' investments in healthcare in the 1990s focused on medical office buildings (MOBs) as healthcare providers facing financial pressures sold off some of their buildings and leasing back the space in order to have funds to reinvest in their core businesses. These developments notably occurred in for-profit hospital systems, which constituted about 15 percent of systems at the time. Industry analysts noted that non-profits were very slow to move in this direction, but were beginning to do so (Lerner 2016).

In the last three decades, the involvement of REITs in health care has accelerated. By 2021, eighteen publicly traded healthcare REITs were operating in the US, with a combined market value of \$120 billion. They owned 7,182 properties, representing 8 percent of all healthcare properties, according to an analysis using the most comprehensive data available (Bruch et al. 2022) (See Table 2.I). Of the total of 91,062 healthcare properties in the U.S., their largest share was in skilled nursing facilities (12 percent, 1,870 properties), followed by senior housing and assisted living (9 percent, 2,619 properties), and medical office buildings (6 percent, 2,515 properties). They owned 3 percent of all hospitals (1,870 properties). While these percentages are relatively low, the accelerated rate of growth in acquisitions is notable. For example, while REITs acquired no hospital properties in the early 2000s, they acquired 40 in the 2012-13 period and 55 in the 2016-1 period. Their growth rate dropped substantially during the 2020-2021 COVID period. In a multivariate logistic analysis, some of the characteristics most strongly associated with REIT-ownership were for-profit status and urban status (Bruch et al. 2022).

Table 2.1: Health Care Properties in the United States Owned by REITs (2021)¹

Property Type	REIT-Owned Properties	Total Properties (% REIT-Owned)²
Hospitals	197	5,835 (3%)
Senior Housing / Assisted Living Facilities	2,619	28,900 (9%)
Medical Office Buildings	2,515	41,000 (6%)
Skilled Nursing Facilities	1,870	15,327 (12%)
Total	7,201	91,062 (8%)
¹ Source: Bruch et al. 2022. Data were available for 152 unique hospital provider numbers of 197 total hospitals; several hospitals within a health system filed under a single provider number or did not have data available in the American Hospital Association 2021 survey.		
² The total properties within each sub-sector were estimates across a range of sources.		

The largest of the healthcare REITs were Welltower (1,706), Ventas (1,173), Omega (970), HealthPeak (528, formerly HCP), Healthcare Trust of America (469), and Sabra (426) (See Table 2.2). They vary in their business strategies, with some focused primarily on one segment - hospitals (MPT), senior housing (New Senior Investment Group), medical office buildings (Flagship HC, Global Medical, Healthcare Realty) – and others more diversified (Ventas, Welltower).

Table 2.2: Total Properties by Healthcare REIT: 2021

Healthcare REIT	Total Properties	Healthcare REIT	Total Properties
CARETRUST REIT, Inc.	197	Medical Properties Trust Inc.	220
Senior Housing	39	Acute Care Hospitals	112
Skilled Nursing	158	Medical Office Building	57
CNL Healthcare Properties	73	Other Hospitals	51
Acute Care Hospitals	1	National Health Investors	242
Skilled Nursing	72	Medical Office Building	18
Community HC Trust	149	Senior Housing	149
Acute Care Hospitals	1	Skilled Nursing	75
Medical Office Building	132	New Senior Investment Grp.	103
Other Hospitals	10	Senior Housing	103
Rehabilitation	6	Omega	970
Diversified Healthcare Trust	392	Acute Care Hospitals	2
Medical Office Building	27	Medical Office Building	37
Medical Office Building	72	Other Hospitals	5
Research (Life Sciences)	32	Rehabilitation	2
Senior Housing	245	Senior Housing	155
Skilled Nursing	16	Skilled Nursing	769
Flagship HC Properties	63	Physicians Realty Trust	80
Medical Office Building	63	Medical Office Building	80
Global Medical REIT	99	Sabra	426
Acute Care Hospitals	1	Other Hospitals	28
Medical Office Building	84	Senior Housing	113
Other Hospitals	6	Skilled Nursing	285
Rehabilitation	8	Ventas, Inc.	1,173
Healthcare Realty	228	Acute Care Hospitals	10
Medical Office Building	228	Medical Office Building	329
Healthcare Trust of Am.	469	Other Hospitals	37
Acute Care Hospitals	15	Research (Life Sciences)	42
Medical Office Building	451	Senior Housing	739
Senior Housing	3	Skilled Nursing	16
Healthpeak	520	Welltower Inc.	1,706
Medical Office Building	322	Acute Care Hospitals	216
Research (Life Sciences)	140	Medical Office Building	369
Senior Housing	58	Other Hospitals	135
LTC Properties	180	Senior Housing	986
Senior Housing	107	Grand Total	7,290
Skilled Nursing	73		

Source: Bruch et. al 2022. Note: Unreported calculations by Bruch et al (2022). There may be some lack of precision in the exact number of investments by REIT due to different naming definitions, which the authors analyzed and harmonized.”

The Business Model and Financial Logic for REITs in Healthcare

The REIT business model in healthcare is based on sale-leaseback transactions: Healthcare providers sell their property to a REIT, which in turn leases the property back to the organization. The REITs make money by negotiating long-term leases with entities that previously owned the property and managing a portfolio of these rent-paying properties. In theory they conform to the IRS rules requiring them to act as passive investors.

Industry practitioners have argued that REITs provide benefits for cash-strapped healthcare providers, while investors find it an attractive investment target due to the aging of the American population and the steadily increasing demand for healthcare services. REIT advocates also argue that unlike a traditional mortgage loan, a sale-leaseback allows property owners to monetize the full value of their real estate holdings. But following the property sale, health care operators become tenants of the property they formerly owned and are newly burdened with ‘triple net leases’ in which they pay rent subject to annual escalation clauses (and continue to pay the costs of property maintenance and improvements, taxes, and insurance). Despite these rental fees, some health care operators may believe that the added expense is worth the infusion of capital that can be used to fund expenditures in existing facilities or external expansion through acquisitions. There is no research, however, that documents how these proceeds have actually been used in for-profit hospitals – whether they are used to improve patient care or are used to provide dividends to shareholders or pay higher executive compensation.

We demonstrate in the cases below, in which the operating companies are owned by private equity, that the proceeds of the real estate sales were largely not plowed back into the operator for use to improve technology, work processes, workforce skills, or other patient-related upgrades. Instead they were used to reduce the excessive debt that the PE owners have loaded on their portfolio companies and to pay themselves and their limited partners dividends. The health care providers are left with inflated rents in long-term leases with annual escalators.

While REITs are defined as passive investors, their investment activities and their effects on providers in the cases below suggest they are not. Their strategies to make money have had profound effects on the companies that pay rent on the properties they own. The clearest example of this pattern is in the business transactions between healthcare REITs and private equity owners of healthcare providers. Healthcare REITs and PE-owned companies behave as partners in sale-leaseback strategies designed to extract wealth for themselves at the expense of the operating companies. Our case analyses illustrate how this happens. They include examples

in skilled nursing: Healthcare Properties (HCP) and HCR ManorCare (owned by Carlyle); and Health Care REIT and Genesis (owned by Formation Capital). In hospitals, they include Medical Properties Trust and its involvement with Cerberus-owned Steward Health, Leonard Green-owned Prospect Medical Holdings, and LifePoint, owned by PE firm Apollo.

The financial logic for splitting healthcare providers into real estate property and healthcare operations is that investors view real estate as a relatively safe investment and nursing homes and hospitals as inherently riskier. As a result, when a PE fund buys a nursing home or hospital, the share of the transaction price attributable to the real estate is usually far higher than the share represented by the hospital. Returns are higher as a result. For example, when Ventas bought out Ardent Health Services from PE firm Welsh, Carson, Anderson & Stowe (WCAS) for \$1.83 billion, it immediately split the hospital real estate from Ardent Health Services. It quickly sold the hospital to another PE firm, Equity Group Investments, for \$475 million (retaining a 9.9% share). Less than a third of the value of Ardent Health Services was attributable to the hospital provider and more than two-thirds to the hospital's real estate (Wong-Hammond 2015).

REITs and Private Equity in Skilled Nursing Facilities

REITs expanded hand in hand with for-profit nursing home chains, which took off after 1984 when Medicare implemented its acute care hospital prospective payment system (PPS). Under the Prospective Payments System, hospitals were no longer reimbursed for the actual costs of caring for an individual patient. Instead, reimbursements for Medicare patients cover the cost of treating a particular medical condition and an expected length of hospital stay. If the actual costs are less than is typical and the length of stay is shorter, the hospital benefits financially. If the patient is more difficult to treat or takes longer to be discharged, the hospital will not be able to cover the full cost of patient care.

This change indirectly supported the expansion of REITs. That is because the new reimbursement rules provided incentives for hospitals to discharge patients more quickly, which in turn increased the percentage of higher acuity patients in nursing homes. Nursing homes benefited as they received higher Medicare reimbursements for the higher acuity care patients; and the heightened demand for nursing home beds led for-profit homes to expand in order to take advantage of higher patient volumes and higher per patient rates. Here, REITs provided needed capital for nursing home chains to expand. That is, the for-profit chains raised capital to finance their new operations by selling off the land and facilities of the new nursing homes to Real Estate Investment Trusts. Other capital sources included generous bank loans and public stock offerings. The sale of real estate to REITs also allowed nursing homes to keep the debt off the balance sheets (Stevenson, Grabowski, and Coots 2006: 3-4). Until recently, long-term lease agreements were not included as company liabilities on financial reports. In sum, the REITs grew hand and hand with the expansion of for-profit nursing home chains.

More generally, these changes in government funding spurred financialization in the nursing home segment – that is, the increased role of finance capital, aka REITs, in the ownership of nursing home assets. It also provided incentives to restructure the industry through the separation of real estate and operations, which in turn led to M&A activity in both segments and the creation of national corporate entities specializing either in healthcare real estate or healthcare operations – but in either case, focused on corporate profit making at the national level with yet to be determined effects on patient outcomes at the local level.

For-profit, publicly traded chains grew substantially in the 1990s. But in the late 1990s they faced financial distress due to increased competition and reductions in federal Medicare payments under the Balanced Budget Act of 1997. Many nursing home operators went bankrupt, including 5 of HCR’s major competitors. Many highly-leveraged public companies defaulted on their debt; and five of the seven largest chains went into bankruptcy by 2000. But they did not disappear. They shed assets, restructured, and re-emerged. Large chains represented 56 percent of all homes in 2001 and about 52 percent in 2004 (Stevenson, Grabowski, and Coots 2006: 5-7). This laid the groundwork for private equity to enter the market in 2004.

The link between the growth of healthcare REITs and private equity ownership of nursing homes became salient in the 2000s -- especially during private equity’s buying spree from 2003 to 2007 – notably cut short by the 2008 financial crisis. Analysts at the time characterized these deals as ‘real estate plays’ in which investors used the sale of real estate to finance acquisitions that relied heavily on leveraged debt – the classic PE model. A key feature reportedly helping the viability of these arrangements was the then recent “stability” in Medicare payment rates, something operators and investors hoped would continue. Examples included the country’s largest nursing home chains -- including Integrated Health Services, Mariner, Beverly, HCR ManorCare, and Genesis (Stevenson and Grabowski 2008: 1400-01).

Of the 15,711 nursing homes in the United States that received Medicaid and Medicare funding in 2009, 1,876 had been acquired by private equity in 77 transactions between 1998 and 2008. This represents 12 percent of all nursing homes and 18 percent of for-profit homes (which in turn constituted two-thirds of all homes at the time). The cumulative number of nursing homes involved in these transactions was higher – 2,500 – because in some cases, the homes were bought and sold more than once; and in others, the operating arm and the real estate assets of the same home were purchased in separate acquisitions by different PE firms (GAO 2010:13-14).⁴

Ten private equity firms accounted for 89 percent of the transactions in this period (1,670 homes) (See Table 2.3). Three of the PE firms targeted three of the largest chains that continued to own

⁴ These estimates are based on data from Dealogic, supplemented with data from websites, the Securities and Exchange Commission (SEC), and nursing home publications.

their own property -- with the intention of splitting them into operating companies and real estate properties and selling off the latter -- both to enhance profitability and to limit liability. They included PE firm Abe Briarwood and National Senior Care Inc. (which owned Integrated Health Services and Mariner Health Care⁵ - a total of 382 homes); and Fillmore Capital Partners (which owned Beverly Enterprises with 324 homes worth \$1.8 billion in a 2006 deal) (Stevenson, Grabowski, and Coots 2006:7).

Another two of the ten PE firms purchased only the real estate of the nursing homes and leased a portion of it back to other PE-owned chains: SMV/SWC (property only for 189 homes) and GE Capital (Healthcare Financial Services, property only for 162 homes). A third, Formation Capital, owned a combination of homes and some property alone (Genesis HealthCare with 245 homes, and property only for 65 of these) (GAO 2010).

Table 2.3: Top 10 Private Investment (PI) Nursing Home Chain and Real Estate Acquirers for Calendar Years 1998 through 2008, Still Owned as of December 31, 2008

Private investment firm	Name of nursing home chain(s) acquired	Number of chain homes acquired and still owned	Number of homes where real estate only was acquired and still owned	Total
Abe Briarwood/National Senior Care	Integrated Health Services Mariner Health Care	382		382
Fillmore Capital Partners	Beverly Enterprises	324		324
The Carlyle Group	HCR ManorCare	279		279
Formation Capital	Genesis HealthCare	180	65	245
SMV/SWC Property Cos.	N/A		189	189
GE Capital, Healthcare Financial Services	N/A		162	162
Warburg Pincus	Centennial HealthCare Florida Healthcare Properties	115		115
Onex	Skilled Healthcare	75		75
The Straus Group	CareOne	20	38	58
Lydian Capital	Trilogy Health Services	49		49

Source: GAO (2010): Analysis of Dealogic data and other information describing acquisitions of nursing homes. All PI firms in this table were private equity firms, except SMV/SWC and GE Capital.

A typical deal structure at the time was to have a master lease agreement for a chain, with each nursing home, as a separate company, subleasing from the chain (GAO 2010:21). These

⁵ Bought out in 2004 for about \$615 million plus the assumption of \$385 million in debt (SEIU 2007)

companies leased real estate to nursing home operators under triple net agreements (also referred to as “full net”), which – as described earlier, require the operators to pay all property maintenance (including capital costs), property insurance, and real estate taxes in addition to rent. Rent was calculated in different ways. Two of the firms in the GAO study calculated a base rent “...plus rent as a percentage of the operator’s adjusted net income or excess cash flow—ranging from 35 to as much as 50 percent (GAO 2010:21).”

Overall, however, the ownership structures of PE-owned chains were much more complex. Exemplary is one chain that set up a holding company for the entire chain; a real estate holding company, which leased properties to each nursing home; a separate limited liability company for each nursing home operation; and a separate company for each nursing home real estate property (GAO 2010:22-3 and Figure 3). The structure had tax benefits as well as financial benefits by limiting liability for patient abuse, violations of labor and employment laws, and other potential lawsuits.

Several of the PE firms sold off the real estate assets within one to five years. National Senior Care took the Mariner Health Care chain private in 2004 and immediately sold about two-thirds of the properties to SMV Property Holdings, which in turn leased back the real estate to the operating companies. Fillmore Capital Partners divided the Beverly Enterprises nursing homes into those that were leased (which retained the Beverly name) and those that it owned (which were branded as Golden Living). Later, Fillmore sold off the nursing homes and kept the property as being the more lucrative end of the deal. The Carlyle Group purchased HCR ManorCare in 2007 for \$6.3 billion (87 percent debt), and sold off all of the property to HCP, the health care REIT, in April 2011 for \$6.1 billion. Similarly, Formation Capital and FER Partners bought the Genesis Health Care chain in 2007 in a \$2 billion deal and sold off the real estate assets in April 2011 to HCP for \$2.4 billion.

