CUSHMAN & WAKEFIELD

REHAB CLINICS

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CUSHMAN & WAKEFIELD
HEALTHCARE ADVISORY

CONTENT

01
FORWORD
P. 04

02
MEDICAL REHABILITATION
P. 06

03
MARKET ENVIRONMENT
P. 10

04
REHABILITATION FACILITIES
P. 26

05
OPERATOR MARKET
P. 50

06
REHABILITATION CLINICS AS AN ASSET CLASS
P. 58

07
SOURCES
P. 64

08
CONTACT & DISCLAIMER
P. 68

FOREWORD

In the past 30 years, the German rehabilitation clinic landscape has undergone an unprecedented structural change. As a result of the legal changes in the mid-1990s and the resulting more restrictive allocation of rehabilitation measures, the rehabilitation and prevention sector suffered a massive drop in the number of patients and occupancy rates initially fell significantly. However, this decline was only a transient effect.

Due to the continuously changing world of work, the higher average retirement age and the increase in environmental influences on the human body, over the last several years ever more people have been requiring rehabilitation and preventive treatment in order to continue to pursue their professional livelihoods until the statutory retirement age or to counter the impending threat of a need for care. Rehabilitation measures in Germany are often still often provided in inpatient rehabilitation clinics. In contrast to other areas of the health and care sector, rehabilitation and prevention will continue to rely on inpatient care and treatment of patients, which is making rehabilitation clinics an attractive asset class for a growing number of institutional (real estate) investors.

We are pleased to present three expert interviews; with Yann Balaÿ, Head of Healthcare and Education at Primonial REIM, Anna-Lena Hetzel, Transaction Manager at BNP Paribas REIM and Dr. André M. Schmidt, CEO of the operator MEDIAN Unternehmensgruppe B.V. & Co. KG. Both investors have been very active in the acquisition of rehabilitation clinics throughout Europe for many years and MEDIAN Unternehmensgruppe B.V. & Co. KG is the largest private clinic operator of rehabilitation clinics in Germany.

We hope you enjoy reading our report on rehabilitation clinics and hope that it will provide you with some interesting insights.

02

MEDICAL REHABILITATION

MEDICAL REHABILITATION

AN INTRODUCTION

Medical rehabilitation is a complex construct comprising various forms of treatment, several funding agencies and multiple fields of treatment as well as varying duration. The aim of medical rehabilitation is to maintain or improve health in order to lead an independent everyday life, to prevent a foreseeable illness or to avoid requiring care.

The forms of therapy applied in medical rehabilitation cover a broad spectrum of measures which are adapted to the specific clinical picture of the person concerned. These range from physiotherapy and occupational therapy to massage, therapeutic baths and psychotherapeutic consultations. In recent years, the importance of preventative treatment concepts has greatly increased, especially in old age or to prevent secondary diseases.

Outpatient or inpatient rehabilitation

Medical rehabilitation can take a variety of forms, depending on the severity of the illness and the circumstances of the person affected. For outpatient rehabilitation, patients visit a therapy centre for certain treatments and rehabilitation measures. If the patient is not able to visit these facilities due to the state of their health, such measures can also be carried out by a mobile rehabilitation team at home. For inpatient rehabilitation, the patient lives in the rehabilitation facility for a limited period and receives 24-hour care. Semi-inpatient rehabilitation is also possible, where the patient stays in a rehabilitation facility close to their home during therapy hours and usually goes home at weekends and in the evenings.

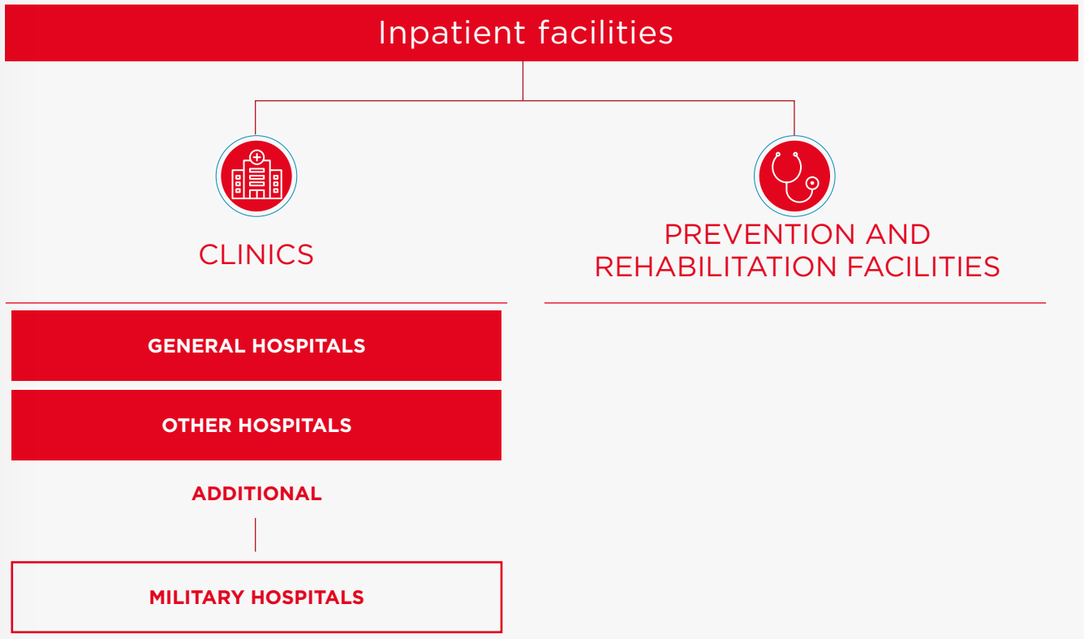
The duration of rehabilitation measures can vary depending on the patient's clinical picture and age. However, for adults and adolescents aged 14 years and older, inpatient treatment is usually scheduled for three weeks and outpatient treatment for 20 days. There is usually a four-year interval between two such courses of treatment. For children under 14 years of age, the duration of treatment is usually four to six weeks. Rehabilitation measures can also be extended if medically necessary.

Who pays for rehabilitation?

In contrast to preventive measures, which in Germany are mostly covered by health insurers, the funding of medical rehabilitation depends on the aim of the measure and the cause of the illness and can be provided by a variety of funding agencies. In the case of rehabilitation with the aim of restoring the ability to work, the costs are borne by the pension insurance scheme, whereas the cost of rehabilitation required due to occupational illnesses or accidents at work is borne by the accident insurance scheme. In the case of rehabilitation with the aim of preventing permanent disability or habituation to the consequences of an illness, the costs are borne by the health insurers.

In addition to hospitals, preventive care and rehabilitation facilities are also counted as inpatient care facilities and are charged as hospitals in accordance with § 2 No. 1 of the Hospital Financing Act (KHG).

According to § 111 Social Statute Book (SGB) V, preventive care and rehabilitation facilities are divided by type of authorisation into preventive care and rehabilitation facilities with and without a care contract. Regarding type of provider and legal form of facility, it is also sub-categorised as a public sector facility, non-profit facility or a private facility.



Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2020

03

MARKET ENVIRONMENT

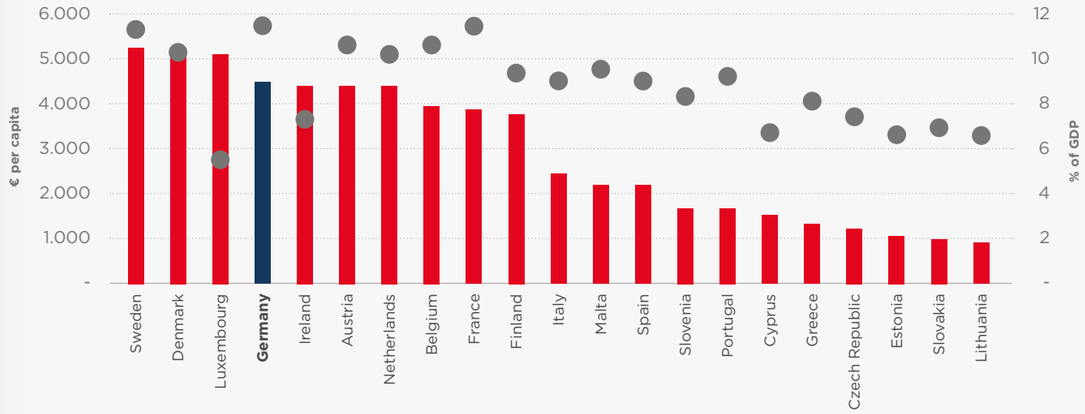
MARKET ENVIRONMENT

GERMAN REHABILITATION SYSTEM IN A EUROPEAN CONTEXT

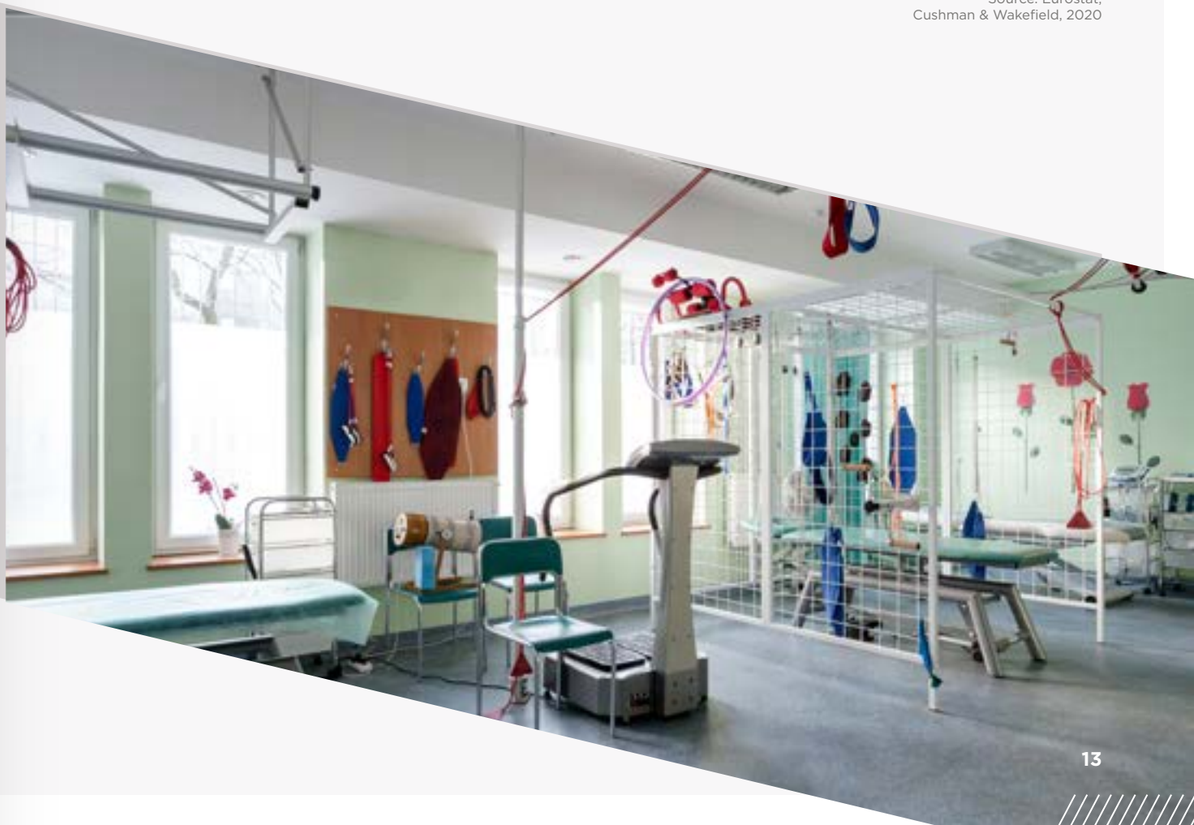
With the introduction of a state health system in 1883, Germany took on a pioneering role worldwide and still has one of the most comprehensive and innovative medical care systems worldwide.

