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National Healthcare REIT Thinks Local: A Conversation with LTC’s Clint Malin

LTC Properties was ahead of its time. The healthcare REIT recognized early on the power of local market knowledge, focusing on partnerships with regional operators to leverage their expertise.

That recognition led to a strategic and targeted investment approach, guided by the senior leadership team at LTC including Clint Malin, executive vice president and chief investment officer at the Westlake Village, California-based company.

NIC chief economist, Beth Mace, recently spoke with Malin about LTC’s methodical strategy and the signs he sees of future opportunities. Here’s a recap of their conversation.

**Mace:** How long has LTC been investing in the seniors housing and care sector?

**Malin:** LTC has been around for 27 years. We went public in 1992 as a mortgage REIT investing in the skilled nursing space. In the mid- to late-’90s, LTC began to diversify its investments into the ownership of assets to focus on long-term hold positions instead of recycling capital with the frequency required by a mortgage REIT.

**Mace:** Do you still offer mortgage REIT structures?

**Malin:** Our preference is ownership. But we will strategically look at mortgage or mezzanine financing primarily as a strategic tool to initiate and develop relationships with operating companies new to our portfolio.

As of today, our portfolio is diversified between private pay seniors housing and skilled nursing.

**Mace:** What is the composition of your portfolio between skilled nursing and private pay seniors housing?

**Malin:** Our portfolio is currently balanced with a property mix of approximately 50% seniors housing and approximately 50% skilled nursing. We don’t have a specified diversification target or threshold; however, we see value in a relative balance between asset types because that impacts the cost of our capital. The yields and returns investors require from purely skilled nursing REITs are higher than that of a REIT with a property mix. Strategic asset-type diversification enables us to access capital at a lower cost, giving us a strong competitive position.

**Mace:** How big is LTC?

**Malin:** Our equity market cap is approximately $1.7 billion. Our enterprise value, including debt, is approximately $2.3 billion. We are one of the smaller healthcare REITs. We view that to be an advantage. We can move the needle on
accretive earnings growth with smaller deals because we have a smaller base. In today’s environment, larger transactions come at a premium and produce fewer opportunities for earnings growth. We feel we can get a better risk adjusted return with smaller transactions and that helps us with operator diversification in our portfolio. We don’t look for transformational transactions, but rather to grow consistently and methodically over time.

Mace: Do you provide capital for acquisitions, development, and expansions?

Malin: On the acquisition side, the core of what we do is 100 percent ownership of the property. In the last couple years, we have also started actively investing in real estate joint ventures with operating companies, a structure that is relatively new for us. As it pertains to development, we were a more active capital provider in the earlier stages of the current, elongated development cycle, but, now in the latter stages of this cycle, we are very selective. The increased cost of development—for land, labor, materials—have caused us to hold back. We selectively financed private pay seniors housing development in the late-’90s, and then again started in 2012 when you could construct a building at a price point below the acquisition cost. The value proposition is different today. There is a saturation of supply, rising development costs, and the risk of lease-up. In regard to expansions, we have always been an advocate of reinvesting in our properties and working with our operating partners. We view that as a win-win. We can deploy capital, earn a yield and return on those dollars, and help our operating partners by providing capital for them to improve the physical plants so they provide a better product.

Mace: NIC’s Spring Conference addresses the theme of collaboration between healthcare providers and seniors housing and skilled nursing operators. Does LTC provide capital for operations?

Malin: We do not. It’s a challenge for the industry to provide capital for operations not tied to real estate. The tangible asset value is in the real estate, but the inherent value of what you are financing, which is operations, is driven by the operator and their performance. It’s a basic disconnect. This applies more to skilled nursing than private pay seniors housing. REITs have used the RIDEA structure to provide operating capital for private pay seniors housing. RIDEA is effectively equivalent to a private equity investment allowing participation in profits and losses but structured for a longer term hold position. And there are few RIDEA investments on skilled side because of the risk.

Mace: Does LTC use RIDEA structures?