The Risks of REIT Ownership of Nursing Homes

The belief that the real estate of nursing homes can be easily separated from care operations – and treated as a tradeable commodity -- became widespread in this period. A salient example comes from Centennial Healthcare, purchased by Warburg Pincus in 2000. It included 100 homes and the real estate for 66 homes, which it set aside in a separate legal entity known as Centennial Real Estate. When the 66 properties went bankrupt in 2004, Warburg’s Centennial real estate sold them to ‘Florida Healthcare Properties,’ also owned by Warburg Pincus, which in turn sold them to Formation Capital; and in 2006, Formation sold them to GE Capital Healthcare Financial Services (GAO 2010:18).

Separating real estate from care operations, however, poses serious risks and dangers for patient care. First, the strategic interests of the real estate company are not aligned with the operating company and may lead to lower investment in maintaining or investing in nursing home

facilities. The quality of care depends in part on the adequacy of the buildings and facilities where patients are housed. Second, if landlords raise rent, then operators may have to pay for the increases by shifting resources away from operations or staffing, directly affecting patient care. Nursing home operators have relatively fixed budget models, with limited flexibility for shifting resources.

It is noteworthy that some PE owners interviewed in the GAO study recognized at the time that sale-leaseback arrangements were likely to undermine the stability of their nursing home operations. Two firms that continued to own both operations and property did so because “...when operating and real estate companies are unaffiliated, tensions can arise over responsibility for improvements, reducing incentive to make improvements to the facility” (GAO 2010:20). One of these owners planned to sell the homes that leased real estate if he could not purchase it. Another operator admitted that sale-leasebacks can spill over into operations and negatively affect patient care because when revenues fall, operators have incentives to cut staff in order to meet rent and also maintain profitability (GAO 2010:20-21).

Third, separating assets from operating companies is a strategy for minimizing exposure to litigation. Cassen and McMillen emphasize that operators can optimize their risk reduction by creating complex ownership structures that consist of a real property SPE [single-purpose entity] to hold each piece of real estate, as well as a separate operating SPE for each nursing home business. This structure prevents litigants from obtaining judgments or penalties against the related companies or the owners personally (Cassen and McMillen 2003; SEIU 2007:9).

Stevenson and Grabowski point out that while licensure inspections are similar across ownership structures, owners may be protected from a range of other liabilities if they separate companies into distinct facility-level operating and ownership entities. Exclusions might include: liability under the False Claims Act for alleged fraudulent billing, tort liability for negligence and malpractice; alleged criminal activity under Medicare and Medicaid; suspension of payment by Medicare fiscal intermediaries or state Medicaid programs for alleged overpayments. Restructuring may not eliminate the risk of these sanctions, but limit their reach to individual facilities as opposed to entire chains (2008: 1406-7). Whether responsibility extends beyond providers who sign agreements with Medicare/Medicaid, for example to real property owners, appears to depend on the extent to which these owners directly or indirectly influence the care process. Here, REIT’s legal definition as ‘passive investors’ would seem to protect them unless their activities can be shown to have patient care effects.

Case Study: HCP, Carlyle Partners, and HCR ManorCare

The details of the HCP and HCR ManorCare (hereafter ManorCare) relationship provide important insights into how and why REITs and private equity firms have together expanded the role of finance capital in the nursing home segment of healthcare. The cases demonstrate the

deep interdependence between REITs and PE firms in their strategies to extract maximum wealth from the nursing homes and properties they own.

HCR ManorCare dates to 1982 as an early example of a for-profit nursing home chain, founded by the world leading glass and bottle manufacturer, Owens Illinois (O-I), as a diversification strategy into healthcare. It invested in the Nashville based “Health Group, Inc.” and began buying up nursing homes. Rechristened Health Care and Retirement Corporation (HCR), it went public in 1991 when it owned 135 facilities. It retained its investment grade status despite the 1997 cuts in federal funding, when five of its six largest competitors filed for bankruptcy. In 1998, it acquired Manor Care Inc. (Maryland), founded by a construction company in 1960 that had accumulated both healthcare and lodging operations. HCR renamed the merged entity “HCR Manor Care,” and became the largest long-term care provider in country -- with 171 skilled nursing centers, 42 assisted living centers, and 1 acute care hospital. Annual revenues exceeded \$2 billion. Notably, both HCR and Manor Care had retained almost all of their own real estate during this growth period. Further merger, acquisition, and divestiture activities continued (with the heaviest concentrations in Illinois, Ohio, Pennsylvania, Michigan, and Florida) until its buyout by private equity firm Carlyle in 2007 (HCR ManorCare n.d.)

The Carlyle Group, founded in 1987 to pursue leveraged buyouts, purchased HCR Manor Care in 2007 for \$6.3 billion, after delays brought about by opposition from the Service Employees International Union (SEIU) and an investigation by Congress and state regulators (de la Merced 2007). Carlyle renamed it “HCR ManorCare” (hereinafter ManorCare). At the time of the acquisition, ManorCare had 60,000 employees in almost 500 facilities providing skilled nursing and rehabilitation services, assisted living, outpatient rehabilitation clinics, and hospice and home care agencies (Carlyle 2007). SEIU calculated that the structure of the Carlyle deal, which relied heavily on debt, would increase interest payments and substantially reduce tax liabilities (SEIU 2007:12-14).

From the start, the REIT HCP was a partner in the PE buyout. The description of financial transactions below shows the level of complexity in financial dealings between the two entities – and how their financial dealings were designed to extract wealth at whatever cost to the financial resilience of the heir nursing home chain. Carlyle financed the buyout with \$1.3 billion in equity and \$4.8 billion debt – that is, almost 80 percent debt loaded on the nursing home chain. Based on ManorCare’s SEC filings, the company had \$994 million in debt prior to the Carlyle purchase and paid \$31.5 million in interest in 2006 (SEIU 2007). After the buyout, ManorCare incurred *three times the amount of debt it had prior to the buyout* -- \$3 billion in mortgage debt as part of the financing for The Carlyle Group's \$6.3 billion acquisition. As part of the deal, HCP invested \$1 billion in a mezzanine loan in the acquired company. The loan was the most subordinated debt in the company’s capital structure – lowest in the queue to be repaid in the

event of bankruptcy -- but a potential equity claim on the real estate assets that was senior to Carlyle's (HealthPeak 2007).⁶

By 2008, ManorCare reported \$4 billion in annual revenues (HCR ManorCare n.d.) In August 2009, HCP appeared to further position itself to eventually own the real estate assets of ManorCare. It purchased a \$720 million participation in the first mortgage debt of ManorCare at a discount of \$590 million. The investment represented 45 percent of the \$1.6 billion investment in the senior tranche of ManorCare's mortgage debt (HCP 2009). At the time, Wall Street analysts speculated that HCP's goal was to eventually own the real estate assets of ManorCare, but in the short term they would earn reasonable returns from the payments associated with the ManorCare mortgage debt (Barclays 2010).

Less than two years later, in April 2011, HCP acquired 100 percent ownership in ManorCare's real estate portfolio of 334 properties in 30 states for \$6.1 billion – almost the entire original purchase price of the chain. HCP paid \$3.53 billion in cash, \$1.72 billion to pay off HCP's debt investments in ManorCare, and \$852 million in HCP's common stock issued directly to ManorCare shareholders. HCP also exercised an option to buy a 9.9% stake in ManorCare for \$95 million.

At this point, the REIT HCP had positioned itself to extract substantial wealth from the ManorCare real estate through a long-term triple-net master lease.⁷ The lease agreement required ManorCare to pay the required rent on all facilities, including those that were struggling financially or had gone out of business. According to the master lease, the nursing home chain would pay \$472.5 million in rent in the first year, with increases of 3.5 percent per year in the next five years, and 3 percent thereafter. Under the agreement, HCP also would have the option to extend the leases to a total of 25 years, with rent increases of 3 percent annually during that time (Carlyle Group 2010). This type of agreement, while not uncommon, represents a huge extraction of wealth from entities that depend substantially on fixed government reimbursement rates subject to the uncertainties of political conflicts in Washington.

HCP's stated investment rationale was based on three expected outcomes: quality, efficiency, and market share. At the time, then HCP CEO and Chairman James Flaherty, remarked, "... the winners are going to be those operating partners that can produce quality outcomes, have efficient operations, and that have critical mass, particularly, at the local level. And that's why we love partners like HCR ManorCare" (HealthPeak 2011b). Despite these assertions, in August, 2011, ManorCare received a \$91.5 million judgment - \$80 million of it for punitive damages –

⁶ Note that HCP rebranded itself 'HealthPeak' in 2021, and most documents relating to HCP prior to that time were renamed accordingly.

⁷ A master lease for the properties leased by a chain requires the operator of the chain to pay rent on all properties, even those occupied by a failing or defunct establishment in the chain.

after a jury found one of its West Virginia nursing homes guilty of failing to properly care for one of its residents, who died shortly after a brief stay at the facility (Gerace 2013a).

Carlyle's sale of its real estate occurred later than analysts expected. When the 2007 buyout occurred, analysts viewed the value of underlying real estate as a primary driver in private equity acquisitions of nursing homes, and several other PE firms that acquired nursing homes made immediate sale-leaseback deals. ManorCare owned virtually all of its properties and was viewed by the industry as having one of the best property portfolios, with facilities that were new, well-maintained, and carrying little mortgage debt (Francis 2007). By waiting, however, the value of ManorCare's real estate increased 315 percent in just four years, according to one analyst: The book value of the property was \$1.47 billion before the Carlyle buyout in September, 2007; \$4.6 billion when Carlyle purchased the chain in December, 2007; and \$6.1 billion with the HCP purchase in 2011 (PEU Report 2011).

In all, Carlyle earned an estimated \$1.5 billion on the deal (PEU Report 2011) – despite the fact that the gains occurred during the great recession of 2008-09. The transaction allowed Carlyle to distribute payouts to investors and pay off some of ManorCare's debt (de la Merced 2010). HCP also benefitted with long term leases and escalators that locked in millions in payments for investor dividends.

Regulatory Change Shakes up Financial Assumptions

The HCP-Carlyle real estate deal occurred when both parties had full knowledge that the Centers for Medicare and Medicaid Services (CMS) was instituting changes in Medicare payments to skilled nursing facilities (SNFs) in fiscal year 2011. But the parties believed they would not be negatively affected. The CMS changes were designed to require more accurate assignment of Medicare payments to actual SNF beneficiary costs. Medicare switched to a system in which it paid a capitated payment - prospective payments to SNFs based on each patient's level of need for skilled care. This was calculated according to 'Resource Utilization Group' (RUG IV) categories, which identify the level of care required for nursing home residents with different levels of therapeutic need (Wright 2011). Under this system, nursing home operators have incentives to 'upcode' the level of care provided – from categories requiring low level therapy and skilled nursing to those requiring higher levels. A 2010 report by the Department of Health and Human Service's Office of Inspector General documented a disproportionate growth in use of the 'ultra-high therapy' category of services -- a practice particularly found in for-profit chains (Sherman 2011). In fact, the Department of Justice (DOJ) began investigating ManorCare in 2013 for submitting false claims on this basis (Mullaney 2015).

CMS intended the rules changes to be budget neutral, but they weren't. They resulted in a 16 percent increase in payments in 2010-11 because SNFs figured out how to work around the new standards. To correct that error, CMS recalibrated the RUG-IV classification system in FY2012

to account for the change in provider behavior, resulting in an 11.1 percent drop from FY2011 spending levels (Wright 2011; Talaga 2014). According to a study by the Medicare Payment Advisory Commission (MedPAC), average Medicare margins at for-profit freestanding SNFs fell from 20.7 percent in 2010 to 16.1 percent in 2012. Note, however, that non-profit margins were much lower and fell more – from 9.5 percent to 5.4 percent. Moreover, Medicare contributed only 22.2 percent on average of SNFs’ total revenue, with Medicaid constituting the disproportionate share. However, for-profit homes also relied disproportionately on private-pay patients rather than Medicaid patients (Talaga 2014).

HCP’s CEO Flaherty responded to the anticipated rate reductions by affirming ManorCare’s, “... proven ability to adapt to a changing reimbursement environment, something they have done successfully on a number of occasions” and that HCP is ‘poised to capitalize’ on opportunities for consolidation and to gain market share (HealthPeak 2011b). Many SNF operators did manage to mitigate the Medicare funding cuts by diversifying their portfolios, increasing private-pay ratios, reducing costs, and cutting down on all unnecessary expenses (Gerace 2011). And ManorCare seems to have done so as well, according to HCP’s earnings calls in the fall of 2012 and early 2013. It cut costs and shifted its business model to garner higher reimbursement rates for higher acuity, more complex shorter stay patients. Flaherty asserted that ManorCare had the largest share of this higher acuity market (HealthPeak 2012, 2013).

Through 2012 and 2013, HCP continued to increase cash profits from ManorCare, primarily driven by its annual rent increases (HealthPeak 2013). Flaherty’s positive statements in earnings calls continued until October 2013, when he was suddenly fired because the board lost confidence in his ‘leadership’ (Gerace 2013b). Note that Carlyle later stated in its 2018 bankruptcy hearing that it had not been able to meet its rent payments as early as 2012 (Whoriskey and Keating 2018).

By the end of 2014, HCP claimed that ManorCare’s reimbursements were negatively affected by a shift from Medicare to Medicare Advantage, which has lower rates for both length of stay and daily rates. In an 8-K filed on December 22, 2014, HCP announced they were writing down the value of their Manor Care investment (HCP 2014). This amounted to HCP admitting that ManorCare’s operating results were below expectations and that HCP expected these trends to continue into 2015 -- even though Medicare reimbursement rates were favorable at the time and ManorCare had taken actions to improve its margins.

By the beginning of 2015, metrics measuring ManorCare’s ability to pay rent on its facilities had declined substantially from their high in 2011. This was a problem for HCP as ManorCare’s rent accounted for 29 percent of HCP’s total net operating income. In the February 2015 earnings call, where HCP announced its 2014 full year results, analysts voiced their concerns about ManorCare’s continued financial weakness. Then, in March 2015, HCP announced a “strategic

repositioning” of their relationship with ManorCare. The repositioning amounted to three major actions: First, HCP reduced ManorCare’s rental obligation by \$112 million through rent reductions and a lower annual rent escalator. Second, HCP and ManorCare jointly marketed 50 non-strategic assets, whose proceeds were used to improve ManorCare’s ability to pay its rent. Third, HCP received a \$250 million deferred rent obligation (DRO), ownership of nine newer SNF assets and a 5-year lease extension (HealthPeak 2015; Mullaney 2016b).

But these strategies wouldn’t solve ManorCare’s unsustainable business model and financial problems caused by excessive debt and rental payments. Less than a month after HCP announced the strategic repositioning, DOJ unsealed the previously filed complaint against ManorCare under the False Claims Act. The complaint consolidated three cases in which former employees sued ManorCare for allegedly setting billing goals that were not tied to actual clinical needs of patients, threatened to terminate skilled nursing facility managers and therapists if they did not provide the unnecessary treatment, and kept patients in facilities after they were fit to be discharged. Media attention surrounding the lawsuit added to investors’ growing discomfort with ManorCare; and HCP believed that ManorCare would be required to spend valuable time and money defending themselves against the lawsuit, rather than improving the underlying business (HealthPeak 2014, Mullaney 2015).⁸

ManorCare Fails and HCP Spins off the Assets

By 2016 ManorCare’s financial situation showed no signs of improvement. In the second quarter of 2016, the metric measuring its ability to meet its rent payments had declined 10 percent on a year-over-year basis. In May 2016, HCP responded to ManorCare’s inability to meet its obligations by splitting HCP’s ‘good performing’ properties (those not connected to ManorCare) and ‘bad performing properties (those of ManorCare) into separate legal entities. It kept the good performing properties and spun off all of the distressed ManorCare property assets into a new, independent REIT, called Quality Care Properties (QCP). QCP’s assets would include ManorCare’s assets, the \$250 million deferred rent obligation, and HCP’s 9.9% stake in ManorCare. ManorCare’s property comprised 90 percent of QCP’s assets (HealthPeak 2016a). Carlyle continued to own the ManorCare operating business. In sum, HCP saved itself by another financial engineering trick – that of spinning off bad assets that it could allow to fail without jeopardizing the good assets.