In European comparison, Germany is the country with the highest per capita health expenditure in relation to its GDP after France. This is due both to the extensive services provided by the German health system and to the above-average GDP, which makes this expenditure possible. As a result, Germany has succeeded in establishing a first-class innovative health care system which not guarantees only excellent primary medical care, but also preventative and rehabilitative medicine, thus contributing to an increase in life expectancy. In recent years, for example, there has been a sharp decline in cardiovascular disease and the average life expectancy at birth in 2018 was 80.9 years, only very slightly below the European average of 81.0 years.

HEALTH EXPENDITURE IN EUROPE (2017)



Source: Eurostat, Cushman & Wakefield, 2020



MARKET ENVIRONMENT

GERMAN REHABILITATION SYSTEM IN A EUROPEAN CONTEXT

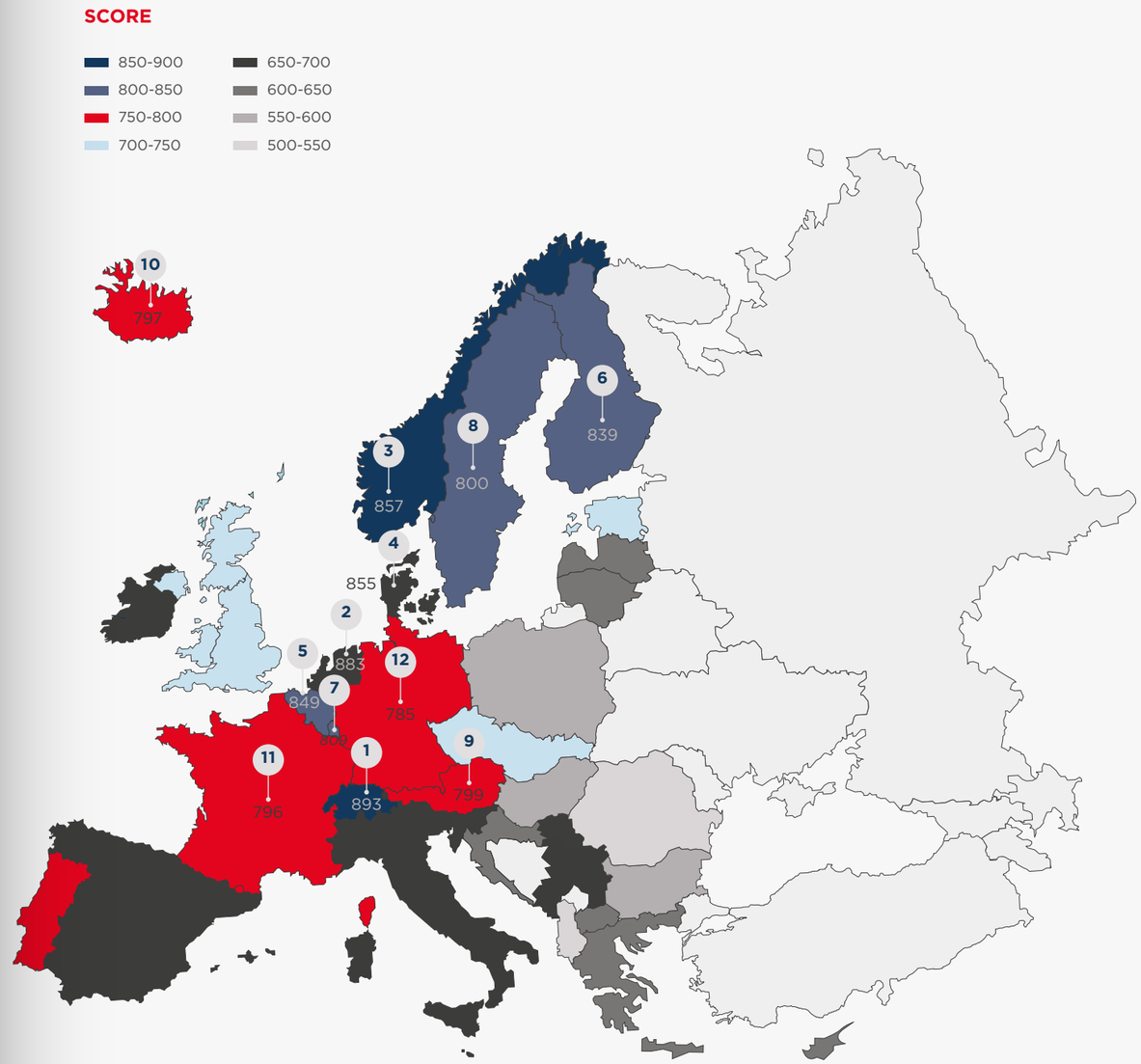
European Health Consumer Index

One of the most renowned public comparative indicators of national health care systems, the Euro Health Consumer Index (EHCI*) by Health Consumer Powerhouse, ranks Germany 12th despite having the strongest quantitative parameters of medical care.

COUNTRY	RANK	TOTAL SCORE	PATIENT RIGHTS & INFORMATION	ACCESSIBILITY (WAITING TIME FOR TREATMENTS)	PROVISION OF RESULTS	ACCESSIBILITY OF SERVICES	PREVEN-TION	PHARMA-CEUTICALS
Switzerland	1	893	113	225	278	99	95	83
Netherlands	2	883	125	175	256	125	113	89
Norway	3	857	125	138	278	120	119	78
Denmark	4	855	121	175	267	120	95	78
Belgium	5	849	104	213	244	115	101	72
Finland	6	839	113	150	278	120	101	78
Luxembourg	7	809	100	188	244	109	95	72
Sweden	8	800	117	113	267	125	101	78
Austria	9	799	108	175	244	104	89	78
Iceland	10	797	121	188	222	104	107	56
France	11	796	104	188	233	104	83	83
Germany	12	785	104	163	244	83	101	89

Source: Björnberg, Phang, Cushman & Wakefield, 2018

* The EHCI considers six different criteria against which the health system is assessed. The following criteria are weighted by the different high maximum points patient rights & information (max. 125), waiting time for treatments (225), outcomes (300), range and reach of service (125), prevention (125) and pharmaceuticals (100).



In the Index, Germany ranks 12th overall. Only in the provision, cost absorption and timeliness of medicines does Germany occupy first place, together with the Netherlands. Switzerland ranks number one in Europe on the Health Consumer Index. It has earned itself an excellent reputation in the healthcare sector, particularly due to its availability and waiting time for treatment.

In terms of the accessibility of service and preventative medicine, few other countries come close to the Scandinavian countries (Denmark, Finland, Norway, Sweden). In terms of patients' rights and information transparency, Germany is in second-last place, ahead of only Luxembourg with the Netherlands and Norway leading the way. Nevertheless, Germany's strength in dealing with exceptional situations is particularly evident in the context of the COVID-19 pandemic. The resilience of the German health care system was recognised worldwide.

MARKET ENVIRONMENT

GERMAN REHABILITATION SYSTEM IN A EUROPEAN CONTEXT

Special characteristics of rehabilitation in Germany

Despite increasing convergence, historic differences between the individual countries shape the picture of the social and health systems in Europe. This also applies to medical rehabilitation. Compared to other European countries, medical rehabilitation in Germany, which is largely similar to the Austrian system, is characterised by a number of things when comparing to other European countries. These include treatment being predominantly inpatient in facilities away from patients' homes and the limited rehabilitation period of three weeks. Other specifics are the strict demarcation of the management of rehabilitation funding between pension bodies, health insurers, accident insurers etc. The free application for rehabilitation, the specialisation of rehabilitation facilities by clinical picture, the acute medical orientation of the treatment and the medical dominance in interdisciplinary treatment teams are some of the most atypical features in European comparison

The German system in European comparison

In contrast to the German system, a large proportion of medical rehabilitation in Finland is carried out in approximately 230 municipal health centres, which also provide the country's basic medical care. Only a small proportion of medical rehabilitation is carried out in inpatient clinics, which are all privately owned. Similarly, in the UK, regional health centres with outpatient services dominate the rehabilitation landscape. In some cases, medical rehabilitation is even carried out at home on the basis of text descriptions. In contrast to Germany, the UK does not rely on interdisciplinary treatment teams under medical supervision, but nurses/carers usually manage the rehabilitation measures. Rehabilitation in France is more similar to the German system however, and is often carried out in an inpatient setting, although in France separate rehabilitation departments are attached to acute hospitals. However, in France as a whole, approximately 40% of acute hospitals have rehabilitation facilities. In a further variant, Switzerland makes no legal distinction between acute hospitals and rehabilitation clinics. Thus, when a patient is admitted to a rehabilitation clinic, no further referral/approval from a hospital is required. Furthermore, in contrast to the German health system, the remuneration of service providers is not regulated. In the Netherlands, the prevention or remediation of a reduction in earning capacity is usually the main focus of medical rehabilitation. In this context most medical rehabilitation measures are prescribed by occupational physicians.