Malin: We do not use RIDEA. We have looked at RIDEA, but it’s something that we believe needs to be done on scale which is evident from the three large healthcare REITs using the RIDEA structure. It’s a different business model. You must employ staff with expertise in operations to effectively manage the investment. We might look at RIDEA structures in the future. But today, it’s not something we are pursuing.

That said, as I previously noted, we have launched a joint-venture product as another consideration for operators in addition to RIDEA. In this model, operating partners participate in a percentage of the propco, while holding 100% of the opco.
This approach allows the operator to enjoy upside generated from the asset in addition to the operations.

**Mace:** What are advantages and downsides of REIT financing?

**Malin:** REITs are suited to certain situations. Our advantage is that we provide access to 100% transaction financing and a long-term relationship. A lot of capital available today is earmarked for a short-term commitment, and the operator has to refinance in 5-7 years. We have consistent access to capital and the ability to help operators grow.

Another advantage is our hands-off approach. The operator is in charge unless there’s a default. We are not dictating how to spend money or when. Operators have the autonomy to run their business in contrast to private equity partners that tend to be more involved in operations from which they typically derive their returns.

We provide capital for renovations, improvements, and expansions. And we are dedicated to the industry. We invest in good and bad times because we are knowledgeable about the space.

**Mace:** How big is your staff?

**Malin:** LTC employs 21 people.

**Mace:** Are you national in terms of investment?

**Malin:** We have just over 200 investments in 28 states.

**Mace:** What do you look for in a good operating partner?

**Malin:** We focus on regional operating companies. Our goal is to build relationships. Operators focused on a region are invested in that market. Our partners tend to be smaller or midsized organizations. We are looking for an operator with the capacity or desire to grow. We do not look for one-off investments.

The whole senior care landscape is changing. We have an aging population and higher acuity levels in both assisted living and skilled care. We look at how potential operating partners approach innovation in their care model. What are they doing to get ahead of the curve as things change on the operating side of the business? Do they have access to sources of capital to invest in technology? As labor rates increase, operators have to be more creative and efficient in order to improve outcomes for residents and to be able to demonstrate that capability to managed care organizations.

On the skilled nursing side, operators need to be knowledgeable about the Medicaid reimbursement models and regulations in the states where they operate. We want to understand their approach to reimbursement under the new Patient Driven Payment Model (PDPM) and their scale within the marketplace to have a meaningful seat at the table with managed care providers. We are also looking for proven success. An operator may be smaller, but they have to have had success.
Mace: How will PDPM play out with operators?

Malin: The majority of our operating partners feel positive about PDPM. Generally, they have evolved to focus on higher acuity patients, and they feel they are going to finally be reimbursed for that care. Migrating high-need patients to more cost effective settings will be good for the industry. But some operators may not be able to manage through the changes which will be an opportunity for regional-based skilled providers to acquire assets.

Mace: Does that impact your investment strategy?

Malin: We have been a long-time supporter of the skilled nursing industry through various cycles. Our skilled nursing acquisitions cooled over the past couple of years simply because we haven’t found opportunities meeting our underwriting requirements. Moving forward, we will continue to evaluate the skilled space with the goal of identifying and developing relationships with operating companies providing good outcomes, sharing data, and retaining talent.

Mace: What other opportunities are on the horizon?

Malin: We see an opportunity as construction slows and private pay seniors housing occupancy catches up to capacity. The aging population will help fill the buildings. But we think there will be an opportunity to pick up properties that have gone through an elongated development cycle and slow lease-up. The new investors that have been attracted to the space might not be patient, especially if interest rates rise. Buildings with a broken capital structure represent investment opportunities for LTC.
Seniors Housing & Care Industry Calendar

March 2019

3/13-14  AHIP National Health Policy Conference  Washington, DC
3/14-15  2019 PREA Spring Conference  Dallas, TX
3/17-20  LeadingAge PEAK Leadership Summit & Great Minds Gala  Washington, DC
3/18-20  Nineteenth Population Health Colloquium  Philadelphia, PA
3/27-28  Health Datapalooza  Washington, DC
3/28  McKnight’s Expo Webinar

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