Management’s public relations justification for the spin-off was that it would maximize the value of the ManorCare portfolio for three reasons. First, there was significant value embedded in the HCR portfolio that was not being recognized by the market. Second, QCP as a standalone

⁸ The DOJ eventually dropped the false claims suit due to missteps on the part of the government. “Federal Judge Orders DOJ to Pay ManorCare’s Legal Fees in Fraud Case,” *Skilled Nursing News*, November 7, 2017, <https://skillednursingnews.com/2017/11/federal-judge-orders-doj-pay-manorcares-legal-fees-fraud-case/>

company would have a dedicated management team able to focus on post-acute and senior housing strategy. And third, QCP's new management would have more flexibility to pursue a broad array of strategies. Although the HCP team claimed they fully expected QCP to succeed, Wall Street analysts forecasted that, as an independent entity, QCP would be able to shed its REIT status to accept more equity in ManorCare's operating company in a tradeoff for a future rent cut. Without this organizational flexibility, any future rent cuts would accrue value to Carlyle rather than HCP shareholders (HealthPeak 2016b).

HCP was now protected from the inevitable bankruptcy of ManorCare. Despite an agreement in early 2017 to defer some rent payments on the QCP properties, ManorCare continued to fall short; and in August 2017 QCP filed a lawsuit to remove ManorCare's management and replace it with a court-appointed receiver, who would have the power to collect rent from Carlyle. QCP also threatened to evict ManorCare from its facilities (Nelson, 2017; Biswas 2017).

Pre-Packaged Bankruptcy and Another REIT-Healthcare Joint Venture

In 2018, less than two years after the QCP's spin-off from HCP, ManorCare filed for Chapter 11 bankruptcy, with a debt load of \$7.1 billion on its chain of some 290 facilities. In its Chapter 11 filing, ManorCare stated that it had failed to cover monthly rent obligations since 2012 and that it owed \$446 million in rent, which was accruing at \$39.5 million per month. ManorCare was also facing four lawsuits by shareholders of its previous landlord HCP Inc, regarding the 2016 spin off of part of the ManorCare real estate portfolio it had acquired from Carlyle in 2011 (Bittner 2018).

In other words, ManorCare went bankrupt because its revenues could not cover the excessive rental payments that Carlyle had agreed to pay HCP in the sale-leaseback agreement of 2011 – the agreement that allowed Carlyle to extract \$1.5 billion only 5 years after it purchased ManorCare in 2006.

ManorCare's operating subsidiaries did not file for Chapter 11, and the parent company's Chapter 11 had no direct impact on the company's operations. All ManorCare employees, creditors, vendors, and suppliers aside from its landlord QCP, were unimpaired by the transaction. In a pre-packaged bankruptcy, QCP agreed to wipe out ManorCare's \$445 million in unpaid rent in exchange for it taking over the company's operating business. Under this arrangement, QCP would no longer qualify for status as a REIT (QCP 2018). Carlyle finally found an exit strategy.

How did all of this financial engineering between the REIT and the PE firm affect patient care? By 2018, , state investigators had cited the chain for thousands of health code violations -- as exposed in an investigative report by *The Washington Post* (Whoriskey and Keating 2018). Between 2013 and 2017, health code violations increased by 25 percent to 2,000 per year –

almost all related to understaffing. They included medication errors, overuse of opioids, failure to treat bed sores or provide special services such as injections, colostomies and prostheses; and failure to provide help with eating and personal hygiene. Serious health code violations posing ‘immediate jeopardy’ rose 29 percent.

These health violations, however, didn’t stop the financial wheeling and dealing. A month after the bankruptcy settlement, QCP announced that the ManorCare operating business would be sold to a joint venture that included healthcare REIT Welltower and non-profit healthcare system, ProMedica, for \$4.4 billion. QCP would sell-off 74 skilled nursing facilities. Welltower would invest \$2.2 billion to acquire the remaining real estate, while ProMedica would invest \$400 million and acquire the ManorCare operations. At the time, ManorCare operated 450 facilities in 25 states with 50,000 employees (CNBC 2018; Welltower 2018a).

For ProMedica, the deal launched it into the top 15 largest healthcare systems in the US by revenue. ManorCare’s portfolio of skilled nursing, assisted living/memory care, and homecare/hospice facilities complemented its hospital-based system and insurance plan (Welltower 2018). For Welltower, the CEO Thomas DeRosa justified the acquisition by saying that they were buying the ManorCare real estate for half of what HCP paid for it; and that the problem was not the skilled nursing segment per se. Under HCP and Carlyle, the amount of debt levered on the company made it unsustainable: Profits “were made off of ridiculous levels of leverage” (Welltower 2018b). ManorCare’s financial stability under ProMedica appeared sound two years after the buyout, with half of its revenue coming from ManorCare (rebranded ProMedica Senior Care). Its stability was primarily due to rent reductions, acquiring ownership of 20 percent of the real estate. Annual rent, which was \$450 million under QCP, dropped to \$150 million under the Welltower deal (Bannow 2020).

Case Study: Health Care REIT, Formation Capital, and Genesis Healthcare

Genesis Healthcare provides a similar story of the inextricable link between private equity and REIT financial fortunes. As Carlyle was buying out ManorCare in 2007, PE firm Formation Capital led a consortium of PE buyers to acquire Genesis Healthcare in a deal valued at roughly \$2 billion. Similarly, in 2011, as Carlyle was selling off ManorCare’s real estate to HCP, Formation Capital sold off the Genesis real estate to Health Care REIT (HCN) for \$2.4 billion cash. The proceeds went to Genesis’ PE owners. And as in the HCP-ManorCare transactions, HCN purchased a 9.9% stake in the operating company for \$47 million -- implying a total enterprise value of \$2.9 billion (\$2.4 billion for the real estate and \$470 million valuation of the operating company). By this logic, Formation Capital had created almost \$1 billion in value (\$2.9B - \$2B) in just four years (Welltower 2011a).

When explaining the transaction rationale to investors, the Genesis CEO explained that in the four years since Genesis had been acquired, the company had “truly been capital constrained.”

Given Genesis' capital needs, it made more sense for them to sell the real estate rather than lever it because the cost of capital would have been significantly higher to do the latter, and would have made any attempts to monetize the real estate even more difficult (Welltower 2011a).

HCN cited four reasons for its decision to invest in Genesis. First, Genesis' focus on the post-acute care model aligned with broader trends in the healthcare sector to provide patient care in a lower cost setting. Second, Genesis was well positioned for growth given their quality payer mix. Third, the Genesis-HCN partnership would provide HCN with a pipeline for external growth opportunities. Management expected CMS regulations to amplify opportunities to gain market share by generating a pipeline of acquisition targets as smaller operators would struggle to satisfy regulatory burdens and institutional operators, like Genesis, would be favored. Finally, HCN cited the geographic overlap between Genesis geographically dense portfolio and HCN's existing senior housing and hospital assets. The overlap would create a continuum of care within HCN's portfolio of operators that could be capitalized by the exploration of synergies (i.e., consolidation), among HCN's portfolio partners (Welltower 2011b).

Genesis Goes Public and Becomes Welltower

In 2014, Genesis acquired Skilled Healthcare Group (later renamed Sun Healthcare Group), creating one of the largest skilled nursing facility providers in the country. Genesis then positioned itself in 2014 to go public – not via a risky IPO, but by merging with a publicly-traded nursing home chain, Skilled Healthcare Group. This created a combined entity of 500 facilities (Olivia 2014). The successful merger relied in part on a \$360 million, 2-year secured loan that HCN provided so the merger could close. When asked about the loan in a 2015 quarterly earnings call, HCN management said, “When we do a loan, it's with an important partner, and Genesis certainly qualifies. The skilled health portfolio included a lot of owned assets, and there was a big loan secured by those assets that couldn't be assumed by Genesis as part of the merger. *To get the deal done they asked us to help out, and we were happy to do that*” (emphasis added) (Welltower 2015.).

In 2015, HCN went on to rebrand itself as ‘Welltower’ – the very same REIT that took over ManorCare's assets on the cheap in the 2018 pre-packaged bankruptcy. Back in February 2016, however, against the backdrop of the QCP spin-off, analysts asked the Welltower CEO about the Genesis assets. He argued that ManorCare's underperformance was unfairly implicating Genesis. While ManorCare's management cited industry headwinds as the reason for their financial distress, the cross-currents were not new and research said that the dramatic increase in the Medicare population would offset the decline in payments based on length of stay and per capita utilization of healthcare services. Moreover, Welltower had not suffered rent reductions (unlike HCP) because Genesis was more financially secure than ManorCare at the corporate and operator level (Welltower 2016)

But in fact, Genesis had its own financial problems that required it to begin divesting properties. In July, Sabra, Genesis' second largest landlord, announced it was selling off 28 facilities (Mullaney 2016c). In November, Welltower announced it had disposed of \$1.7 billion of Genesis properties (Businesswire 2016). And that same month, Genesis agreed to a \$52.7 million settlement with federal authorities to resolve allegations of improper billing practices (Mullaney 2016a).

Financial problems accelerated in 2017. In September, Sabra, the historic landlord of Sun Healthcare Group (which had merged with Genesis in 2013), announced a "Genesis Exodus" plan to divest of its remaining Genesis assets (which once totaled 89 assets) by the end of 2018 (Spanko 2017a). In November, Genesis announced a major restructuring of its leases with its top landlords, Sabra and HCN (Spanko 2017b). And on November 30, Genesis received a stock delisting warning from the NYSE because the Company's stock averaged less than \$1 per share over a recent 30-day period (Spanko 2017c). With ongoing financial problems in 2018, Genesis entered into a \$555 million credit facility with MidCap, a unit of Apollo (S&P Global 2021), before announcing in March that a key long-term goal would be to own more its own real estate (Flynn 2019). But it received another listing warning after its share price dropped to below \$1 for 30 consecutive trading days (Spanko 2020a). By August 2020, Genesis issued a statement casting "substantial doubt" on its ability to survive into 2021 (Spanko 2020b). In response, several of Genesis' REIT landlords responded to its troubles by taking rent write-downs and switching the tenant to cash-based accounting terms (Spanko 2021a). By February 2021, Welltower logged 2 percent same-facility revenue growth in its long-term and post-acute care portfolio as compared to the prior year quarter. The significant concentration of Genesis assets in that category drove down the ability of Welltower's healthcare tenants to pay the rent (Spanko 2021b). In March 2021, Welltower ended its relationship with Genesis by selling 51 assets to a joint venture consisting of Welltower, Aurora Health Network and Peace Capital for \$500 million, for later 'transitioning' to other regional operators (Spanko 2021c).

Conclusions: The Outcomes of REITs and Private Equity in Nursing Homes

The case studies of ManorCare and Genesis expose the legal fiction that REITs are passive investors in real estate that should be exempt from taxation because they simply collect rent that they pass along to their investors. In both cases, REITs partnered with private equity firms in their acquisition of nursing homes. From the start, HCP was a partner in Carlyle's acquisition of ManorCare. The REIT provided Carlyle with a mezzanine loan that enabled the PE firm to close the deal. The loan also positioned HCP to own much of ManorCare's assets if the nursing home business failed. In 2011 HCP acquired all of Manor Care's real estate in a deal that earned Carlyle \$1.5 billion on its nursing home investment in less than five years. If ManorCare failed after that, Carlyle could walk away – and it did.

In the meantime, the sale-leaseback agreement allowed HCP to extract excessive and rising rent payments that made ManorCare financially unsustainable and undermined ManorCare's ability to care for patients or adhere to basic health and safety standards. In 2016, acknowledging ManorCare's inability to make rent payments, it was HCP that spun-off the ManorCare properties into separate REIT – QCP – so that HCP's good performing properties would be out of reach in the event of a ManorCare bankruptcy. Both Carlyle, which still owned ManorCare operations, and HCP had positioned themselves to survive a bankruptcy – having already extracted their millions from the nursing home chain. Patients and healthcare workers bore the brunt of the financial engineering that led to understaffing and massive health code violations over several years.

The acquisition of financially stable nursing home chain Genesis Healthcare by a group of PE firms led by Formation Capital tells a similar story. Soon after the leveraged buyout of Genesis, Formation Capital soon sold off all of Genesis' real estate to healthcare REIT HCN for more than it had paid to acquire the chain. That deal, valued at \$2.9 billion, exposed the imbalance in valuations for nursing home real estate and nursing home operations: the real estate was valued at \$2.4 billion, the nursing home operations at \$400 million. Investors valued HCN's ability to extract rising rent payments much more highly than the nursing home operator's ability to provide excellent patient care and grow organically. Genesis eventually went public via a merger with a publicly traded nursing home chain -- a merger that relied on a \$300 million loan from HCN to close. HCN facilitated Formation Capital's dealings at every stage. Despite HCN's assurances that Genesis was still financially stable, it soon became clear that the nursing home operator was in financial difficulty. Genesis settled claims that it fraudulently overcharged Medicare and Medicaid for services provided to patients by reaching a \$52.7 million settlement with federal authorities. Its share price deteriorated, sometimes trading at less than a dollar a share.

Far from being passive real estate investors, HCP and HCN were active partners with PE firms Carlyle and Formation Capital in driving the financialization of nursing home care. They engineered profitable exits of the PE firms from their nursing home acquisitions and they drove up rents to the detriment of the nursing home operators. It was the REIT's drive for profits that put these nursing home patients, as documented by Whoriskey and Keating (2018), at risk of poor treatment and serious health problems.

More generally, recent evidence clearly documents the negative effect of private equity ownership on nursing home patients. A rigorous study published by the National Bureau of Economic Research (NBER), carried out prior to the COVID-19 pandemic, found that mortality rates in PE-owned nursing homes were 10 percent higher than the overall average. This occurred because PE-owned homes shifted resources away from patients, utilizing lower nurse to patient staffing ratios. Moreover, to compensate for lower staffing, the homes made 50 percent higher

use of antipsychotic drugs (drugs associated with higher mortality rates). They also spent more money on things unrelated to patient care, such as monitoring fees, while Medicare billing was 11 percent higher (Gupta, Howell, Yannelis, and Gupta 2021).