MARKET ENVIRONMENT

EXPERT INTERVIEW - YANN BALAŸ, PRIMONIAL REIM

PRIMONIAL REIM

Yann Balaÿ

Yann Balaÿ is Head of Healthcare and Education at Primonial REIM. The French asset and investment manager, headquartered in Paris, is one of the largest in Europe with approximately €22 billion assets under management and with properties in seven European countries.

Interview

Thank you very much for the opportunity to discuss this special asset class today. Primonial REIM is one of the leading real estate investors in healthcare properties in Europe. Could you briefly explain your strategy on focusing on this asset class?

Our strategy is to procure long-term and secured cash flow for our private and institutional investors. This strategy in the healthcare real estate sector is driven by 3 main principles. First, be global: we invest in all types of healthcare: pre-acute, acute care, post-acute care and long-term accommodation. Then, organize and develop partnerships with international and local operators to assist them in their own development. Third, expand the investment in brownfield and greenfield projects in order to constantly increase the quality of the portfolios.

You have been active as healthcare investor for a long time. Do you remember the first investment in a rehabilitation facility? What was the background for the decision to invest in rehabilitation facilities?

We've been investing in rehabilitation clinics for a long time and if I remember correctly, one of our first standalone investments in this category was in 2013, a French "soins de suite et de réadaptation" clinic, operated by one of the leaders in the French private market.

Rehabilitation clinics, similarly to acute care and long-term facilities, are part of the global spectrum of patient-care provision. So, it was obvious for us to integrate specific post-acute care into the scope of our healthcare strategy. One of the additional reasons is because in France, the rehabilitation sector represents a substantial proportion of some of the major operators' activity. And so, as we consider the relationship with operators a key aspect of healthcare real estate investment, it wouldn't have been consistent to cut ourselves off from a complete segment of opportunity.

What makes rehabilitation facilities sustainable and attractive as a real estate investment product for you, as a long-term investor?

As I said, we have a global strategy in terms of healthcare types because the majority offer identical, and persistent, advantages such as long-term leases, fixed rent with periodical indexation, good visibility in terms of an operating business driven by the shifting demographic structure of the population. With such an increase in the number of older people, there is growing demand for care and state-support.

We should also mention the development of new areas of activity, for instance the increasing need for mental care facilities in recent years due to the fact that mental disorders are increasingly more acknowledged and recognized in our societies.

> **Periods like this COVID-19 crisis will intensify this increased demand for mental care.**

Additionally, we might mention in France, that current policies are leading patients' length of stay of in acute care facilities to be continually reduced, while at the same time increasing the need for more post-acute care facilities and/or increasing their intensity/density of operation.

With all your experience as an investor in this asset class what do you think are the most critical and important property-, location- and operation-based aspects for an attractive rehabilitation investment opportunity?

I think the most relevant for a rehabilitation facility investment opportunity is the quality of the operator and the possibility of a fair discussion, beyond the simple tenant/landlord relationship in order to understand the operator's requirements in order to better run their business.

Of course, the intrinsic qualities of the building are also essential to ensure it is fulfils the requirements for good operation and/or has the capacity to evolve over time to fulfil any potential new regulations and/or changes to the business.

The question of the location needs to be looked at simultaneously with the demand in a certain area to be sure the facility answers specific requirements. For example, care homes are needed in large cities as well as in small towns. And one of the major goals of every government is to make sure inhabitants/patients – and their relatives –have access to healthcare infrastructure without having to travel miles. Of course, without losing sight of the main parameters of real estate investment such as price per sqm.

On a European level, what are the most significant differences regarding the general market environment, refinancing structures and the operator market?

A huge question, which we would need several books to answer. But in brief and in terms of what we observe at Primonial REIM regarding the main countries we invest in (France, Germany, Italy, Spain, etc.) we can say that the main differences are driven by national, even infra-national, policies and regulations. Healthcare and thus healthcare real estate, is a very highly regulated segment.

Thus, to perform investment is this sector, it is important to understand each specific environment to have the capacity to measure the sustainability of the activity performed by the operator. To take one example in the rehabilitation sector, in some countries operators have to renegotiate tariffs every year, whereas in others they benefit from being able to look ahead at a stable situation for 4 or 5 years at a time.

In a European context, are there major differences between countries regarding the prime net initial yields for stabilised core assets?

Speaking about nursing homes, for instance, which can be considered as the most comparable type of property in terms of operation from one country to another, we are still observing differences in prime net initial yields. But, in my opinion, the most relevant point in this regard is the fact that those prime "local NIYs" have been compressing for several years, and in some countries more quickly than others, leading to these differences diminishing.

Some factors can explain this compression, such as the consolidation of the business with ever more international operators increasing their footprint is many countries and thus improving the creditworthiness of the tenant. Additionally the investment advantages offered by this asset class, and therefore the development of competition for healthcare real estate. A process that should continue in future, the COVID crisis having demonstrated the resilience of such investments.

What are the most relevant challenges in terms of investing in rehabilitation facilities and performing proper due diligence?

In terms of due diligence, the most salient challenge is to have the capacity to obtain performance figures to enable the operation of the facility to be benchmarked; and thus to assess the position of the facility in its competitive landscape.

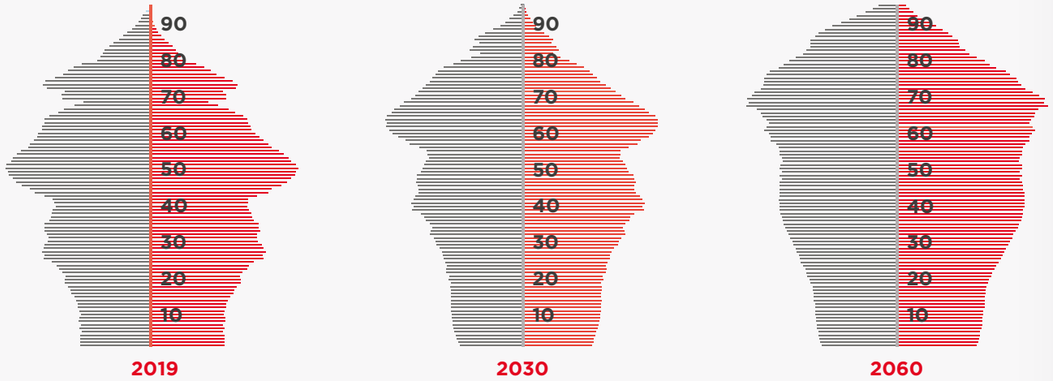
Could you give us a few insights – Do you intend to strengthen your activities in Germany in the future?

I can confirm that Primonial REIM retains the same objectives: to continue to expand our capacity to invest in the healthcare real estate sector. This is particularly the case in Germany where the fundamentals for this type of investment are very good, the quality of the operators is unassailable and demand for new facilities to respond to the challenges of the ageing population amongst the highest in Europe. Our current footprint in this country, representing more than EUR 5bn of value, provides us with a good basis for achieving our goals.

MARKET ENVIRONMENT

GENERAL MARKET ENVIRONMENT

83,2 MIO. MILLION PEOPLE



Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2018

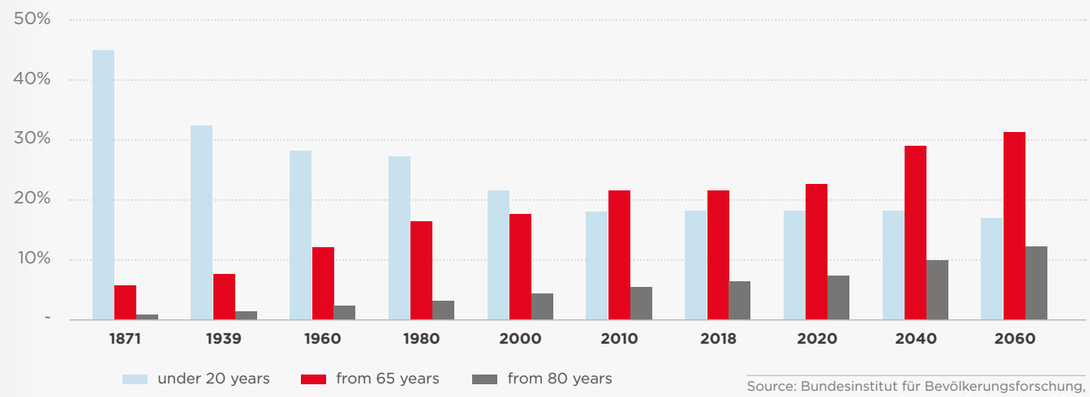
Rising demand for care

Germany has been undergoing demographic change over several decades as well as medical and therapeutic change. The ever-ageing population requires an ever-increasing amount of care provision, rehabilitation and medical treatment, which is being met with immense progress in inpatient and outpatient medical care. In this context, outpatient care is defined as treatment by a general practitioner (including employed doctors) or in the outpatient department of a hospital or rehabilitation facility. In contrast, inpatient treatment is defined as the treatment in which the patient is admitted, cared for and treated in a clinic for at least one night.

Demographic shift due to increase in generation 60+

The life expectancy of Germany‘s population is showing a significant increase. According to the 2017/2019 mortality table of the Federal Statistical Office, life expectancy at birth is 83.4 years for girls and 78.6 years for boys. By 2060, the Federal Authority forecasts that it will continue to rise to 88.8 years and 84.8 years respectively. Moreover, the increasing size of the 60-plus generation as a proportion of the total population represents a major challenge for the German health system. Today, every fourth German citizen is 60-plus. This corresponds to about 20 million people. As a result, care for the elderly as well as medical care and medical rehabilitation are gaining importance due to the increasing incidence in old age of multimorbidity - the suffering of multiple chronic illnesses which have a lasting impact on health and require continuous treatment - and are facing unavoidable structural change.