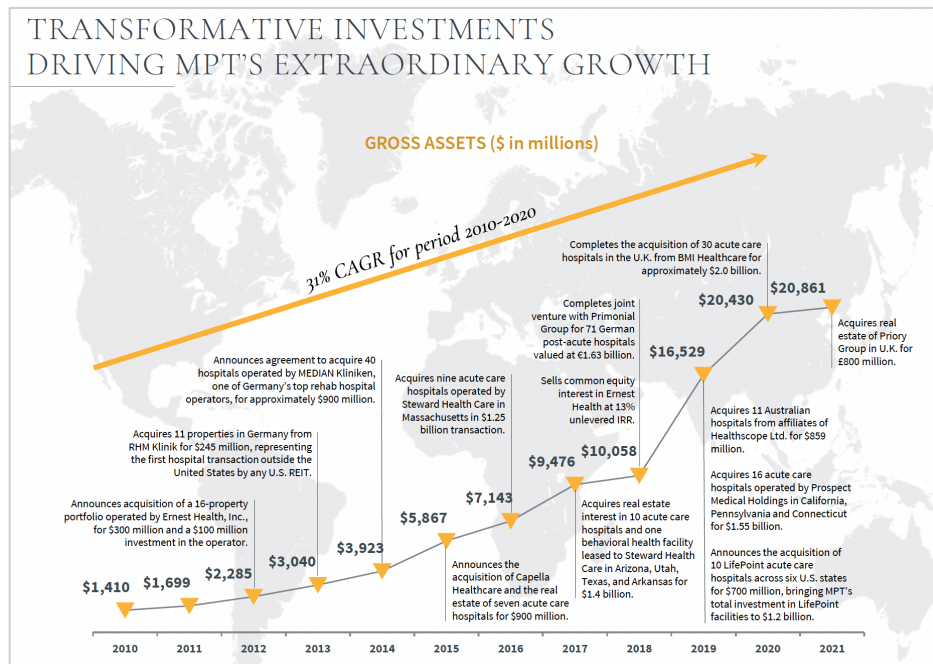
REITs and Private Equity in Hospital Systems

Historically, hospitals have owned their own property, and the overwhelming majority still do, as most hospitals continue to be relatively small, community based, and non-profit. Very few REITs attempted to enter the hospital market until the 2000s. REIT entrance into the hospital segment lagged behind their penetration into medical office buildings and SNFs. Like the skilled nursing home segment, REIT expansion into hospital property ownership has depended importantly on the rise of for-profit chains; and after a growth spurt in the 1990s, they have grown rapidly since about 2010 in conjunction with the penetration of private equity investments into hospitals. Medical Properties Trust provides a leading example of a healthcare REIT in this segment. It illustrates the logic of the business model as well as how value extraction has grown explosively in conjunction with three PE-owned chains: Steward Health System, Prospect Medical Holdings, and LifePoint Health.

Medical Properties Trust

Medical Properties Trust (MPT) is a leading healthcare REIT which in 2021 owned 425 properties in 9 countries, with 51 operators in both for-profit and non-profit health care entities (MPT 2021). It boasted a compound annual growth rate (CAGR) of 31 percent between 2010 (when its gross assets were \$1.4 million) and 2021 (with \$21 billion in gross investments worldwide). See Figure 1.

Figure 2.1: Medical Properties Trust CAGR Growth Rate: 2010-2021



Source: MPT. 2021. "MPT Investor Presentation." 2021-06-10_Medical Properties Trust Inc._IP_English.Pdf." Pg 27.

MPT claims it is a highly diversified REIT, but 77 percent of its properties are in acute care hospitals. In the US, while it operates in 33 states, it is heavily concentrated in five: Texas, Massachusetts, California, Utah, and Pennsylvania. These properties make up fully 75 percent of its US portfolio and are linked to two major private equity owned chains: Steward Healthcare and Prospect Medical Holdings. These two systems alone accounted for 29 percent of MPT's global portfolio in 2021 (MPT 2021). According to its Founder, Chairman, President, and CEO, Edward Aldag, in 2020, MPT's pipeline in 2020 was, "... almost entirely, maybe 90% general acute care hospitals from a dollar standpoint" (MPT 2020a).

According to Aldag, he founded MPT in 2003 because, "... we saw that hospitals are certain to generate growing amounts of profitable revenue.... we decided let's capture the portion of revenues that absolutely have to be paid to occupy delivery systems, right, delivery systems that's real estate, that's what we own" (MPT 2021).

MPT Business Model

MPT has pursued a business model based on owning and leasing its properties rather than providing loans for mortgages. In a 2020 Earnings Call, then CFO Steven Hammer noted that, "We have reduced this mortgage exposure primarily by acquiring the underlying mortgaged assets rather than simply taking dilutive repayments" (MPT 2020a).

In its sale-leaseback model, the tenant pays rent and bears all additional costs, including maintenance and repairs, utilities and taxes. Leases are long term – typically 10 to 20-years in the US, with multiple 5-year extensions, and longer terms internationally. Ninety-nine percent of its leases have inflation-based or fixed annual rent escalators (with a floor based on the Consumer Price Index, CPI). Annual escalators have averaged about 2 percent). Notably, hospital reimbursement rates have consistently outpaced cost inflation. Over 95 percent of MPT properties are master leased, cross defaulted⁹, and/or with a parent guarantee (MPT 2021: 12-13). In addition to sale-leaseback payments, MPT also makes money from interest income from loans to tenants and other facility owners, and from profits or equity interests in some of its tenants' operations (MPT 2020b).

MPT views the hospital segment of the industry as filled with opportunities for REITs to grow – with \$500-750 billion in operator owned hospital real estate in the US and abroad, accelerating consolidation of hospitals systems as they search for cost efficiencies, the growing percentage of hospitals owned by for-profit and PE entities, and the growing acceptance of sale-leasebacks even among non-profit hospitals (which constitute 75 percent of all community hospitals) (MPT 2021: 14).

In targeting real estate deals, MPT states that it looks for certain key conditions. It targets 'proven operators' and communities with positive population growth, density, and an aging population. It looks for 'accommodating economic and political conditions,' high barriers to entry and no local substitute hospital. Rent payments to MPT are not 'controllable' expenses – that is, they are fixed, and rent/interest is functionally senior to parent creditor obligations (MPT 2021: 16).

Of critical importance in its decision on where to invest is whether a community needs the hospital – that is, if the hospital operator fails, the real estate will be safe because another operator will be needed. In its Annual 2020 Report, MPT stated, "Finally, we always address two primary questions when underwriting an investment – 1) is this hospital truly needed in the market and 2) would the community suffer were the hospital not there. We believe answers to these two questions provide significant insight on whether or not to move forward with a particular investment" (MPT 2020b).

In acknowledging risks to its business model in its 2020 10-K report, MPT cited adverse effects due to tenants' financial or operational setbacks: "If any one of these tenants were to file for bankruptcy protection, we may not be able to collect any pre-filing amounts owed to us by such tenant. In a bankruptcy proceeding, such tenant may terminate our lease(s), in which case we would have a general unsecured claim that would likely be for less than the full amount owed to

⁹ Cross default in a loan agreement means that the borrower is in default in one loan if the borrower defaults on another obligation – for example, a car loan default would automatically trigger a mortgage default.

us” (MPT 2020b:20). “Defaults by our tenants under our leases may adversely affect our results of operations, financial condition, and our ability to make distributions to our stockholders. Defaults by our significant tenants under master leases (like Steward, Circle, Prospect, Priory, and MEDIAN) will have an even greater effect” (MPT 2020b: 21).

Despite the high dependence of hospital systems on government reimbursements, MPT did not raise this as a substantial risk factor. In fact, in an investor presentation in 2015, then CFO Hammer noted, “And reimbursement evolution does not bother us.... nobody gets bothered about reimbursement evolution or the fact that there is evolution, because we all know it's going to happen. We can go back 10, 15, 20, 30 years and there had been significant changes in the reimbursement environment, starting with going from the cost plus to DRGs, what about the HMOs, any number of transactions or changes in reimbursement” (MPT 2015).

MPT and Private Equity Owned Hospitals

Private equity firms poured into the hospital sector in the run up to the 2010 Affordable Care Act, with 7 of the largest 11 for-profit chains in PE ownership by 2011 (Appelbaum and Batt 2020: 26, Table 3.1). But the revenues anticipated under the ACA didn’t materialize and Medicaid and Medicare reimbursement rates stalled. As a result, private equity firms found it difficult to exit their investments with ‘outsized returns’ in their desired 5-year time frame. Several found a path forward by partnering with healthcare REITs, and MPT was perhaps the most preferred partner. The PE firms relied heavily on separating hospital real estate from health care operations and selling off the hospital property to monetize these assets. They used the proceeds to finance additional acquisitions and pay themselves large dividends (Brynestad and Fourie 2020). This strategy has undermined the financial stability of hospitals, which received little or none of the sales proceeds and must pay rent on property they once owned.

More recently three hospital systems illustrate the new model for private equity to extract wealth from its hospital systems by partnering with REITs to finance buyout deals and to allow the private equity general partners to exit with the requisite outsized returns: Steward Health Care, Prospect Medical, and LifePoint.

Case Study: MPT and Steward Health Systems¹⁰

Private Equity firm Cerberus Capital Management formed Steward Health Care in 2010 when it acquired Caritas Christi – the largest community-based health care system in New England, with six hospitals employing 10,000 workers and serving more than half a million patients annually. Cerberus acquired the six hospitals and affiliated units in a \$420 million leveraged buyout plus assumed debt and pension liabilities of \$475 million that valued the healthcare system at \$895 million (PitchBook 2016). Steward quickly added-on five more acute care community hospitals

¹⁰ For a detailed examination of Cerberus strategies at Steward Health System over a 10-year period, see La France, Batt, and Appelbaum (2021).

in 2011 and 2012, two of which it acquired from PE-owned Essent Healthcare. By 2012, Steward was a \$1.8 billion company, with 17,000 employees (making it the third largest employer in Massachusetts); it cared for 1.2 million patients annually (Mohl 2012).

Because Cerberus was converting the nonprofit Caritas Christi into a for-profit system, the Massachusetts Attorney General required that certain conditions be met, including that Cerberus invest \$400 million in upgrading the hospitals' infrastructure. Cerberus funded the system's operating losses as well as its infrastructure expenditures and the acquisition of additional hospitals by monetizing some of Steward's assets via sale-leaseback deals for its medical office buildings and by having the health care system load up on junk bonds and other debt. In its 2015 report, the AG noted that, "The solvency position of the system declined as debt increased, while operating losses and pension fund charges eroded equity." (Massachusetts Office of the Attorney General 2015). Nonetheless, Cerberus had met the stipulations for investment in infrastructure and was released from AG oversight thereafter.

Enter Medical Properties Trust. By 2016, Cerberus had sold off most of its hospitals' property for \$1.25 billion to MPT, which took a 5 percent (\$50 million) equity stake in Steward. The hospitals assumed the long-term costs of inflated leases, substantially reducing their net revenues. Cerberus used the sale proceeds to pay itself and its investors almost \$500 million in dividends, pay down debt, and launch a massive debt-driven acquisition – buying out 27 hospitals in 9 states in three years between 2016 and 2019. MPT was a critical partner in all of these deals – entering into sale-lease-back arrangements, which substantially funded the additional buyouts while leaving the acquired hospitals with long term leases that substantially curtailed net revenues.

The first acquisition was of eight hospitals in Ohio, Pennsylvania, and Florida, purchased at a discount for \$311.9 million from the failing CHS system, which was selling off large numbers of hospitals to pay down its own debt and avoid bankruptcy (Barkholz 2017). While CHS had retained ownership of the hospital properties, Steward immediately sold them off to Medical Properties Trust for \$301.3 million, which means that MPT essentially financed the eight-hospital purchase and implies that the hospitals' operations were only worth \$10.6 million to MPT and its investors (Brynestad and Fourie 2020; Medical Properties Trust 2020).

The sale-leaseback undermined the hospitals' financial stability. Illustrative is the case of Easton Hospital in Easton, PA, where the hospital had owned its own real estate since its founding in 1890. Then in 2020, when the COVID-19 pandemic hit, Cerberus announced that Easton Hospital was financially at risk and would have to be closed unless the governor granted it federal bailout funds of \$8 million per month. To prevent a greater public health catastrophe, the governor complied (Batt and Appelbaum 2020).

In 2017, Cerberus moved on to strike a deal with PE firm TPG to buy IASIS Healthcare – a chain of 18 hospitals strewn across Utah, Arizona, Colorado, Texas, Arkansas, and Louisiana. TPG had led a consortium of PE investors to acquire IASIS in a 2005 LBO worth \$1.484 billion (Bloomberg 2017). After a 2011 dividend recapitalization of \$1.88 billion designed to pay off debt and pay out investor dividends, TPG sought but failed to exit from the hospital chain (IASIS 2012). Enter MPT in 2013 to purchase the real estate of 3 IASIS hospitals, which garnered \$281.3 million in proceeds for TPG (IASIS 2013).

In 2017, MPT was also pivotal in TPG’s sale of the IASIS hospitals to Steward for \$2 billion. MPT and IASIS entered into a sale-leaseback and mortgage financing arrangement amounting to \$1.5 billion in total (MPT 2017). At the time, IASIS had \$1.85 billion of debt, some of it due in 2018; IASIS debt was retired as part of the transaction. TPG earned an estimated 50 percent on its equity investment of \$434 million in IASIS, including debt funded dividends. MPT paid \$710 million to acquire the real estate of nine hospitals and provided a \$700 million mortgage loan on two other hospitals. MPT also invested \$100 million in Steward, bringing MPT’s ownership of Steward to 9.9 percent (Medical Properties Trust, Inc. 2017:10-k).

With the IASIS deal, Cerberus almost doubled the size of the Steward system, but also absorbed a system loaded with debt by the previous PE owners – a debt level estimated at 6.5 times its earnings. At the time, then CEO of MPT Edward Aldag, reported in an earnings’ call that, “Steward is doing a fantastic job with the integration of not only the original CHS acquisition or the second CHS acquisition, but also with the IASIS acquisition. And we expect that their growth is going to be somewhere in the 3% to 4% range in their EBITDAR this year”¹¹ (MPT 2018a). Later that year, Aldag remained optimistic, despite being questioned about the fact that Steward represented 37 percent of MPT’s portfolio. He justified it by saying that Steward properties were divided into different markets, with the largest division (Massachusetts) at 14 percent and the Utah division at 10 percent (MPT 2018b). In 2018, Medical Properties Trust leased additional properties to Steward and acquired five others, leading MPT to own a total of \$4.052 billion worth of Steward-related real estate as of December 31, 2019 (Brynestad and Fourie 2020; MPT 2020b).

But as Adlag was singing Steward’s praises, Steward’s Massachusetts hospitals were in deep financial trouble – the worst financial performers of any system in the state, with the highest level of debt and with higher-than-average rates of patient falls, hospital acquired infections, and patient readmissions (CHIA 2019). It also found that Steward had an equity financing ratio of negative 37.6 percent in the fiscal year 2018 (CHIA 2019: Figure 5). Steward’s negative equity financing ratio indicates how highly leveraged and financially unstable Steward had become. S&P Global Ratings also gave MPT a negative outlook because of its increased exposure to

¹¹ EBITDAR is defined as earnings before interest, taxes, depreciation, amortization, and restructuring or rent costs, and is an indicator of the tenant operating company’s ability to pay rent.

Steward, which represented 36.6% of the REIT's revenues at the time (Maqbool, 2018). Steward could not direct more funding and resources to stabilize hospital finances or to improve the quality of care without increasing the chance that it would default on its debt.

Despite these problems, MPT was ready to help Cerberus exit the Steward System in 2020. Having more than recouped its investments, Cerberus turned to a novel strategy that depended on MPT financing. In May 2020, Cerberus transferred ownership to a group of Steward's doctors, led by its CEO Ralph de la Torre, in exchange for a note due in five years that paid regular interest to Cerberus and that could be converted back to equity – ensuring that Cerberus would gain whether the system did well or not (Willmer 2017). If Steward were to head to bankruptcy, Cerberus would do better as a bondholder than a stockholder— as equity is frequently wiped out.

In January 2021, Steward borrowed \$335 from Medical Properties Trust to buy the Cerberus' note -- making MPT Steward's largest creditor, its landlord, and a minority owner of the hospital system as well as; and in May 2021, Cerberus exited Steward completely (Hechinger and Willmer 2020). Only a month later, Steward went on to buy out another five hospitals in Florida – this time from Tenet Healthcare – for \$1.1 billion. As part of the deal, MPT acquired the real estate underneath the hospitals for \$900 million (Paavola 2021b).

As these details confirm, MPT has partnered fully with Steward, its largest tenant, in the acquisition of hospitals for the Steward chain. This has made MPT one of the largest owners of U.S. hospital real estate. MPT, a publicly-traded company, has been able to attract investors because of its rapid growth, due disproportionately to its partnership with Steward, and to the long-term leases it has with health systems that provide essential services. The rent payments, scheduled to rise steadily over the length of the lease, promise an unending stream of lucrative dividends. Should Steward, MPT's largest tenant, falter financially, however, the effects on MPT could be disastrous. Steward depends on MPT to finance its expansion, and MPT relies on rental income from the Steward system to retain its investors and protect its share price. This intertwined relationship between MPT and Steward has raised questions and come under scrutiny.

Despite assurances from MPT in 2019 that Steward's profits were strong, the health system constantly lost money. Steward lost about \$207 million in 2017 and about \$271 million in 2018. The pandemic wreaked havoc on Steward's finances as it did on most hospitals. Despite receiving more than \$441 million in government funds to address problems created by COVID-19, Steward had a net loss of \$408 million that year. With Steward on track for its largest loss ever in 2020, there were concerns that the hospital system would not be able to meet its 2020 rental payment of \$385 million to MPT. Steward's finances improved dramatically as a result of two transactions in which it engaged. In the summer 2020, Steward executives, acting in their personal capacity, formed a joint venture with MPT. MPT loaned \$200 million to the joint

venture (JV). The JV used the \$200 million to buy Steward's international assets, valued by Steward at a book value of \$27 million, yielding a \$173 million cash gain for Steward. In a second transaction in July 2020, MPT converted the mortgages it held on two Utah hospitals owned by Steward into leases, acquiring the real estate and paying Steward \$200 million. MPT says the JV transaction was valuable to it because it opened up new international opportunities. Steward says the Utah transaction valued the hospitals fairly, if not conservatively (Spengle 2022; Katz 2022).

Who were the winners and losers in these transactions? Clearly patients, healthcare workers, suppliers, and communities lost out. In the tension between making ever increasing rent payments that reduce hospitals' net revenue and improving hospital technology, processes and wages, rent payments took precedence. Cerberus walked away with an estimated \$700 million,¹² which it could not have done without the critical role played by the REIT, Medical Properties Trust. And what about MPT? It had invested \$4.5 billion in the Steward System and owned 36 facilities, according to its Investor Presentation in June 2021. In response to a question from reporters for the Wall Street Journal in February 2022, MPT said that since 2016, Steward has paid MPT roughly \$1.2 billion in rent and mortgage interest. Its CEO, Edward Aldag Jr., earned \$16,857,637 in total compensation in the 2020 pandemic year -- above the average in the S&P 500 (AFL-CIO 2021).

Case Study: MPT and Prospect Medical Holdings

The growth and expansion of Prospect Medical Holdings also illustrates the critical role that MPT has played in the safety-net hospital chain owned by PE firm Leonard Green between 2010 and 2021. Prospect Medical Group was founded by a group of California physicians in 1996, and expanded to include additional medical groups and a Health Maintenance Organization (HMO). In 2007, it acquired ProMed Health Care Administrators, increasing HMO members to some 80,000. At that time it also acquired Alta Hospital System, LLC, with four community-based hospitals in southern California, which became the platform for its hospital division.

Alta started out in 1998 as an eight-hospital network of community hospitals in Los Angeles, created by a hospital marketing executive, David Topper. Topper gained a \$3 million investment from private equity firm Kline Hawkes and financed the rest of the \$34 million purchase price through debt. A young employee of the firm, Sam Lee, oversaw the Alta investment, and by 2001, quit the PE firm to become a 50-50 co-president with Topper. Their business model combined intense cost cutting with maximum, and often fraudulent, billing. According to a

¹² Cerberus had originally invested an estimated \$253.4 million. Cerberus and its investors received more than \$700 million from the 2016 sale-leaseback deal and another \$335 million from the sale of the hospital chain to the Steward physicians, financed by a loan from the Medical Properties Trust. Subtracting Cerberus total expenditure on Steward yields a profit of more than \$700 million (Willmer 2021a, and author private correspondence with Willmer).

former company CFO, Alta's hospitals, "... were sort of war-zone hospitals. They were very, very dirt cheap in every respect" (Elkind 2020). Lee and Topper were able to sell Alta to Prospect Medical based on inflated estimates of forthcoming profits, which Prospect's auditors caught only after the company had agreed to pay off Alta's debt and pay \$50 million to both Lee and Topper. Prospect defaulted on its loans, leading to millions in lender penalties, and was delisted on the American Stock Exchange.

Nonetheless, Lee became CEO of Prospect Medical by consolidating power and ousting Prospect's 74-year-old founder. His management of the company led to ongoing litigation, with dozens of lawsuits over unpaid vendor bills, broken contracts, and unpaid compensation of fired executives. It acquired one more LA hospital before attracting private equity firm Leonard Green (LG) to acquire it in a leveraged buyout worth \$363 million in December 2010. Leonard Green acquired a 61.3 percent stake, with Topper owning 14.9 percent and Lee, 20.2 percent (PitchBook 2021a). LG partners controlled the board while Lee ran operations as CEO with a \$2 million annual salary. In 2012, Prospect acquired Nix Health System in San Antonio for \$48 million. The system went from earning roughly \$20 million annually to losing money; and in 2019, Prospect shut down the system and laid off close to 1,000 employees (Elkind 2020). By 2013, Leonard Green had received two rounds of dividends worth \$188 million (financed with junk bonds), thereby almost matching its initial investment of \$205 million. It went on to buy out two Rhode Island hospitals for \$45 million in 2014, a New Jersey hospital for \$44 million in 2015, three Connecticut hospitals in 2016, and five Pennsylvania hospitals for \$300 million in 2016 as well (Elkind 2020).

By 2019, its debt-financed chain included 20 hospitals and 165 clinics scattered across the US in Texas, Connecticut, Rhode Island, New Jersey, and Pennsylvania. In the meantime, its legacy of poor management practices and broken agreements continued. Between 2013 and the present, several lawsuits and government investigations have charged Prospect with improper Medicare billing and fraud, leading to penalties estimated in the tens of millions of dollars. More importantly, state health inspectors have repeatedly uncovered unsanitary conditions at its hospitals – lack of infection control and sterility in surgical rooms, broken refrigeration systems that caused a corpse in the morgue to decompose, inoperable elevators, leaky rain-soaked ceilings with tiles falling on patients, bedbugs, mold growth on walls, and at least three patient deaths due to inadequate staffing. The Joint Commission on Hospital Accreditation denied accreditation to Prospect's Waterbury, CT hospital after they found 42 violations of quality standards in December 2019 – leading to \$24 million in penalties. The Centers for Medicare and Medicaid Services (CMS) annual quality of care rankings have put all but one of Prospect's hospitals in the bottom 17 percent of all US hospitals. And since 2010, government inspectors have deemed Prospect facilities to pose "immediate jeopardy" to their patients, a situation the US Department of Health and Human Services (HHS) defines as having caused, or is likely to cause, "serious injury, harm, impairment or death" (Elkind 2020).

In the meantime, Leonard Green began searching for exit options, attempting two sales – each for an estimated \$1 billion – in 2015 and again in 2018. They failed due to Prospect Medical’s poor financials – declining revenues, lowered credit ratings, excessive debt, and an EBITDA (earnings before interest, taxes, depreciation, and amortization) margin of 10.8 percent in 2015 and 0.6 percent in 2018. In response, Prospect issued a \$1.31 billion dividend recapitalization to refinance existing debt, reduce the underfunded pension liability in Rhode Island hospitals that it had promised to cover, and pay a dividend to the PE partners and investors. The resulting dividend of \$457 million, along with the management and transaction fees charged by the PE firm, yielded an estimated \$658.4 million to Leonard Green Partners and its investors (PitchBook 2020, PESP 2020).

In 2019, Medical Properties Trust entered the saga to bail out Prospect Medical – at least in part – through a sale of Prospect Medical’s real estate in California, Connecticut, and Pennsylvania for \$1.386 billion – essentially replacing debt payments with rent payments. A year later, despite this capital influx, Prospect’s liabilities still exceeded its total assets by \$1.06 billion, according to a September 2020 independent financial analysis commissioned by the Rhode Island AG (PYA 2021). Leonard Green agreed to sell its 60 percent stake in Prospect Medical to Lee and Topper for \$12 million, to be paid by Prospect Medical, plus Lee and Topper’s assumption of \$1.3 billion in lease obligations.

The sale to Lee and Topper, however, required approval from the Rhode Island Attorney General, who placed conditions on the sale in order to ensure that the Prospect-owned hospitals in that state would be financially viable. The state had already sunk \$20 million into the Leonard Green fund that owns Prospect. In the spring, 2021, the Rhode Island AG stated that it would approve the sale on condition that Leonard Green put \$120-150 million in escrow to cover the two safety-net hospitals – given that Leonard Green had extracted millions in dividends while the hospitals had been losing \$1 million per month and were financially distressed. Leonard Green refused and threatened to shut down the hospitals (Gagosz 2021). After a series of negotiations, the state AG reduced the required escrow to \$80 million, while also requiring that Leonard Green make a financial commitment of \$34.8 million before transferring ownership and that Prospect Medical make a capital investment of at least \$72 million to the hospitals between 2020 and 2026 (Deveraux 2021).

Case Study: MPT and LifePoint Health

LifePoint Health exemplifies the kind of horse-trading of hospitals and hospital property that PE firms and REITs have engaged in. LifePoint is a system formed through the mergers of Essent Healthcare, Capella Healthcare, RegionalCare Hospital Partners, and LifePoint Health. LifePoint was founded in 1999 as a for-profit chain with 23 rural community hospitals in nine states – a spinoff of Columbia/HCA when it had to unload hospitals in order to pay its fraud

settlements with the federal government. Essent Healthcare was founded in 1999 as a for-profit hospital with private equity growth capital from Thomas Cressey Equity Partners. In 2004, it received additional PE backing from Cressey and Vestar Capital Partners; and in 2007, \$120 million in a leveraged recapitalization from GE Capital. Capella (10 hospitals) was bought out by PE firm GTCR in a leveraged buyout with \$685 million in debt financing in 2005, and an additional debt financing of \$600 million in 2010. MPT acquired Capella in 2015 for \$900 million (Powderly 2015).

In 2009, PE firm Warburg Pincus created a platform for hospital acquisitions named RegionalCare Hospital Partners. In 2011, it acquired the Essent hospitals in a \$250 million LBO and merged them into its platform. Essent had three hospitals and RegionalCare, four – all targeting non-urban small hospitals. Just two years later, in 2015, Apollo Global Management bought out RegionalCare (renamed RCCH Healthcare Partners) in an LBO worth \$800 million (PitchBook 2016). Apollo then went on to buy out Capella Healthcare in 2016 from REIT MPT for \$550 million – and merge it into RCCH (with 18 hospitals) for a combined company worth \$1.7 billion (Byers 2016). In 2018, Apollo went on to buy out LifePoint Health for \$5.6 billion (\$4.7 billion in debt) and merge it with RCCH Partners, renaming the system LifePoint Health (with 84 hospitals and \$8 billion in annual revenue) (Bannow 2018; PitchBook 2021b). MPT re-entered the picture in 2019, when it acquired the real estate of 10 LifePoint hospitals for \$700 million, in addition to the six it already owned (Berryman 2019). Regarding the deal, MPT's CEO at the time, said, "They [Apollo] had a number that they knew that they wanted to get so that they could make some different changes to their balance sheet. And so they pretty much gave us their entire portfolio and said, "Here, pick what you'd like to have for this particular price" (MPT 2020c).

The negative impact of the real estate deal emerged when one rural community, Riverton Wyoming, fought back. Riverton hospital was one of the 10 sold to MPT in the sale-leaseback deal, and it was the only hospital in this working-class town. Now Riverton pays rent on property it used to own, undermining net revenues. Under Apollo's ownership, LifePoint also merged the Riverton hospital with another LifePoint hospital 30 miles away, and then started consolidating services. Despite criticism from Wyoming's Republican senators and governor, who said consolidation was not part of the original deal, Apollo continued with its plan. Local residents point to poor quality service, the absence of adequate physician coverage, and lack of trained staff at the hospital – in one case leading to the death of a patient by another psychiatric patient. The need for air ambulance trips also quadrupled – from 155 in 2014 to 937 in 2019 (two-thirds of air ambulances are owned by private equity firms and charge tens of thousands of dollars for one trip). Local residents have mobilized to raise funds to build another local hospital – securing a \$40 million low-interest loan from the Agriculture Department despite LifePoint's lobbying heavily against it (Spegele 2021).

In 2018, while Apollo was consolidating LifePoint, PE firms TPG Capital and WCAS, along with Humana, Inc., a for-profit health insurance company, bought out Kindred Healthcare, a large diversified healthcare provider, in a \$4.1 billion public-to-private LBO. They split the company in two: one with the home healthcare operations and the other with long-term acute care hospital and rehabilitation operations. Humana then took over the homecare business (renamed Kindred at Home, the largest home healthcare chain in the country), and the PE firms retained the long-term hospital side (retaining the Kindred Healthcare name) (Livingston 2017). By June 2021, TPG and WCAS sold off their Kindred Healthcare assets to Apollo.

That allowed Apollo to consolidate Kindred Health with LifePoint to create a chain with 89 hospitals, 50 post-acute providers, 35 outpatient clinics, and 125 rehabilitation facilities in 30 states (Kacik 2021). In the same month, Apollo engaged in yet another round of financial engineering in which it sold LifePoint to itself – that is, from its PE Fund VIII to its Fund IX, which had closed in 2017 with a record \$24.7 billion. In 2021, Apollo sold LifePoint for \$2.6 billion to Fund IX after having invested about \$975 million in the hospital chain since 2013, thereby netting about \$1.6 billion for itself and its investors. The advisory boards of both funds approved the deal.

Apollo's profiteering, however, didn't stop there. As of July 2021, LifePoint had received \$1.64 billion in COVID stimulus grants and loans, while in 2020 it slashed salary and benefit costs by \$166 million compared to 2019 and charity care by 21 percent. Taxpayer subsidies coupled with these substantial operating cost cuts allowed LifePoint to earn \$1.14 billion in EBITDA and \$304 million in net income during the 2020 pandemic year. By September 2021, LifePoint continued to maintain a profitable balance sheet, with \$1.8 billion cash on hand, according to Moody's, while its CMS ratings for quality patient care substantially lagged the national average (O'Grady 2021; Willmer 2021b).

Conclusions: REITs and Private Equity in Hospital Systems

The intertwined relationships among financial actors – REITs like MPT and PE firms like Cerberus, Leonard Green, and Apollo – have allowed them to extract millions and millions of dollars from urban safety net, community-based, and non-urban hospitals that serve millions of patients across the US. Together REITs and PE firms have extracted wealth via financial engineering tactics that are, in the current legal context, perfectly legal. Both REITs and PE firms have engaged as active partners in determining the fate of hospital systems, patients, and healthcare workers, despite their status as 'passive investors' who are not held accountable for the financial distress or bankruptcies of the assets they own. Notably, neither REITs nor private equity firms are held legally accountable for the outcomes of their financial strategies. It is the operating company, patients, and employees who share the risks and suffer any downside outcomes.

Public health expenditures through Medicaid, Medicare and other government programs provide a steady and predictable core of financial support for these financial actors. Short cuts in the care of patients increase cash flow of hospitals in the hands of these Wall Street firms, creating opportunities for extraction of resources by financial agents. Extraction of resources through PE dividend recapitalizations and above market rents collected by REITs threaten hospitals' ability to upgrade technology, increase nurse staffing ratios, and improve cleaning and sanitation processes.

In the MPT-Steward relationship, Cerberus was able to go on a national buying spree of hospitals as it was financed by MPT, which paid Cerberus for the property owned by those hospitals. In other words, the REIT facilitated the consolidation of hospitals while extracting wealth from them through high rents in long term leases with annual escalator clauses. Cerberus didn't worry that the high rents would reduce the hospitals' net revenues and financial stability because it would soon cash out altogether. In fact, in 2017 and 2018 alone, Steward lost almost \$500 million. But between 2016 and 2021, MPT earned at least \$1.2 billion in rents and mortgage interest, and Cerberus cashed out in 2021 with at least \$700 million. Meanwhile, investigative reports documented widespread understaffing, lack of supplies and equipment, and poor-quality care.