AGE GROUPS 1871 TO 2060



Source: Bundesinstitut für Bevölkerungsforschung, Cushman & Wakefield, 2020

MARKET ENVIRONMENT

GENERAL MARKET ENVIRONMENT

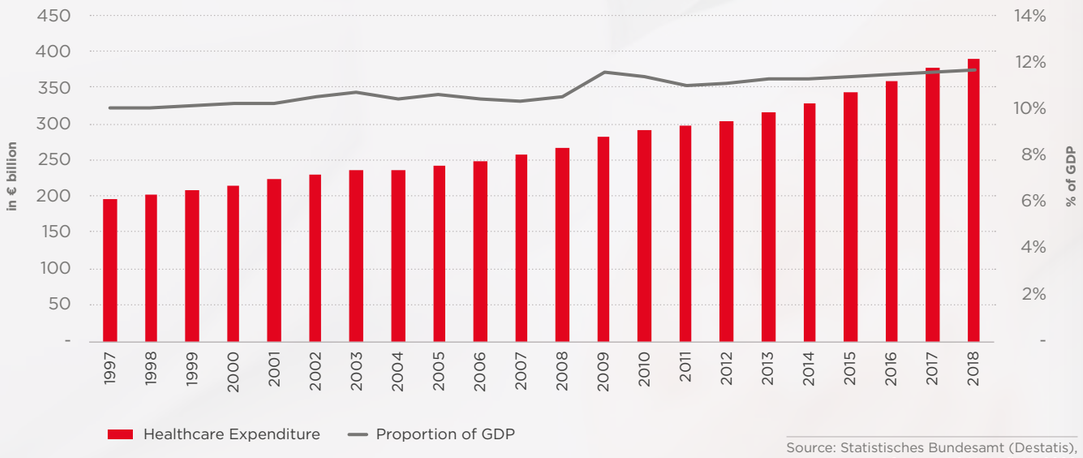
In 2017, for the first time in the history of the Federal Republic of Germany, the threshold of €1 billion per day of health expenditure was exceeded. In 2017, almost €375 billion, which in turn corresponds to 11.5% of gross domestic product, was spent on health care. In 2018, this figure rose by 4.4% to €391 billion. In 2018, employees and employers financed almost half of all health expenditure through social security contributions.

Per capita costs will rise

The future imbalance between contributors and per capita expenditure will lead to a necessary adjustment of the cost-unit landscape and maximisation of the efficiency of medical care. The current pay-as-you-go system of statutory health insurance funds faces the problem of a considerable increase in costs for future contributors to finance health services. This becomes clear with a brief explanation of the health insurance system. Every citizen in Germany is obliged to take out health insurance. Statutorily insured persons currently pay 14.6% of their subject-to-contributions income into a health fund, with this contribution being borne equally between the employee and their employer.

The health fund, which also receives state subsidies, distributes this money according to certain criteria to the statutory health insurance funds, which are then responsible for paying for the treatment of patients. In contrast the premiums paid to private health insurers are calculated independently of gross income, solely on the basis of the scope of benefits and the state of health of the contributor. Unlike those insured in the statutory health insurance sector, privately insured persons must pay in advance, but are reimbursed for medical treatment. In contrast to private health insurance companies, statutory health insurance companies are not required to build up reserves, which will make it more difficult to reconcile the difference between contributors and expenditure per capita in the coming years.

HEALTHCARE EXPENDITURE AND PROPORTION OF GDP

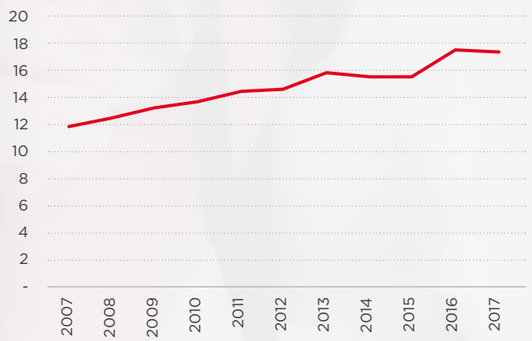


Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2020

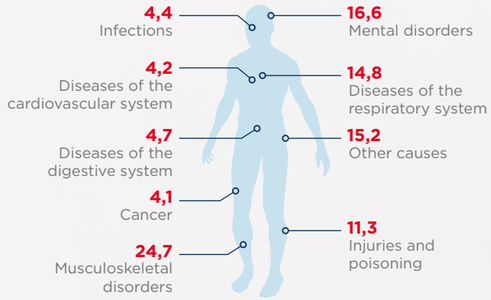
Cost driver sick days

However, not only the ageing demographic structure of the population, but also the rise in multimorbidity and the average number of sick days are increasing the costs of the German health system. Over the last ten years, the average number of sick days per compulsorily insured member of workforce health insurance funds (including recipients of unemployment benefit, excluding pensioners) has risen by 30.8% from 11.9 to 17.2 days. The majority of absences due to illness do not last longer than one working week, according to the umbrella organisation of workforce health insurance funds, and 80% of employees are back at work after two weeks at the latest.

AVERAGE SICK DAYS



PERCENTAGE OF SICK DAYS ACCOUNTED FOR BY ...



Source: BKK Dachverband, Cushman & Wakefield, 2019

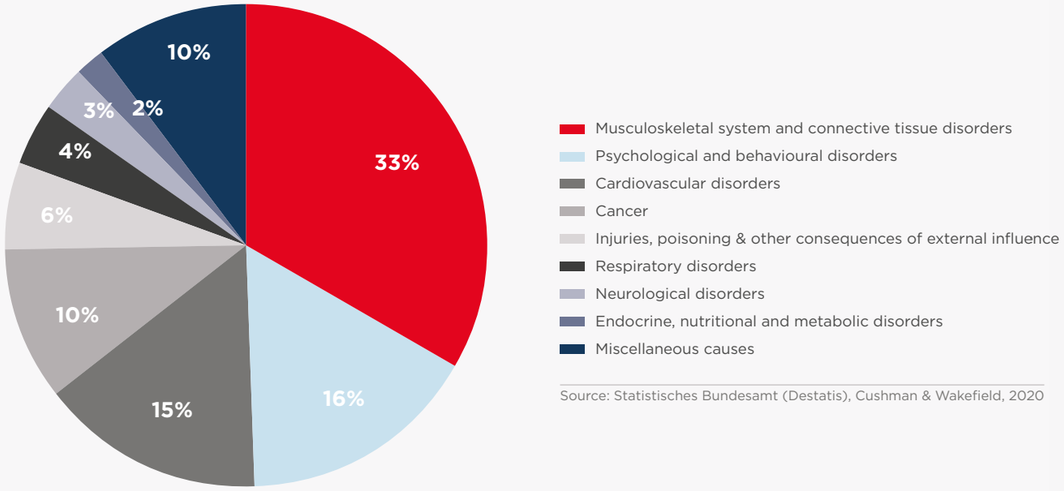
As the population ages, the percentage of sick days due to musculoskeletal disorders is increasing dramatically, accounting for just under 25% of sick days in 2017. In addition, mental disorders (16.6%) and respiratory disorders (14.8%) are increasingly causes of employee absences. Together these account for 31%, or almost a third of the costs of absences in Germany. Symptoms of multimorbidity are becoming increasingly common with age. It is also noticeable that increased age not only leads to increased absenteeism, but also increased recovery time. For example, the average length of absence from work is twice as long for employees over 55 than for the 35-39 age group. Demographic change is likely to increase the incidence of longer periods of sick leave. Employers must therefore expect increased costs due to the employee absences.

MARKET ENVIRONMENT

REHABILITATION IN GERMANY

The main focus of rehabilitation in Germany is on inpatient treatment. In 2018, 1,668,223 cases of prevention and rehabilitation were treated. Diseases of the musculoskeletal system and connective tissue were the most frequent reason for inpatient rehabilitation stays, at 33% in 2018, followed by psychological and behavioural disorders at 16% and cardiovascular disease at 15%.

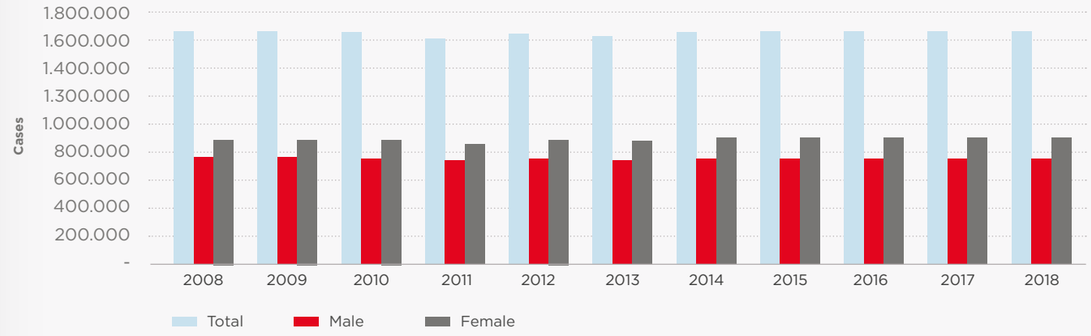
REASON FOR INPATIENT REHABILITAION BY NUMBER OF CASES (2018)



Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2020

Between 2008 and 2018, the number of inpatient rehabilitation stays remained relatively stable. The number of male patients fell by 1.1% while the number of female patients increased by 1.0%. The percentage distribution of rehabilitation stays by gender was also very stable between 2008 and 2018. In 2018, 54% of stays were attributable to female patients and 46% to male patients. Compared to rehabilitation inpatient stays, however, both the number of sick days and the number of hospital admissions grew quite dynamically. The average number of sick days per employee per year rose by 23% over the same period, while the number of admission increased by 10%. Thus, with increasing (multi-)morbidity and hospital inpatient treatment, proportionately fewer inpatient rehabilitation treatments are prescribed.