MPT-Prospect Medical story provides a parallel story. PE firm Leonard Green bought out 20 safety-net hospitals and ancillary clinics between 2011 and 2019 -- loading them with debt and cutting resources so much that government investigations led to tens of millions of dollars in penalties for on unsanitary conditions, broken equipment, leaking ceilings, bedbugs, and fatalities. But the MPT came to Leonard Green's rescue by buying the property underneath the hospitals. The PE firm made millions in dividend and from the sale proceeds, while the REIT is making millions on long term leases on property the safety-net hospitals previously owned. At the same time, the hospitals were losing millions each year, and what will become of them is unclear.

Finally, the LifePoint Health case also exemplifies how REITs contribute to hospital consolidation and undermine their financial independence. LifePoint was created through a decade of PE firms buying and selling of hospitals among each other -- with each trade leading to further consolidation. Along the way, MPT financed a number of the deals, and by 2019, owned the real estate of at least 16 LifePoint hospitals through deals with PE firm Apollo Global.

In sum, these cases show how PE ownership of hospital operations combined with REIT ownership of hospital real estate undermines hospital financial stability and patient care -- as profits for PE firms and REITs take precedence over improvements in hospital operations that are important to patients and communities. The facts in these cases raise serious doubts about whether REITs should retain their tax-exempt status.

Part III: REITs in the Hotel Industry¹³

The hotel industry has unique features that have shaped corporate business strategies and structures over time; and these in turn, have influenced the development of hotel REITs and their business model. Importantly, the sector has very high capital requirements with high fixed investment costs in property and ongoing need for re-investment to maintain or enhance it to match changing consumer expectations. It is highly cyclical, creating much more volatility and unpredictability in profit margins than that found in most other industries. And hotels as business enterprises are highly complex operations, with profitability contingent on the integration of facility services (maintenance, security, grounds, heating, lighting, plumbing, parking) and ongoing guest services (reception, housekeeping, food and beverage services, etc.).

Despite the need for integration, hotel chains began dividing hotels into two separate ownership structures -- one for business operations (OpCo) and one for real estate property (PropCo) -- in the 1950s and 1960s when they were expanding internationally. They did so in order to grow rapidly and to avoid exposure to economic and political instability in other countries. Leasing property in overseas locations was the solution.

The vertical disintegration of integrated hotels into two legally separate structures -- the OpCo/PropCo model -- expanded domestically in the 1990s due to a number of factors, but especially the decline in real estate values and the credit crunch in the first years of that decade. At this point the rationale for doing so was *financial* because success in property ownership is driven by the cost of capital and need for investment yield, while success in hotel operations is dependent on effective management in a profit and loss margin business (Roper 2018). Profit and loss in this industry is highly dependent on the business cycle as expenditures on hotels and resorts are largely discretionary and are cut back in an economic downturn. The Marriott Corporation was the lead ‘innovator’ of vertical disintegration domestically when in 1992 it successfully spun off its failing real estate from its healthy hotel management business -- creating two publicly traded corporations. Other hotel bankruptcies in that decade (in which the property and business operations were still under one owner) led Wall Street and shareholders to push for fee-based or ‘pure play’ business models that were easier to understand and more predictable, and hence commanded higher share prices. That is, the proliferation of this strategy was driven by a *financial* rationale for how investors could make more money -- not by a business rationale of providing an integrated service to customers.

¹³ In this section we focus on the hotel and resorts segment of the larger lodging sector, which includes motels, bed and breakfasts, Airbnb, and the like, because REITs have been primarily engaged in the hotel segment of the industry. Hotels and resorts are part of the broader hospitality sector, and we refer to that when discussing trends that apply to that broader sector, such as COVID or the business cycle.

The drive to increase profits by reducing costs also led hotels to further restructure their operations by outsourcing and subcontracting different departments or services -- including dining, housekeeping, maintenance, and management. This has led to reductions in job and income security for workers now employed in low cost contractors rather than in major hotels -- a process that David Weil has referred to as the ‘fissuring’ of employment relations (Weil 2014).

This ‘asset light’ model of the hotel operating companies garnered higher share-price multiples (Guggenheim, Janda, and Kremser 2013). By spinning off the real estate, hotel operating companies could conserve cash flow that it would otherwise need to use to meet the costs of ongoing re-investment to maintain or enhance hotel properties and invest in growth. The major chains moved in this direction, including IHG, Hilton, Marriott, Wyndham, Choice, Carlson, Accor, and Hyatt (Roper 2018:21). This, in turn, led to the emergence of hotel property as an investment asset class (de Haast 2015) – and hotel REITs became a viable investment option. We refer to hotel REITs also as the hotel owners or property owners in this section as they own the physical hotel facility and its real estate. We refer to hotel operating or management companies as operating companies.

It is important to note, however, that the OpCo, PropCo model is not conducive for operating hotels as businesses whose financial fortunes depend on meeting customer needs. Value creation for the property company depends on successfully managing complex contracts for leasing, managing, and franchising assets. However, the financial fortunes of the property owner depend on how well the hotel is managed -- as it determines overall customer satisfaction, occupancy rates, and gross revenues. “A corporate structure that distances the owners of lodging assets from the day-to-day operation of their holdings is detrimental to shareholders” (Gujar 2012: 12; Beals and Singh 2002). So, property owners have incentives to influence the management of the hotels even though they don’t own the operating business. This creates conflicts of interest, and these tensions are more pronounced in the context of hotel REITs that are legally constrained to be passive investors but whose financial interests depend on a well-managed property. As detailed below, legal changes in the 1990s provided ‘work-arounds’ for these conflicts, but did not fundamentally alter them.

Trends in REIT Ownership of Hotels

In this context of growing demand for hotel property investors in the 1990s, hotel REITs took off. As Beals and Singh note, “Excess room inventory, the declining value of hotel real estate, the inability of hotels to meet debt service, the savings and loan debacle, and a national recession all combined to shut down virtually all funding for hotel projects in the early 1990s. In particular, traditional lenders, such as commercial banks, life insurance companies, and savings and loans, stopped lending for hotel projects” (2002: 15). The vacuum was filled by the securitization of equity financing via equity REITs and the securitization of debt financing by commercial mortgage-backed securities. Securitization is a process of pooling various financial assets into a

group of prepackaged assets, which the issuer then sells to investors. Equity hotel REITs provided a vehicle for individual and institutional investors to invest in hotel properties by owning shares of the hotel REIT rather than owning hotels. Hotel REIT investments totaled \$73.6 million in 1993, and \$380.1 million by 2000 (Beals and Singh 2002: 22).

By the end of the 1990s, the aggressive acquisition activity of hotel REITs led to the consolidation of the U.S. hospitality industry, with fewer property companies controlling a larger number of rooms. REITs have dominated the M&A activity in the hotel sector because their tax-exempt status allows them to pay higher premiums for properties, compared to non-REIT hotel property owners (Gujar 2012: 12). The rapid expansion of the supply of REIT-owned hotel properties, in turn, allowed hotel operating companies to expand their operations more rapidly by leasing property owned by the REITs. That is, hotel operating companies could increase the number of hotels they operated without the cost of property acquisition or maintenance (Stotler 2019). At this point, then, the industry included integrated hotel companies (owning property and operations, many of which were independent businesses that were not part of chains); non-REIT hotel property corporations (organized as C-Corporations rather than S-Corporations); hotel REITs as property owners that did not manage hotel company operators; and hotel operating companies (often called management companies) that managed operations but did not own property. Over time, the integrated companies declined, and the OpCo, PropCo model came to dominate the industry. In addition, over time, many brands stopped managing their own operations, but instead contracted with management companies to do so.

Another important dimension of the hotel industry that affects trends in REIT ownership and performance is the cyclical nature of the industry. The hotel sector is always cyclical, and lags the business economic cycle by about six months. Because hotel rooms are priced daily -- as opposed to office, residential, or other real estate sectors with long-term leases -- the industry is more volatile than almost any other -- higher highs and lower lows. In periods of economic growth or inflation, hotel REITs can achieve some of the highest annual returns as they can reset their 'lease rate' daily and increase prices, with the opposite occurring in downturns (Krewson-Kelly and Thomas 2016:80). As detailed below, hotel REITs bear the brunt of this volatility compared to hotel operating companies with more stable revenue based on management or franchise fees.

The sector's sensitivity to cyclicality means that hotel REIT profitability depends on timing acquisitions at the right time: Hotel property owners would profit by buying low during downturns and selling high during market peaks. But hotel REITs raise capital to fund acquisitions by issuing stock -- largely when they are first created or when the market is performing well. This makes it difficult to buy hotels during downturns, and REITs are often forced to sell instead when the economy craters. This market dynamic is particularly important

for hotel REITs (as opposed to non-REIT property owners) as the REITs grow almost entirely via acquisitions (Gujar 2012:12).

In this context, debt matters. In fact, compared to other private property owners, REITs have typically taken a conservative approach to debt, apparently as a hedge against volatility (Krewson-Kelly and Thomas 2016:141-143). Research shows that those REITs with low relative debt levels manage better during downturns because they have the financial flexibility to capitalize on market opportunities. For example, a study compared two groups of REITs in 2007 before the Great Recession: one with low debt levels (averaging 5.67 times EBITDA) and one with high levels (7.23 times EBITDA). It found that the former had almost double the dividend payouts of the latter for the period 2008-2015. A primary reason for the underperformance of highly leveraged REITs was their inability to acquire assets at deep discounts in the 2007-2009 period. More generally, too much debt at any time increases the cost of capital, thereby limiting opportunities for property acquisitions (Krewson-Kelly and Thomas 2016:127-8).

The major downturns in the US business cycle that have affected REITs over the past two decades occurred in 2001-2 (hotel occupancy rates fell to 59 percent in 2001), 2008-9 during the Great Recession (occupancy rates at 54.6 percent in 2009), and 2020-21 due to the COVID pandemic (occupancy rates at 44 percent in 2020 and 53.3 percent in 2021) (Statista 2022b). Industry analysts estimate that 40-50 percent occupancy rates are required for hotel REITs to break even (Seeking Alpha 2021).

The hospitality industry was among the worst affected by the COVID pandemic, and hotel REITs were the worst performing among all US REITs. Returns from the onset of the pandemic through November 2021 averaged 20.8 percent for all equity REITs, but -8.8 percent for lodging REITs (Nareit 2021b:6). Dividend payouts of hotel REITs in 2021 averaged 0.1 percent (Seeking Alpha 2021). Particularly hard hit were upscale hotel REITs like Host Hotels, Park Hotels, and Pebblebrook, which depend on conference and business travel; and in 2021, their occupancy rates were still 25-30 percent below their 2019 rates (Seeking Alpha 2021). The industry association nonetheless reported that, as of December 2021, hotel REITs were recovering due to a pick-up in leisure travel, while business travel remained low (Nareit 2021b:12). The total number of REITs, however, has not changed: As of May 2022, there were 22 publicly traded hotel REITs with a combined market capitalization of roughly \$62 billion (See Appendix A) (FKnol.com 2022).

Changing Legal Regulations and Hotel REIT Structures

The original legal restrictions on REITs made it particularly challenging for them to compete effectively in the hotel sector. Recall that in order for REITs to maintain their tax-exempt status, their income must only come from passive real estate investments. But property owners in the hotel industry typically provide extensive services to their hotel operators, and as noted above,

have a financial interest in making sure that their properties are well managed. Under the provisions of the original Act, hotel REITs were required to lease their property to a leasing company (the lessee), which in turn contracted with a hotel operating company to manage the business. This left REITs at a disadvantage relative to their non-REIT competitors because the lessee captured some of the rents, or what is referred to in the industry as ‘leakage’. To correct this problem, the REITs campaigned heavily to change the law, and Nareit claimed credit for the passage of the REIT Modernization Act (RMA) of 1999, which allows REITs to use wholly owned taxable REIT subsidiaries (TRS) to replace the independent lessee and capture more of the rents (Beals and Singh 2002; Nareit 1999). Notably, however, the RMA prohibits a TRS from operating or managing hotels. Thus, an arm’s length relationship must exist between the REIT and the TRS and the TRS and the management company (Edwards 1999).

In general, the customary services that all REITs can provide while still maintaining their exemption from corporate taxes include basic services – for example, application fees, security services, laundry, common area cleaning, trash collection, utilities, and sprinkler and fire safety. Non-REIT hotel property owners, however, typically provide additional ‘non-customary’ services, such as food services and catering, maid service, valet parking, childcare, and car washing, for which they receive taxable income. And the non-customary services are typically those that allow hotels to serve higher market segments and charge premium prices. If hotel REITs were to provide these services directly, however, they would be subject to a 100 percent penalty tax and lose their REIT status. This difference clearly puts the hotel REITs at a competitive disadvantage vis-à-vis their non-REIT counterparts (REIT Institute 2019). Thus, REITs cannot directly run a hotel, nor can they license, franchise, or provide other rights to a branded hotel operating company. The hotel REIT must maintain an ‘arm’s-length’ relationship with the hotel operating company, defined in the law as an “eligible independent contractor (EIK).”

As described in more detail in the section below on the REIT business model, the TRS option solved that problem by allowing hotel REITs to use a TRS to provide the same non-customary services that non-REIT competitors provide, with the TRS paying taxes on income earned (TRS assets may not exceed 20 percent of the REIT’s total assets). It is noteworthy that REITs cannot provide non-customary services even if they don’t charge for them. Each property owned by a REIT may create a special taxable subsidiary, which is wholly owned by the REIT and which contracts directly with the operating company. This option allows REITs to compete with other real estate owners without jeopardizing their tax benefits. REITs may also use these taxable subsidiaries for short-term buying and selling of real estate without triggering a prohibited transaction penalty – as the law requires REITs to hold property as a long-term investment (REIT Institute 2019).

As Gujar notes, “Through the legislative actions and clever strategies used by some firms, the REIT has evolved to become more than just a passive investment vehicle As a result, the gap between a hotel REIT and a hotel C-Corporation has narrowed” (2012: 12).

The Business Model: How REITs Make Money

The legal framework governing REITs coupled with the unique characteristics of hotel markets has led to highly complex organizational structures. While REITs are legally required to be passive investors to retain their tax-exempt status, they are a particularly poor fit for hotels due to the complex nature of services that must be provided. Even with the TRS structure, REITs have strong interests in ensuring that hotel operations are effectively managed, but they cannot be directly involved. According to one industry analyst we interviewed, “... Really, hotels really shouldn't be in the lodging [REIT] space because, again, cash flows are volatile, margins are low, high capital requirements, and you can't even operate the asset you own.”

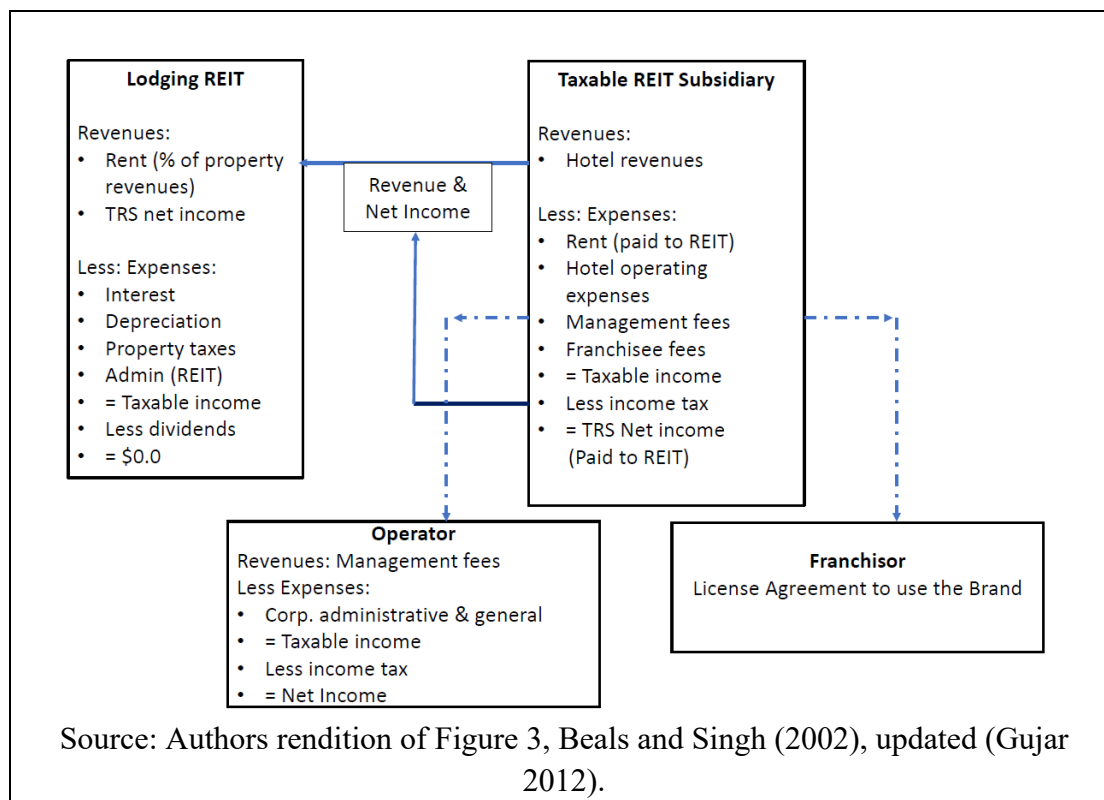
Moreover, due to the volatility of the hotel sector, hotel REITs do not use sale-leaseback agreements, which as we have discussed in Part II, are the most common form used in healthcare. That is because sale-leasebacks depend on a stable environment with long term cash flows. In healthcare, REITs can use fixed long-term leases with annual escalators because of the stability and security of government reimbursements.

According to one of our interviewees, a REIT equity analyst, lodging is ‘egregiously more volatile’ than any other sector. The margins are the lowest, and the volatility the highest, which reflects the fact that ‘rent’ – that is, hotel pricing, fluctuates on a daily basis. He noted:

Very, very few hotels do leasebacks because it would really be a negative for both the lessor and the credit of the asset. Because it's such a cyclical business, it's very hard to know what cash flows are going to do, particularly in a recession. And so it would not be a good idea to subject yourself to a high cost in a very arcane business model that has a lot of operating leverage.”

An REIT make money through a business model based on a set of contracting arrangements in which it leases its property to a taxable subsidiary, which in turn signs a management agreement with an operating company. The management contract spells out the services that the REIT-TRS will provide to the operator and the fees that it will pay the operator to manage the business. The basics of this model and how the parties make money is well illustrated in Figure 3.1, developed by Beals and Singh (2002)

Figure 3.1: Post RMA REIT Business Model



and updated based on later developments by Gujar (2012). All contracts, however, are subject to negotiation, and contemporary versions include many variations and layers of complexity, including the addition of incentive fees, as described below.

The hotel business consists for four functions: property ownership, property leasing, hotel management, and brand franchising. Property ownership usually takes one of two forms: A standard corporate form or a REIT. Under the corporate form (sometimes referred to as a ‘C-Corporation’) the corporation buys, sells, and owns property; pays corporate taxes; raises capital through bank loans or by issuing stock to shareholders; and is liable for any wrong-doing. If an owner, it enjoys minimal financial risk because it receives rental income from the leasing (operating) company, which in turn assumes all operating and financial responsibilities (funding, working capital, operating expenses, and rent). The leasing company is a profit and loss business, with revenue (from lodging, food, and beverage services) minus expenses. It – not the Corporation -- bears the greater financial risk in a downturn (Gujar 2012:15).

A REIT, by contrast, is a pass-through entity set up to own and operate real estate and make mortgage loans (Fass, Shaff, and Zief 2009). In the classic REIT model, the hotel REIT assumes the financial risks of a profit and loss business, and the operating company’s revenues depend on

a management fee (minus expenses). As depicted in Figure 3.1, the TRS (the leasing company) is a wholly owned subsidiary of the REIT that serves the purpose of separating the REIT from the operating company to preserve its tax status as a passive investor in real estate. The net income of the TRS includes revenue from hotel operations minus the expenses of rent paid to the REIT, income taxes, and operating expenses. The TRS operating expenses, for example, would include the customary and non-customary services it provides to the operating company. TRS' expenses also include the management fee paid to the operating company as well as a franchise fee paid to a brand, as most hotels, whether REIT or non-REIT, now operate under a brand name. Only rarely do hotel brands also manage the operating company. The REIT's net revenue is the sum of the rent (a percentage based on gross hotel operating revenues) plus the TRS net income minus expenses (EBITDA). Once the REIT pays dividends, the REIT's net income should equal zero or close to it.

Thus, the REIT retains the majority of risk and potential reward and is responsible for replacement and renewal of the furniture, fittings and equipment (FF&E) in the hotel, which are regularly exposed to heavy use. Often the management contract will require that a separate account be established with a reserve each month to cover the funding of these expenditures – typically in the range of 3-5 percent of revenue (Angelini 2020; Pinsent Masons 2021).

The allowable transactions between the REIT and the TRS are defined by law in order to avoid tax arbitrage between the tax-exempt REIT and its 100 percent owned TRS (a tax paying C-Corporation). Thus, all transactions between the REIT and the TRS must be 'arm's length' – that is, priced as if between third parties. To meet this standard, the IRS applies standards developed for transfer pricing (under IRC Section 482), designed to ensure that an appropriate amount of taxable income is apportioned between the two entities (Adey 2019).

Four types of REIT-TRS transactions are of increasing concern to the IRS: Rent, service fees, financing, and sharing of resources. For example, the REIT has incentives to charge the TRS above market rent because higher rent leads to lower net taxable income for the TRS and in turn boosts REIT revenues and dividend payouts – making the REIT a more attractive investment vehicle. The IRS found Ashford Hospitality guilty of overcharging rent to its TRS and imposed a 100% excise tax on the excess amount -- by \$3.3 million for 2008 and a TRS adjustment of \$1.6 million for agreeing to be party to the REIT's loan agreement. The IRS also found that La Quinta Corporation (a former REIT of La Quinta Holdings) overcharged rent to its TRS and imposed a 100% excise tax on the REIT of \$158 million for 2010 and 2011 (Noronha 2020).

Service fees are of concern because the REIT has incentives to undercharge the TRS for services it provides to the REIT, as they constitute taxable income for the REIT. The IRS also monitors intercompany loans or financing arrangements between the REIT and TRS to ensure that the interest payments or guarantee fees are arm's length. And if the REIT and TRS share resources

(office space or employees), the IRS will examine whether the allocation of costs between the two is reasonable (Noronha 2020). If data on comparable arm's length pricing is not available, the REIT can receive a 'safe harbor' protection against a federal tax penalty if it pays the TRS at least 150 percent of its direct costs for providing services to the REIT (Silver 2002).

A conflict of interest often exists between the interests of the REIT and those of the hotel operating company due to the form that the typical management fee contract takes. The typical fee paid to the operating company is based on a percentage of gross revenue (sometimes referred to as 'total revenue') while the REIT's income is based on net revenue or profits. The base fee structure provides the operating company with incentives to maximize revenue, but not efficiency (Pucciarelli 2011; Rivera 2011). This also means that managers are rewarded not for how well they manage but how fast total hotel revenue grows -- which depends considerably on market conditions. It may be achieved via higher room prices (revenue per available room, or RevPar) or via more hotel rooms through hotel expansion. But the more hotels that are built, the more supply expands -- and the more competition the hotel REIT owner must contend with. The REITs, by contrast, focus on efficiency -- minimizing costs -- which is why they want to influence operations. In sum, the REIT wants to maximize cash flow -- minimizing costs to maximize profit margins. The operating company benefits from gross revenue maximization as the management fee is a percentage of gross revenue.

Over time a management incentive fee was added to management contracts to better align the interests of the different parties. The incentive fee is linked to efficiency -- typically is in the range of 8-10 percent of 'operating profit' (gross revenues minus certain operating expenses) -- with operating profit hopefully 30-35 percent of gross revenue (Pucciarelli 2011). The incentive fee is typically paid after the net operating income exceeds a 'hurdle' of the property owner's return on investment of 8-10 percent (Rivera 2011).

Management contracts are often quite complex. The base fee paid by the REIT to the operating company, for example, may be a single fee, or a sum of an advisory/operating/management fee and licensing/royalty fee. The fee may be constant, or increase each year in the early phase before stabilizing (HVS 2017). The operating company may include additional fees for such centralized services as reservations, sales and marketing, loyalty programs, training fees, purchasing costs or accounting (Pinsent Masons 2021). These fees are typically defined as a percentage of total revenue or room revenue and range from 2 to 5 percent. According to one industry analyst, the current trend is to lump these together and cap at 3.5-4 percent of room revenue, with larger operators typically receiving lower percentages than smaller operators (Angelini 2020).

Management fee contracts are subject to intense negotiations, depending on current market conditions, the relative bargaining power of the parties, and the particular characteristics of the

hotel in question. For large international hotels, the fee is in the 1-2 percent range (Curtis, Mallet-Prevost, Colt & Mosle LLP 2011). A 2017 global survey of 475 hotel management contracts (including both REIT and non-REIT) found the average management fee was 2.8 percent of gross revenues (HVS 2017), but the rate varied across market segments -- from a higher rate for budget hotels (3.21 percent) to lower rates for mid-market, upscale, upper upscale, and luxury hotels (the latter only 2.37). A 2019 survey of 840 US hotel owners (including REITs and non-REITs) put the *average* management fee at 3.6 percent of gross operating revenue. That survey also found that in the ten-year period between 2009 and 2019, management fee growth far exceeded the overall expense growth rate (Mandelbaum 2021). As hotel operators have consolidated, the power of the brands has increased (Angelini 2020).

In addition to the contract fee structure, the contract term length matters and also tends to reflect the relative power of the parties. Hotel owners (the REITs) prefer shorter term contracts while hotel operators prefer longer terms so that they can have predictable operations and don't have to worry about changes in contract renewal clauses (Pinsent Masons 2021). Historically, initial term contracts were very long – about 30 years in the 1980s – and 20 years in the 1990s and 2000s. These tended to be contracts with 'first-tier' hotel operating companies – the large brands. Since the 2000s, more flexible contracts with 'second-tier' operating companies have emerged, with shorter durations. In the 2017 HVS survey (for US based contracts only), the initial contracts of first tier companies averaged 21 years, compared to 11 years among second tier companies. After the initial contract, the renewal contract terms averaged 7.9 years, with 10.2 years for the luxury hotels, and successively shorter terms for the lower market segments, with budget renewal terms of 5.5 years. These terms clearly reflect the relative power of the property owners vis-à-vis the operating company owners (HVS 2017:7).

Hotel property owners also want to ensure that operating companies perform as expected and thus include some type of right to terminate the contract based on poor financial performance by the operator. Two types of performance tests are common: a) a mutually agreed upon minimum for revenue per room typically set as 80-95 percent of the weighted average of a set of competitor hotels, and b) a mutually agreed upon annual budgeted level for gross operating profit (GOP) (typically 80-90 percent of budgeted GOP), or more commonly adjusted GOP (which deducts the base management fee). The performance test begins in year three or four, and the operating company fails if it fails both tests for two years. Failure allows the hotel owner to terminate the contract although operators often negotiate a clause allowing them to pay for the shortfall instead (Angelini 2020). But these tests have many problems, including the availability of appropriate competitor data and events that are beyond the control of the operator, as the recent pandemic has made clear.

Management contracts also include ‘approval rights’ for the property owner, defining the extent to which the owner’s consent is required for decisions that affect the hotel’s operation.¹⁴ They generally cover such issues as: opening and closing bank accounts, insurance and liability coverage, auditors, licenses and permits, the annual budget, employment of key senior managers, renovations, compensation schemes, outsourcing, capital expenditures, and delegation of authority (Angelini 2020).

Do Hotel REITs Influence Hotel Operations and Employment?

The analysis of the hotel REITs’ business model makes it clear that inherent contradictions exist: To maintain their tax-exempt state, REITs cannot interfere with their TRS and operating companies’ decision making, but their profitability and dividend payouts depend importantly on doing just that. Moreover, despite the seemingly detailed rules governing the relationships between the REIT, TRS, and operating management companies, significant gray areas exist that REITs may take advantage of in order to exert influence over their hotel operations. These actions may violate the intent of the law while still staying in technical compliance with it. One example is evident in how REITs negotiate their management agreements and use their asymmetric power in relationships with managers. For example, as stated in a DiamondRock annual report:

“Our philosophy is to negotiate management agreements that give us the right to exert significant influence over the management of our properties, annual budgets and all capital expenditures (all, to the extent permitted under the REIT rules), and then to use those rights to continually monitor and improve the performance of our properties. We cooperatively partner with our hotel managers in an attempt to increase operating results and long-term asset values at our hotels. In addition to working directly with the personnel at our hotels, our senior management team also has long-standing professional relationships with our hotel managers’ senior executives, and we work directly with these senior executives to improve the performance of our portfolio.” (DiamondRock Hospitality 2012)

The case of Park Hotels and Resorts is also illustrative.¹⁵ In its 10-K report to the SEC, it states that it leases its hotels to TRS lessees, which in turn enter into management agreements with third-party managers (operating companies). A major risk cited in these arrangements is that, “We are dependent on the performance of our managers and could be materially and adversely affected if our managers do not properly manage our hotels or otherwise act in our best interests”. These third-party managers often manage, own, or lease other hotels that compete with Park Hotels, and thus may have conflicts of interest (Park Hotels and Resorts 2020:14).

¹⁴ It is not clear whether these exist in REIT management contracts.

¹⁵ Park Hotels is a real estate spin-off of Hilton Property Holdings in 2016. Its portfolio in 2020 consisted of 60 properties with 33,225 rooms in primarily the upper upscale chain segment of the industry, with 75 percent of its properties under the Hilton brand.

Moreover, as labor costs constitute the largest proportion of operating costs, REITs have a keen interest in keeping those costs as low as possible. In Park Hotels' 10-K, for example, it notes that,

“We are subject to risks associated with the employment of hotel personnel, particularly with hotels that employ unionized labor, which could increase our operating costs, reduce the flexibility of our hotel managers to adjust the size of the workforce at our hotels and could materially and adversely affect our revenues and profitability” (2020:18).

It goes on to highlight its concerns over labor contracts that may increase wages or benefits or change work rules that increase operating costs.

The COVID pandemic illustrates how these contradictions reveal themselves, and how REITs may be involved in determining the staffing and employment levels. During the pandemic, hotel occupancy rates plummeted, and hotels began laying off workers. The question became which entity was responsible for the layoffs – the REITs or the operating companies? It is the REITs that hold the purse strings and that are most concerned about profit margins – lower revenues require reduced expenditures on labor.

Recall that the REIT provides the working capital for day-to-day expenses and reimburses the operating company for employee wages and benefits. This means that even though the operating company is the legal employer, the ability to finance operations and meet payroll depends on working capital from the hotel REIT. One industry analyst provided an example. The hotel operator would bill the REIT for whatever hours the employee works, and then the REIT pays the hotel operating company, who pays the employee. That's why the line item for 'employee labor costs' in income statements could be the exact same for the operator and the REIT. During COVID, if the hotel REITs were shutting down their hotels, then they weren't paying for labor.