DEVELOPMENT OF INPATIENT REHABILITATION MEASURES*

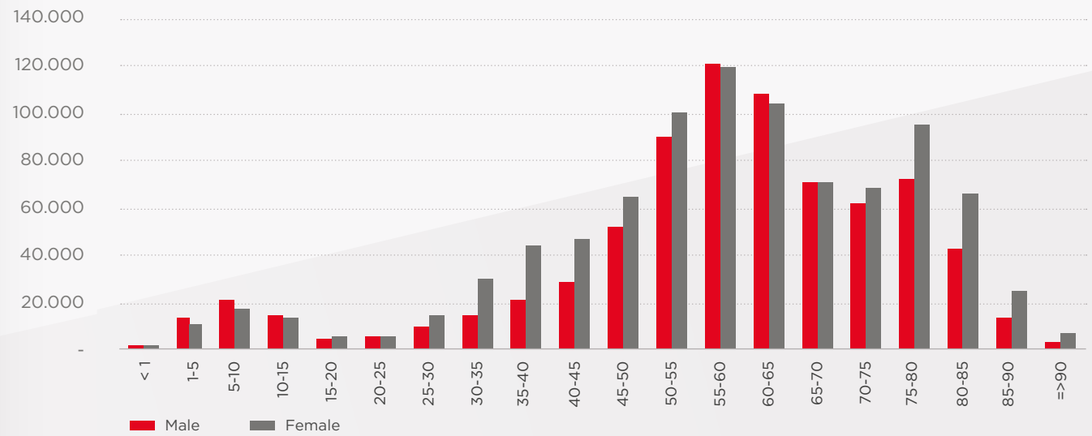


* in facilities with more than 100 beds

Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2020

In 2016, the average age of inpatient rehabilitation patients was 57.0 years. The average age of the female patients was 57.3 years, slightly higher than the average male patient age of 56.8 years. Although the overall average age increased by only about 1% from 56.0 to 57.0 years between 2012 and 2016, the average age of female patients is now higher than that of male patients. The mean age of male patients increased by only 1.4% between 2012 and 2016, while the mean age of female patients increased by 2.7%. With increasing age, both multimorbidity and the incidence of chronic diseases increase. A particular increase can be observed in the area of joint wear and tear. Thus, in 2016, arthritic deterioration of the hip and knee joints were the most frequent reasons for rehabilitation stays. In a gender-specific analysis, however, rehabilitation stays by male patients are most often due to chronic heart disease, which is in only fifteenth place for female patients.

GENDER DISTRIBUTION OF REHABILITATION STAYS 2018



Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2020

04

REHABILITATION FACILITIES

REHABILITATION FACILITIES

CATEGORIES

Preventative medicine and rehabilitation facilities are defined by law in § 107 Para. 2 Social Statute Book (SGB) V and serve the inpatient treatment of patients with the aim of:

- Eliminating a deterioration of health which may lead to illness in the foreseeable future
- Combating threats to children's healthy development (prevention)
- Curing, or preventing a worsening, of diseases
- Alleviation of disease symptoms
- Ensuring and consolidating the success of inpatient treatment in hospital. This also includes averting and mitigating an impending disability or need for care or its consequences (rehabilitation)

Preventive and rehabilitation facilities pursue the goal of improving the health of their patients with the help of a medical treatment plan, supporting the development of healing and strengthening the body's defences. The implementation of the medical treatment plans is carried out under constant medical supervision and is supported by professionally trained specialist medical staff. In addition to physiotherapy, movement therapy and speech therapy, medical treatment plans can also include occupational therapy, depending on the clinical picture. During inpatient treatment, the rehabilitation facility must ensure not only the implementation of the medical treatment plan but also provide accommodation and meals for the patients. When the health insurer assumes the costs of medical services for preventive or medical rehabilitation, both inpatient and outpatient facilities must be able to submit a care contract in accordance with § 111 Social Statute Book (SGB) V.

REHABILITATION FACILITIES

LEGAL BASIS AND MAIN AMENDMENTS

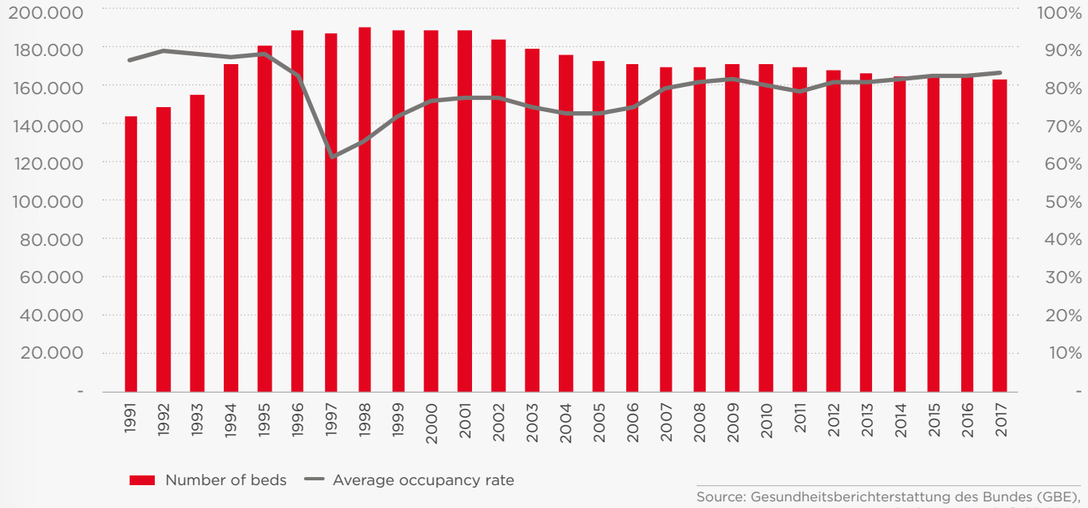
The decisive definition of rehabilitation in Germany is given in Social Statute Book (SGB) IX „Rehabilitation and Participation of People with Disabilities“. This describes both the scope of benefits for the respective recipient and the framework within which the benefits are provided. Additional legal foundations are provided by Social Statute Book (SGB) V „Statutory Health Insurance“, Social Statute Book (SGB) VI „Statutory Pension Insurance“ and Social Statute Book (SGB) VII „Statutory Accident Insurance“. In addition, the rights of people with disabilities have been strengthened by the Federal Participation Act since 1 January 2017.

From rehabilitation boom to increasing restrictions

From the beginning to the middle of the 1990s, the unified Germany experienced a „rehabilitation boom“. The coffers were full and rehabilitation approvals were granted almost extravagantly! Both the statutory pension insurance and the statutory health insurance funds generated surpluses until the early 1990s - this was reflected extremely positively in the allocation of rehabilitation measures. However, with the beginning of the 1990s, the statutory pension insurance and the statutory health insurances became increasingly loss-making. With the adoption of the Growth and Employment Promotion Act in 1996, the rehabilitation landscape in Germany changed permanently. For example, the number of people entitled to an inpatient rehabilitation stay was reduced, the duration of the service was limited to three weeks and the interval between two courses of rehabilitation was increased from three to four years. In addition, the patient‘s contribution to rehabilitation costs increased by almost 50% and employers became able to consider days spent in rehabilitation as days taken from the employee‘s holiday allocation.

These measures led to a rapid decline in the rehabilitation services provided and thus to a drop in the occupancy rate of rehabilitation facilities in 1997, with the occupancy rate of inpatient rehabilitation facilities falling from 83% in 1996 to 62% in 1997, a drop of 25%. The number of beds in rehabilitation facilities also stagnated up to the turn of the millennium and has been declining slightly since then.

DEVELOPMENT NUMBER OF BEDS AND THEIR OCCUPANCY RATE



Source: Gesundheitsberichterstattung des Bundes (GBE), Cushman & Wakefield, 2020

REHABILITATION FACILITIES

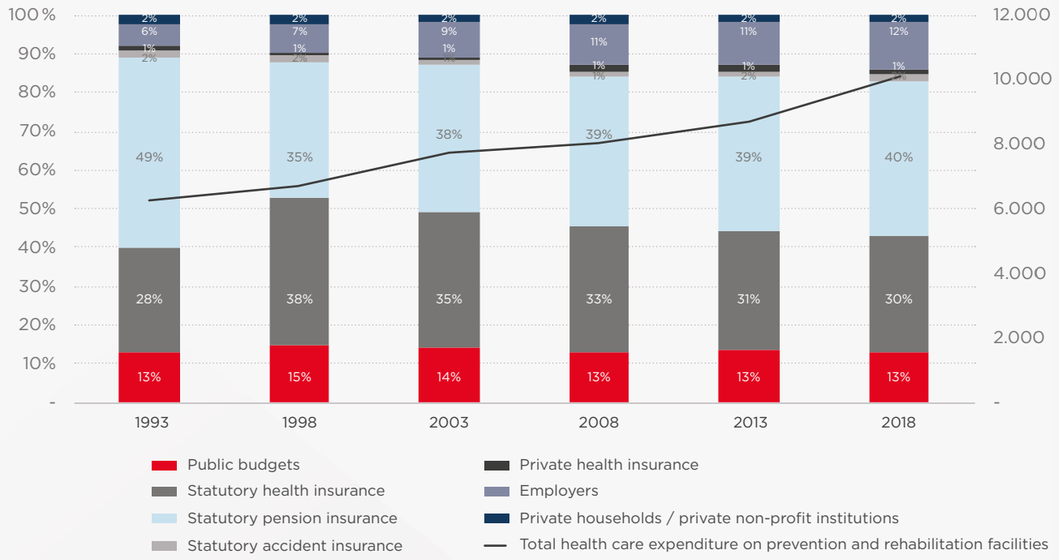
FUNDING BODIES AND SERVICE PROVIDERS OF PREVENTIVE CARE AND REHABILITATION

The assumption of costs for preventive and rehabilitation measures is a complex construct, which depends on both the objective of the measures and the cause of the underlying disease. § 6 Social Statute Book (SGB) IX defines the following institutions as funding bodies of such services:

- Statutory health insurers
- Federal employment agency
- Providers of statutory accident insurance
- Providers of statutory pension insurance
- Welfare providers for victims of war
- Public youth welfare organisations
- Institutions responsible for social integration aid

Health expenditure on prevention and rehabilitation facilities by the various funding bodies has risen by 76% since 1992. 70% of the expenditure on prevention and rehabilitation is covered by statutory health insurance (SHI) and statutory pension insurance (SPI), although this share has fallen by 9% since 1992. The proportion of this from statutory health insurance rose by 7%, and that of statutory pension insurance fell by 18%. Employers are becoming increasingly important as funding bodies for prevention and rehabilitation, their contribution having risen by 110% to a total of 12% in the same period.

HEALTH CARE EXPENDITURE ON PREVENTIVE MEDICINE AND REHABILITATION FACILITIES (IN € MILLION)



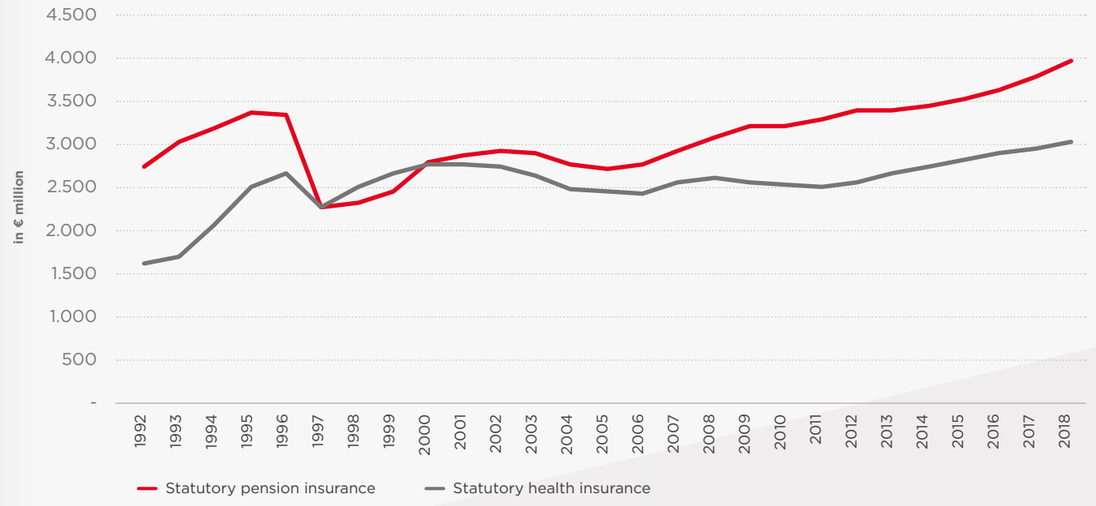
Source: Gesundheitsberichterstattung des Bundes (GBE), Cushman & Wakefield, 2020

Rehabilitation rather than retirement

„Rehabilitation rather than retirement“ is the principle of the statutory pension insurance, the largest funder of preventive and rehabilitation measures. The legal definition of rehabilitation by the SPI is based on § 9 Social Statute Book (SGB) VI. The aim is to avert or delay the premature withdrawal of patients with acute or chronic illnesses from working life. Through targeted measures, those affected can thus return to their previous job or enter another occupation via vocational reorientation.

The principle of „rehabilitation rather than nursing care“ is applied by the second-largest funder of preventive and rehabilitation services, the statutory health insurance. In contrast to the SPI, which focuses on returning to work, the SHI pursues the goal of averting or delaying an imminent disability or need for care. The legal definition of medical rehabilitation by the health insurance funds is set by Social Statute Book (SGB) V. § 11 para. 2.

DEVELOPMENT OF HEALTH EXPENDITURE OF THE STATUTORY HEALTH INSURANCE AND THE STATUTORY PENSION INSURANCE



Source: Gesundheitsberichterstattung des Bundes (GBE), Cushman & Wakefield, 2020

REHABILITATION FACILITIES

FUNDING BODIES AND SERVICE PROVIDERS OF PREVENTIVE CARE AND REHABILITATION

While the funding agencies are only responsible for covering expenses incurred in a course of rehabilitation, the service provider is responsible for providing all rehabilitation services as well as, for inpatient rehabilitants, accommodation and meals. Service providers may take the form of rehabilitation facilities and rehabilitation services and conclude service provision contracts with the funding bodies.

What defines the rehabilitation budget

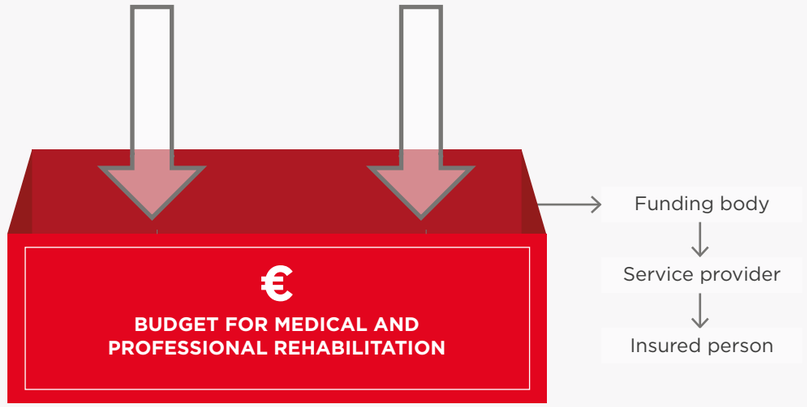
Since the Growth and Employment Promotion Act came into force in 1997, a capped amount, which is redefined annually, has been available to the providers for rehabilitation services paid for by the statutory pension insurance - the so-called rehabilitation budget. Only a change in gross salaries per employee determined the annual change in the budget until 2013. However, the rehabilitation budget did not increase in the same proportion to gross wages, as the rehabilitation budget also takes into account the low-wage sector and part-time employees.

The demographic shift has only been taken into account since the introduction of the Pension Insurance Benefit Improvement Act in 2014. Nevertheless, the lifetime working hours, the spectrum of illnesses and treatment options that influence the need for rehabilitation are not currently taken into account when calculating the rehabilitation budget. The introduction of the second component, age-related needs, led to an increase in the rehabilitation budget until 2017, but this will be gradually reduced from 2017 onwards as the baby boomers of the 1950s and 1960s reach retirement age.

Rehabilitation Budget

ADJUSTED TO DEMOGRAPHIC CHANGE

THE DEMAND FOR REHABILITATION SERVICES BY THOSE BORN IN THE YEARS WITH THE HIGHEST BIRTH RATES IS INCREASING



Source: Bundesministerium für Arbeit und Soziales, Cushman & Wakefield, 2020

REHABILITATION FACILITIES

FUNDING BODIES AND SERVICE PROVIDERS OF PREVENTIVE CARE AND REHABILITATION

For the remuneration of rehabilitation measures, the funding agencies have contracts with the rehabilitation facilities listing the services to be provided. These contracts are based on joint and uniform care provision agreements between the health insurance funds' regional associations and are only specified with the individual facilities. Remuneration is based on fixed payments per case and per diem. In most cases, flat rates per case are charged when the costs are covered by the statutory health insurance and charges per day are more likely when the costs are covered by the statutory pension insurance.

However, due to the predefined length of a patient's stay in the institution, the daily rate totals charged are tending to converge ever more with the flat rates charged per case. A differentiation of the remuneration is only made according to the department providing the treatment. A main critique of the system is that it is only roughly indication-specific and takes into account neither the severity of the case nor the success of the treatment provided.

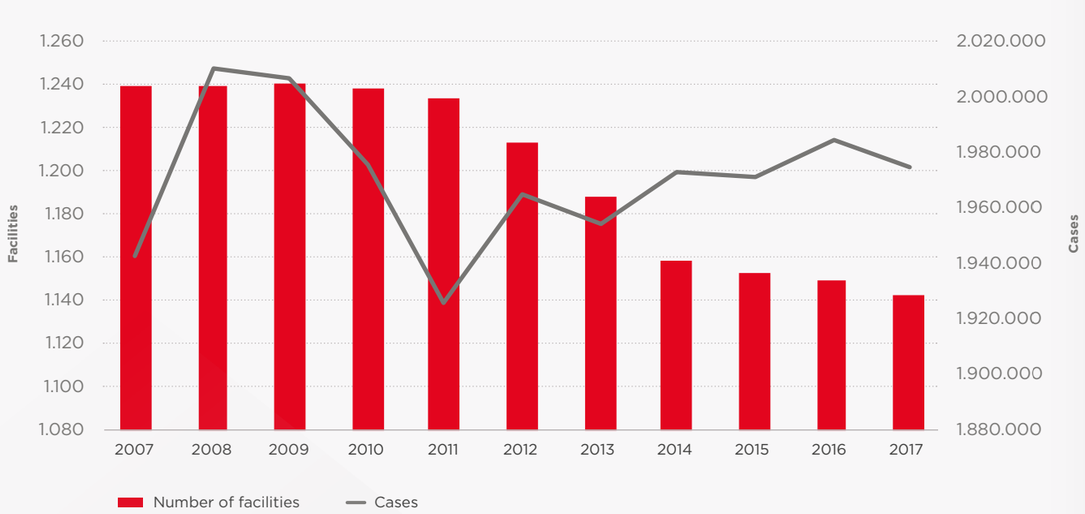
Operating and investment costs are covered by this system. However, there is no representative data regarding the level of compensation. Analyses show, however, that remuneration is not growing at the same rate as input prices, which is putting additional pressure on service providers.

REHABILITATION FACILITIES

GROWTH AND DEVELOPMENT

Following the adoption of the Growth and Employment Promotion Act and the initial subsequent collapse in the prescription of rehabilitation measures, the occupancy rate began to rise again in the early 2000s. The primary reason for this was demographic change! At this time the baby boomer generation began to reach 50-plus years of age, and thus also increased susceptibility to multimorbidity as well as joint-wear-related disorders. This resulted is an increase in the number of courses of rehabilitation prescribed and a consequential increase in the occupancy rate. Although the record levels of the early 1990s remain unmatched.

DEVELOPMENT OF THE NUMBER OF REHABILITATION FACILITIES AND CASE NUMBERS



Source: Gesundheitsberichterstattung des Bundes (GBE), Cushman & Wakefield, 2020

Fewer facilities versus rising number of cases

In terms of the number of institutions, despite the adoption of the Growth and Employment Promotion Act, there was a renewed increase in the number of institutions by the end of the 1990s. At the turn of the millennium, however, the number of institutions began to decline, while the number of cases increased slightly. Between 2007 and 2017, the number of institutions fell by 8%, while the number of cases increased by 2%. In 2016 23% of facilities had fewer than 49 beds and 27% had more than 200 beds. In 2016, the average total bed occupancy rate was 83%. While the facilities with a rather small number of beds (up to 149 beds) had lower than average occupancy rates, the facilities with 150 beds or more had higher than average occupancy rates.

The more specialist areas, the larger the facility

The correlation between the size of the facilities and their occupancy rates is attributed to the number of departments within the facilities and their specialisations. While facilities with large numbers of beds often comprise a large number of specialist departments, smaller facilities have only a few and are thus more dependent on the number of patients with particular ailments. On the other hand, the length of stay of patients in smaller facilities is significantly longer than in those with a large number of beds. For example, facilities with 49 beds or fewer recorded the longest stays, with an average duration of 30.5 days, while duration of stay was shortest in the 150 to 199 bed segment, at 24.3 days.