Hotel REITs have also made explicit public statements regarding how they intend to use the COVID pandemic to reduce labor and employment costs in their hotels permanently. A major focal point is the cost of housekeeping services, which are provided by the TRS as non-customary services and paid for by the REIT. Park Hotels describes these efforts under the category of 'aggressive asset management,' or 're-imagining the operating model.' According to its fourth quarter 2020 earnings call, it planned to eliminate \$85 million in labor costs through a permanent reduction ("right-sizing") of hotel-level staffing as well as operating model changes. The goal is to eliminate daily housekeeping services by pushing an 'opt-in' or 'opt-out' model for hotel customers – based on the rationale that this is what consumers want. Also, part of the plan is to move to 'contactless check-in/room service (Park Hotels and Resorts 2021a). These staffing cuts not only reduce headcount, but lead to higher workloads and work intensity for the remaining employees. Dirtier rooms, after all, are more difficult to clean. Park Hotels promoted

the plan to industry counterparts in a November 2021 presentation to the National Association of REITs (Park Hotels and Resorts 2021b). It and many other REITs have directly opposed local (Healthy Buildings) ordinances in San Francisco and Los Angeles that would require daily cleaning of hotel rooms (Baltimore 2020).

In sum, Park Hotels' business strategy is to maximize hotel profitability via active asset management by "... continually improving the operating performance and profitability of each of our hotels and resorts" (Park Hotels and Resorts 2020:4). In the meantime, as Park Hotels prioritized plans to eliminate labor, the pandemic didn't stop it from rewarding its executives with supersized compensation packages: Park Hotels Chairman Baltimore received \$12.7 million in total compensation in 2020, nearly double the \$6.8 million he made in 2019, according to the company's SEC filing. Every member of Park's executive team also made more in 2020 than in 2019, due to a special one-time November performance award that the company provided in order to 'motivate and retain' executives in light of COVID-19's impact on the company (Park Hotels & Resorts 2021c).

Other hotel REITs have announced similar plans, including Pebblebrook, Hilton, and Host Hotels & Resorts (Sainato 2021). According to Host Hotels CEO, Jim Risoleo, "We view... this crisis truly as an opportunity to redefine the hotel operating model," said CEO Jim Risoleo of Host, the largest private-sector owner of Marriott hotels (Host Hotels & Resorts 2020a). "We won't have the incremental cost associated with housekeeping" (Host Hotels & Resorts 2020b).

The union representing hotel workers in the US (UNITE-HERE) has called out the hotel REITs as 'shadow bosses' who are driving cuts in employment levels and hotel services. In a National Day of Action in January 2022, the union mobilized workers in 21 cities and called on Congress to close the REIT tax loophole that allows REITs to avoid paying taxes while paying out billions in dividends. Eighteen hotel REITs paid \$3.4 billion in dividends in 2021 but paid no corporate income taxes (UNITE-HERE 2022). A report issued by the union estimates the 180,000 housekeeping jobs would be lost – 39 percent of all hotel housekeeping jobs – mostly held by women of color (UNITE-HERE 2021).

Another place where hotel REITs may violate the 'arm's length' relationship with operating hotels concerns their ownership of 'Select Hotels,' which are hotels with minimal services (rather than full services) and which are managed directly by Park Hotels. Its 2020 10-K report notes that, "Managing and operating the Select Hotels ... requires us to employ significantly more people than a REIT that does not operate businesses of such type and scale" (2020a:19). Here, the issue may turn on the interpretation of what constitutes an "eligible independent contractor," which appears to be loose enough to permit the hiring of a hotel or casino manager owned or controlled by a director or executive of the REIT or TRS (Cornell LLI ND).

Conclusions: Hotel REITs

Hotel REITs have become dominant players in the hotel industry over the last three decades. Due to their tax-exempt status, which allows them to pay higher premiums for properties than non-REIT hotel owners, they have dominated M&A activity in the industry -- leading to extensive consolidation and fewer property companies controlling a larger number of rooms. They maintain their tax-exempt status by using taxable REIT subsidiaries as lessees, which in turn contract with management companies to operate their hotels and with brands to attract customers via brand recognition and loyalty. The REITs pay dividends to investors from the rental income and net revenues paid by the taxable subsidiaries. This complex set of relationships helps the REIT comply with the technical requirements of the law, but not its intent. With REIT profitability dependent on how hotels are managed, their business strategy is to maximize hotel profitability via active asset management and influence over hotel operators while maintaining the fiction that the relationship is arms-length and that REITs should be treated as passive investors by the IRS.

Conclusions

REITs were designed by law to be passive investors, and as a result, few scholars or policy makers have paid attention to whether they have in fact played a more important or active role in the US economy. Over time, however, political leaders in both parties supported amendments to the 1960 law that have relaxed the original constraints on REIT activity – constraints put in place to justify their tax-exempt status. In this study, we have reassessed the conventional wisdom about REITs. Our evidence suggests that their tax-exempt status should be revisited because their activist strategies to improve their profits move them far beyond the passive investors they claim to be.

Our evidence identifies three important ways in which REITs have had a powerful impact on productive enterprises, and on the US economy more broadly – whether intended or not.

First, because REITs were designed to facilitate retail investing in the real estate market, they have become an important mechanism for expanding the financialization of the US economy. That is, they expand the reach and influence of finance capital by expanding the pool of capital available to buy up real property. They have grown substantially over the last three decades due to their success in lobbying for legal changes that allow them to maintain their tax-exempt status while operating more and more like standard corporations that do pay taxes. They also benefit from a lack of careful oversight by tax authorities and lax enforcement of regulations

Second, they have played a major role in industry restructuring and consolidation. They have done so by promoting REITs as a separate asset class – one that should be legally separate from the commercial enterprises that produce goods and services on real estate property. By separating

real property from the enterprises operating on that property (OpCo/PropCo model), investors may more precisely calculate the returns to capital based on the risk-reward features of the asset class – in this case, real estate assets versus the goods or services produced on the property. The stock market generally values the real estate assets more highly than operating assets.

Thus, REITs have grown and expanded their reach by separating real estate assets from productive assets. They have dominated M&A activity in real estate markets, due to their tax-exempt status, which allows them to pay higher premiums for properties than non-REIT property owners. As REITs buy up local property and consolidate it into national or global property corporations, they also facilitate the consolidation of the operating companies that become their tenants. That is, they facilitate industry consolidation both at the property level and at the commercial enterprise level. This is evident in the three sectors analyzed in this study. In healthcare, they have served as the handmaidens of private equity firms in their leveraged buyout activities. They have helped finance these buyouts through sale-leaseback deals with private equity firms, which have greatly facilitated the expansion of PE-owned nursing home and hospital chains into mega-chains with enhanced local, regional, or national market power. A similar pattern is evident in the hotel sector, where REITs dominated M&A activity and fostered industry consolidation – both at the level of the hotel real estate and also at the level of the brands and operating companies that manage the property assets.

Is industry consolidation problematic? Scholarly evidence is growing that the level of consolidation in local healthcare markets is leading to anti-competitive conditions, higher patient care prices, and higher insurance payments (Gaynor and Town 2012; Gaynor, Ho, and Town 2015; Cooper, Craig, Gaynor, and Van Reenen 2015; Dafny, Ho, and Lee 2016; Craig, Grennan, and Swanson 2018). Healthcare mergers are facing increasing scrutiny by political leaders and antitrust regulators (Gaynor 2011, 2018; Scheffler, Alexander, and Godwin 2021) and the Federal Trade Commission has halted several recent proposed mergers, including the merger of Rhode Island's two largest healthcare systems (Lifespan and Care New England) (Mensik and Liss 2022) and the HCA's attempt to purchase Steward system hospitals in Utah (Liss 2022).

A third effect of REITs occurs at the level of operating companies. By law, REITs must act as passive investors to retain their tax-exempt status, which means that they cannot interfere with the management or operating decisions of their tenants. The OpCo/PropCo model satisfies these legal requirements, but creates major problems for the effective management of business operations. That is because successful operations depend importantly on the quality and maintenance of the underlying property. The quality of patient care depends on how well facilities are maintained; hotel revenues depend on customer satisfaction with both services and facilities. In other words, the financial logic of maximizing returns for investors drives the separation of property ownership from operations. But that undermines the business logic of

providing high quality integrated services. Ironically, that separation undermines the ability of real estate owners to make sure that operations on their properties are managed effectively. To overcome this dilemma, REITs have developed work arounds to allow them to influence or partner with the companies that manage their properties. Legal changes have freed up REITs to behave more and more like publicly-traded corporations but without the corporate taxes that their counterparts pay. Beyond that, the cases in this report show how REITs achieve their financial goals through work arounds that directly or indirectly shape the decisions or business strategies of their tenants. These work arounds vary based on different risk-reward assumptions across industries.

In healthcare, our case studies demonstrate how REITs' use sale-leaseback agreements with health operating companies in which the companies are tenants and the REITs are landlords. These agreements are based on the assumption that government reimbursement systems provide long term predictable funding mechanisms. The tenants bear all of the profit-loss risks, as well as the costs and risks of property maintenance. Thus, healthcare REITs are viewed as safe investments that yield reliable dividends, almost as safe as bonds. They bear little risk if an operating company fails; and in that event, their properties may be repurposed for a new tenant. Healthcare operating companies in nursing homes and hospitals, however, bear substantial risk of financial failure due to ongoing cost increases and uncertain and unpredictable funding. While REITs appear to be passive investors in these cases, a deeper analysis shows how they have made it possible for private equity firms to extract wealth through excessive debt financing; and that they have undermined healthcare providers' financial stability through charging excessive rents with unsustainable escalator clauses in long-term renewable leases. The accumulated evidence shows that their partnerships with PE firms have resulted in quite negative consequences -- driving nursing homes and hospitals into financial distress or bankruptcy, and leading to understaffing, equipment shortages, poor patient care, and even fatalities.

In hotels, by contrast, REITs bear most of the risk of profit and loss, as they lease their properties to taxable REIT subsidiaries, which in turn contract with hotel operator -- paying them a fee for managing the properties and reimbursing them for labor and other expenses. Hotel REITs hide behind the complexity of contracting relationships to argue that they maintain arms-length relations with operators. But their financial concerns over risk management lead them to promote strategies to 'actively manage' their assets and drive down hotel operating costs, which became particularly evident during the COVID pandemic.

Thus, REITs can exert a large influence over the strategies of operating companies and the outcomes for consumers, patients, and employees; but they bear no liability or responsibility for those outcomes, which may be quite negative, at least according to the case evidence in this study.

In sum, this report suggests that scholars and policy makers need to take a much closer look at REIT activities. Their profits and executive compensation have been extraordinary in recent years, with little discomfort caused by the COVID pandemic. Their financial transactions offer little or no transparency, and taxpayers deserve a clear assessment of how much they are subsidizing yet another asset class that may be contributing to greater inequality in the US economy.

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Appendix A: US Hotel REITs by Market Capitalization, 2022

Company ticker	Market cap (billions)	Company description
Host Hotels (HST)	\$14.56	Host Hotels & Resorts, Inc. (Host Inc.), incorporated on September 28, 1998, operates as a self-managed and self-administered REIT.
MGM Growth Properties LLC (MGP)	\$11.17	MGM Growth Properties LLC, incorporated on October 23, 2015, is a REIT engaged primarily in entertainment and leisure resorts
Ryman Hospitality Properties (RHP)	\$5.17	Ryman Hospitality Properties, Inc., incorporated on June 21, 2012, is a self-advised and self-administered REIT, focused on group-oriented, destination hotel assets
Park Hotels and Resorts (PK)	\$4.65	Park is the second largest publicly traded lodging REIT with a diverse portfolio of market-leading hotels and resorts, consisting of 54 premium-brands - middle-range hotel properties under the Hilton, DoubleTree, and Hyatt Regency brands in locations such as Honolulu, Chicago, and Key West
Apple Hospitality REIT (APLE)	\$4.00	Apple Hospitality REIT, Inc. (NYSE: APLE) is a publicly traded REIT that owns one of the largest and most diverse portfolios. Features inexpensive family vacation hotels such as Courtyard, Fairfield, and Residence Inn
Pebblebrook Hotel Trust (PEB)	\$3.20	Pebblebrook Hotel Trust is a publicly traded REIT organized to opportunistically acquire and invest primarily in high-end, full-service hotels and beach resorts such as Jekyll Island and Key West
Sunstone Hotel Investors (SHO)	\$2.67	Sunstone Hotel Investors, Inc., incorporated on June 28, 2004, operates as a self-managed and self-administered REIT.
RLJ Lodging Trust (RLJ)	\$2.31	RLJ Lodging Trust, incorporated on January 31, 2011, is a self-administered REIT, engaged in the acquisition of focused-service and compact full-service hotels.
Diamondrock Hospitality (DRH)	\$2.23	DiamondRock Hospitality Company is a self-advised REIT with a leading portfolio of geographically diversified hotels concentrated in top gateway markets
Four Corners Property Trust (FCPT)	\$2.22	FCPT is a REIT primarily engaged in the acquisition and leasing of restaurant properties.
Xenia Hotels and Resorts (XHR)	\$2.17	Xenia Hotels & Resorts, Inc., incorporated on August 27, 2014, is a self-advised and self-administered REIT, focused on premium full service, lifestyle hotels
Service Properties Trust - Shar (SVC)	\$1.33	Service Properties Trust is a REIT, or REIT, which owns a diverse portfolio of hotels and net lease service and necessity-based facilities

Summit Hotel Properties (INN)	\$1.02	Summit Hotel Properties, Inc., incorporated on June 30, 2010, is a REIT focused primarily on owning premium-branded, select-service hotels in the Upscale segment; primarily major Sunbelt cities such as New Orleans, Houston, Dallas, and Oklahoma City.
CorePoint Lodging (CPLG)	\$0.95	CorePoint Lodging Inc., a REIT company, focuses on midscale and upper-midscale lodging business, with a portfolio of 316 hotels and 40,000 rooms as of 2018
Chatham Lodging Trust REIT (CLDT)	\$0.67	Chatham Lodging Trust, incorporated on October 26, 2009, is a REIT, focused primarily on upscale extended-stay and premium-branded select-service hotels.
Braemar Hotels & Resorts (BHR)	\$0.45	Braemar Hotels & Resorts is a conservatively capitalized REIT that invests primarily in high RevPAR, full-service luxury hotels and resorts.
Hersha Hospitality Trust (HT)	\$0.42	Hersha Hospitality Trust, incorporated on May 27, 1998, is a self-advised REIT that invests primarily in high-end luxury brands in gateway markets - 36 hotels in 7 states - Hotels such as the Parrot Key Hotel, Villas in Key West, The Envoy in Boston
Ashford Hospitality Trust (AHT)	\$0.28	Ashford Hospitality Trust, Inc., incorporated on May 13, 2003, is an externally-advised REIT focused on investing in the hospitality industry
Sotherly Hotels (SOHOO)	\$0.86	Sotherly Hotels Inc. is a self-managed and self-administered lodging REIT focused on upscale to upper-upscale full-service hotels in the Southern US
Sotherly Hotels (SOHOB)	\$0.85	Sotherly Hotels Inc., incorporated on August 20, 2004, is a self-managed and self-administered lodging REIT
Sotherly Hotels (SOHO)	\$0.70	Sotherly Hotels Inc. is a self-managed and self-administered lodging REIT focused on the upscale to upper-upscale full-service hotels in the Southern US
InnSuites Hospitality Trust (IHT)	\$0.25	InnSuites Hospitality Trust (NYSE MKT symbol: IHT) first listed on the NYSE in 1971 is headquartered in Phoenix, Arizona
Total mkt capitalization	\$62.12	

Source: FKnl.com (Financial Knowledge and Info). 2022. "Hotel REIT Stocks List of 2022." May . <https://fknol.com/stock/list/hotel-reit.php>