PREVENTIVE AND REHABILITATION FACILITIES BY NUMBER OF INPATIENT BEDS (2016)

NUMBER OF BEDS PER FACILITY	TOTAL NUMBER OF FACILITIES	TOTAL NUMBER OF BEDS	OCCUPANCY	AVERAGE DURATION OF STAY
< 49 beds	259	8.022	77,4%	30,5
50 to 99 beds	231	16.823	80,9%	27,6
100 to 149 beds	159	19.597	80,2%	25,8
150 to 199 beds	194	33.863	84,8%	24,3
> 200 beds	306	86.918	83,9%	24,8
Total	**1.149**	**165.223**	**83,0%**	**25,3**

Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2018

REHABILITATION FACILITIES

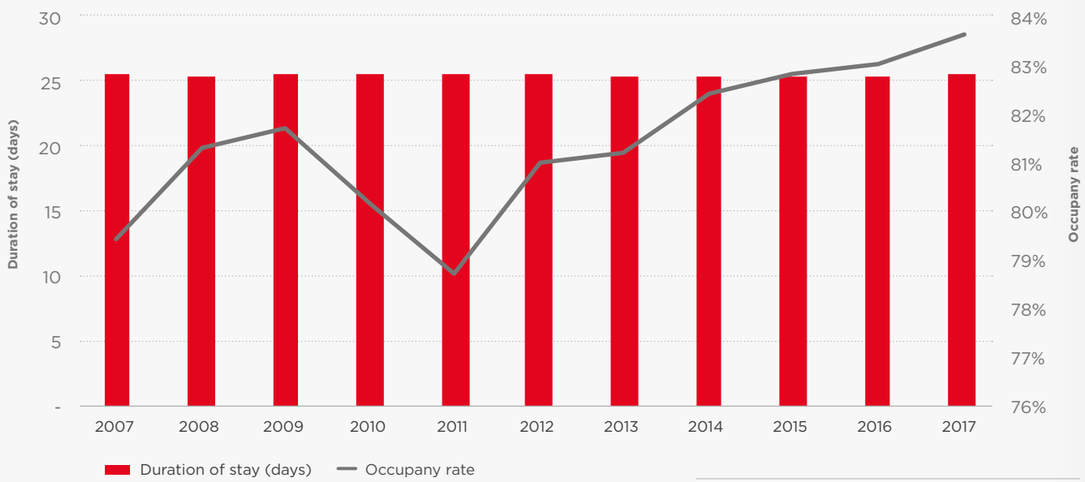
DURATION OF TREATMENT AND CAUSES

20-day benchmark

Since 1997, the treatment duration of an inpatient course of rehabilitation has been limited to three weeks or 20 days of treatment. An exception is psychosomatic or neurological treatments for depression for example, which has a usual initial treatment period of five to six weeks, depending on the case. However, if an increased level of medical success is expected via a stay of more than 20 treatment days, it can be extended with the consent of the funding agency.

In 2017, the average length of stay for a course of inpatient rehabilitation was 25.4 days. Since 2012, the occupancy rate of rehabilitation facilities has increased continuously. Between 2007 and 2017, the occupancy rate grew by 5% and reached 84% in 2017. This is the first time since the adoption of the Growth and Employment Promotion Act that the occupancy rate has exceeded 83%.

DEVELOPMENT OF LENGTH OF STAY AND OCCUPANCY RATE

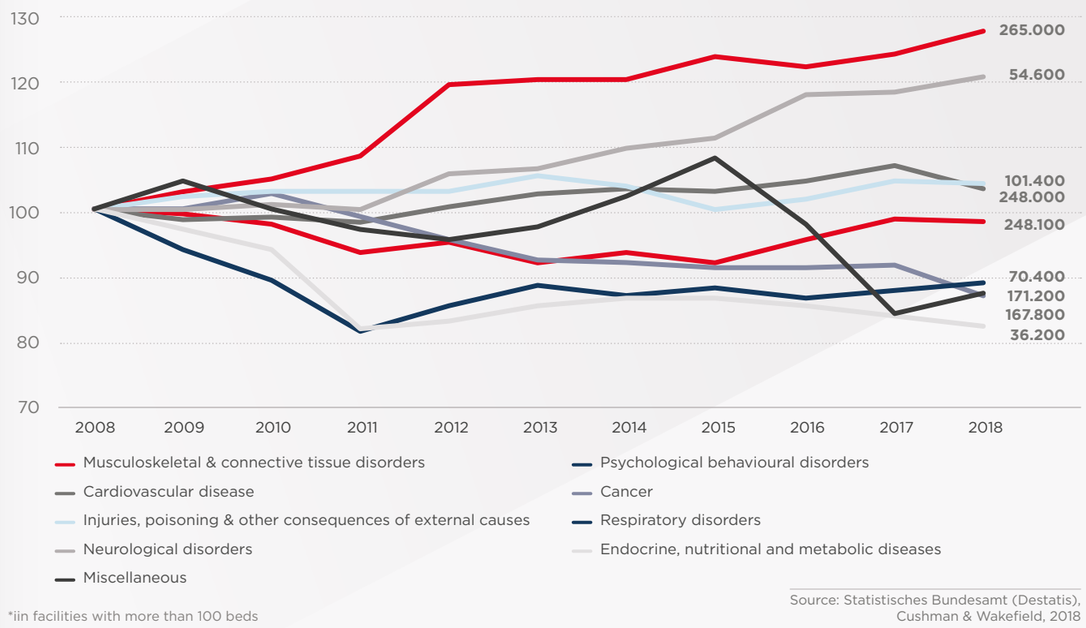


Source: Gesundheitsberichterstattung des Bundes (GBE), Cushman & Wakefield, 2020

Musculoskeletal illnesses – The No. 1 reason for rehabilitation

One third of courses of rehabilitation are for musculoskeletal & connective tissue disorders which have long accounted for the plurality of inpatient rehabilitation stays, however this proportion fell by 2% between 2008 and 2018. The second and third most frequent reasons for prescribing inpatient rehabilitation measures were psychological and behavioural disorders, at 16% and cardiovascular disorders at 15%. While cardiovascular diseases recorded an increase of only 3%, the number of rehabilitation stays to treat psychological and behavioural disorders increased by 29%; more than any other category in the same period. Between 2008 and 2017 rehabilitation measures due to injuries, poisoning & other consequences of external influences as well as cardiovascular diseases were the only other indicators with a positive development with increases of 4% and 3% respectively. The largest decrease in the number of rehabilitation measures prescribed was in those diagnosed with endocrine, nutritional and metabolic disorders, at 18% between 2008 and 2018. Over the same period the number of courses of rehabilitation measures for cancer and miscellaneous diagnoses fell by 13% each.

DEVELOPMENT OF CASE NUMBERS BY DIAGNOSIS (2008=100)*



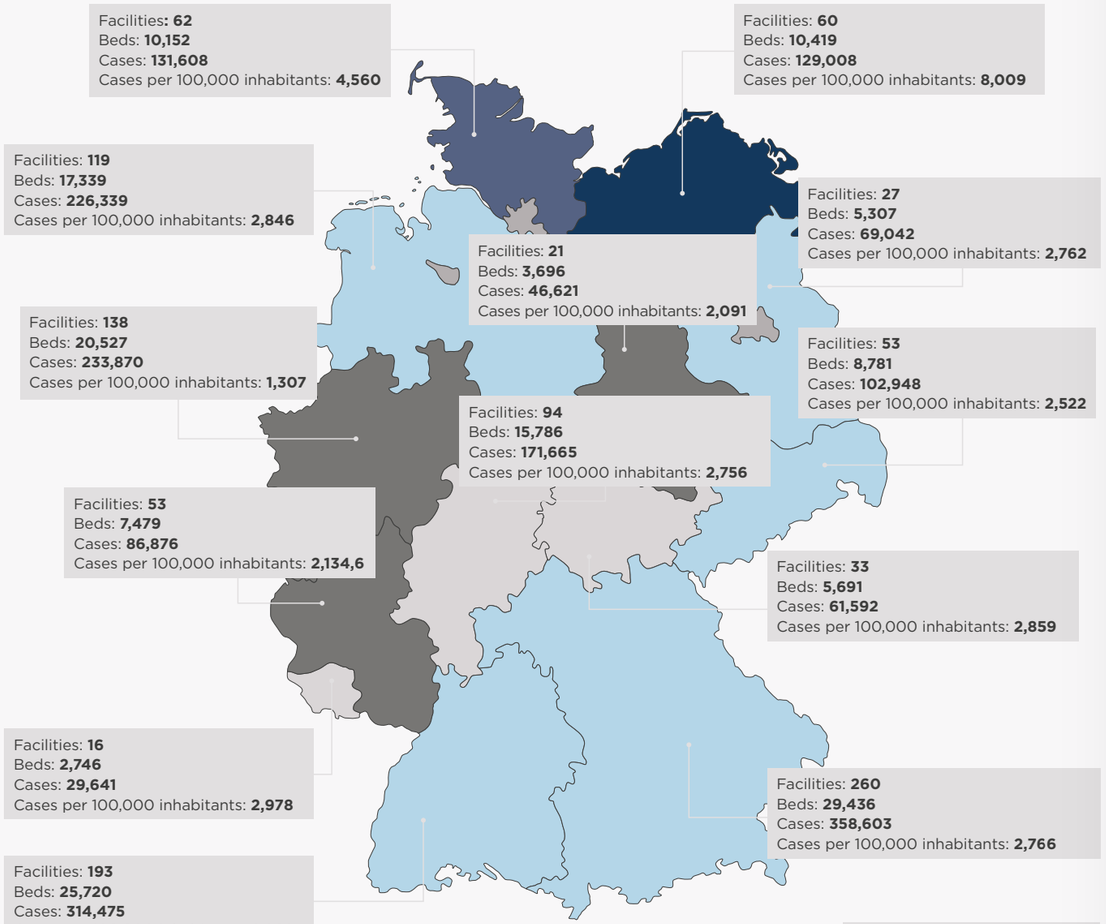
*iin facilities with more than 100 beds

Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2018

REHABILITATION FACILITIES

MAJOR DEVELOPMENTS

Rehabilitation in Germany 2017



Source: Gesundheitsberichterstattung des Bundes (GBE), Cushman & Wakefield, 2020

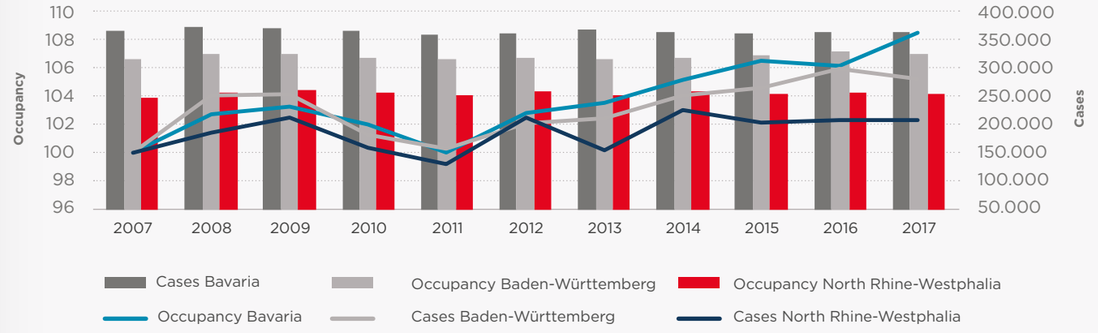
The German federal states with the largest populations are also those with the largest numbers of rehabilitation facilities. With 260 facilities in 2017, Bavaria has the most, followed by Baden-Württemberg with 193 and North Rhine-Westphalia with 138.

In the period between 2007 and 2017, all three federal states exhibited growth in occupancy rates. While Bavaria recorded the strongest increase of 9.7%, occupancy rates in Baden-Württemberg and North Rhine-Westphalia rose by 5.6% and 2.4% respectively, both of which started from a higher base than Bavaria in 2007. While case numbers in Baden-Württemberg and North Rhine-Westphalia rose by 4.0% and 3.5% respectively, those in Bavaria fell by 0.7% over the same period.

Pronounced east-west divide

In terms of the distribution of rehabilitation facilities, there is still a strong east-west divide in Germany 30 years after reunification. Mecklenburg-Western Pomerania, with 60 facilities, was the only formerly East German state to have more than 55 facilities in 2017. In contrast, the new federal states exhibited stronger growth rates in the number of facilities between 2007 and 2017. While among the former West German states only North Rhine-Westphalia showed slight growth of 1% over this period, among the former East German states, Saxony and Saxony-Anhalt exhibited positive growth of 18% and 11% respectively. The city states of Berlin, Hamburg and Bremen, with 3 facilities in 2007 and 13 facilities by 2017, recorded growth of 333%, are not considered here.

DEVELOPMENT OF OCCUPANCY RATES AND CASE NUMBERS IN THE FEDERAL STATES WITH THE MOST PREVENTIVE MEDICINE AND REHABILITATION FACILITIES



Source: Gesundheitsberichterstattung des Bundes (GBE), Cushman & Wakefield, 2020

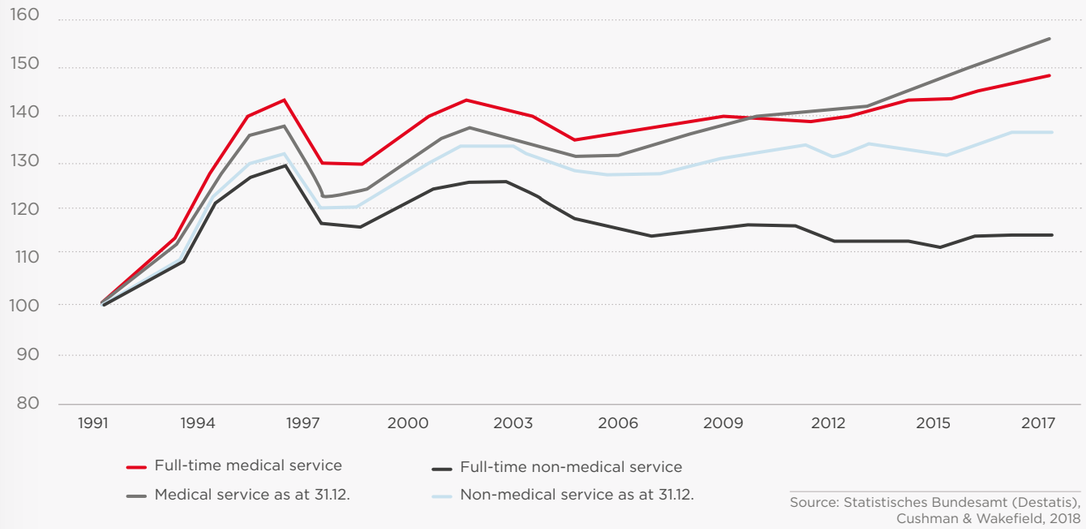
REHABILITATION FACILITIES

EMPLOYMENT MARKET AND PERSONNEL STRUCTURE

Medical rehabilitation in Germany always takes place under the supervision of a specialist, while medical implementation is usually carried out by qualified non-physician medical staff. These include physiotherapists, speech therapists and occupational therapists, but also psychologists and psychotherapists, as well as occupational educators and health and nursing staff.

The number of full-time employees rose sharply between 1991 and 1997 and recorded a sharp fall with the adoption of the Growth and Employment Promotion Act, followed by a renewed increase in staff by the early 2000s. It is striking that the proportion of medical specialist physician staff has steadily increased, while the proportion of full-time non-physician medical staff has decreased. In 2017, the proportion of physician staff was 10% while the proportion of non-physician medical staff was 90%. At the end of 2017, 122,571 workers were employed in the rehabilitation sector comprising 10,547 medical staff and 112,024 in the non-physician medical staff, of whom 1,598 were students or trainees.

PREVENTIVE OR REHABILITATION FACILITIES (INDEX OF EMPLOYEES 1991=100)



Source: Statistisches Bundesamt (Destatis), Cushman & Wakefield, 2018

The shortage of trained staff requires solutions

As in other social and medical professions, the shortage of skilled workers is one of the central challenges in rehabilitation. While the Nursing Staff Strengthening Act supports the recruitment of additional nursing staff in hospitals, it ignores the shortage of nursing staff in rehabilitation facilities. In addition, the basic wage rate applicable in rehabilitation leads to lower pay levels for nursing staff in rehabilitation facilities than in hospitals, making the sector an unattractive employer.

REHABILITATION FACILITIES

EXPERT INTERVIEW – ANNA-LENA HETZEL,
BNP PARIBAS REIM

BNP PARIBAS REAL ESTATE

Anna-Lena Hetzel

As Transaction Manage at BNP Paribas REIM Germany, Anna-Lena Hetzel is responsible for the healthcare sector. With 31 billion euros of real estate assets under management, BNP Paribas REIM is one of the major players in the European real estate market and recorded a transaction volume of five billion euros in 2019 alone.

Interview

How long have you been involved with rehabilitation clinics as an asset class?

Due to the fact that we now have three healthcare funds that focus on rehabilitation clinics among other things, this asset class has been part of our purchasing profile for many years. At the beginning of 2020, we launched the Healthcare Property Fund (HPF) Europe, the first pan-European healthcare fund, so that we are now investing in rehabilitation clinics, particularly in the German and Austrian markets, and are increasingly examining this asset class.

What are the major challenges facing the rehabilitation market due to demographic shift and the resulting increased incidence of multimorbidity?

In particular, larger specialist clinics with specialisations in the geriatric field or geriatric specialist clinics create great added value for patients here. If, in addition to physical complaints, which is often the case with older people, cognitive or mental illnesses also occur, it is all the more important that the respective clinics have specialist staff in the respective areas and that the coordination as well as exchange of information between nursing, therapy and rehabilitation functions. Particularly with regard to the multimorbidity mentioned above, we therefore see a geriatric approach as indispensable. At the same time, however, we also believe in rehabilitation concepts which, in addition to the treatment of older people, also provide for young adults and children who, for example, also have an increased requirement for rehabilitation after major operations, especially in the light of the trend towards ever-shorter stays in hospitals.

What is special about this type of property for you as a real estate investor and what makes it attractive from your point of view?

Healthcare real estate in general, i.e. not only rehabilitation clinics but also retirement homes, assisted living facilities with outpatient care, day care and even hospitals, are already special properties that require a great deal of specialisation on the part of all parties involved (operators, developers, investors and consultants). Within this area, rehabilitation clinics are a further specialisation that requires additional competences.

Clinics are not yet in investors' focus to the same extent, so that we see a competitive advantage here through the corresponding development of expertise, which also helps us to build up a diversified portfolio for our end investors. This high degree of specialisation still allows us to achieve higher returns than is the case with many other asset classes. However, here too, there is a slow convergence towards classic nursing homes.

Another aspect is the social component of this asset class: healthcare can be an interesting asset class for investors as it not only increases portfolio diversification but also enables social commitment. As the BNP Group has a proven, very conscious and convinced commitment to sustainability and global ESG goals, investments in this type of use are also in line with our self-image of acting responsibly. This is done with a great deal of care and precision in accordance with strictly defined criteria.

In your opinion, has the perception of a rehabilitation clinic as an investment opportunity changed in recent years?

Absolutely. As already explained, healthcare real estate is experiencing increased investor demand. As a result, the demand for rehabilitation clinics as an asset class and as a good investment opportunity is also growing. At the same time, supply is low and the transaction market is generally very small, which means that demand significantly exceeds supply. In the past year in particular, the market has, in our view, been characterised by sale and leaseback transactions as well as some smaller portfolio adjustments. In conclusion, it can be said that rehabilitation clinics are also increasingly coming into the focus of experienced investors and their perception as a strong asset class is growing continually - a trend that we believe will continue unabated in the coming months and is only somewhat slowed by the low availability of suitable product.

What is the biggest challenge in building up a real estate portfolio in this asset class in Germany?

Due to the high degree of specialisation inherent in this asset class, it requires a great deal of know-how, which must either be provided internally or should be covered by external advisors. The transaction market is very small and diversified and is dominated by regional players, both on the operator side and on the broker side. This makes a structured acquisition process difficult and usually leads to intransparency in the market. In addition, the market is still recovering from past overcapacities in the rehabilitation sector, so a detailed examination of the concept and the operator is essential. The professionalisation of the sector must therefore continue.

Banks are increasingly opening up to the healthcare real estate market and are willing to finance purchases in this asset class. But here, too, rehabilitation clinics are not yet recognised in the same way as is the case with nursing homes, for example. The operator risk is still considered high. At the same time, however, a rethink is also taking place here and a positive change regarding the financing of rehabilitation clinics is already noticeable, especially among smaller and specialised banks.

What does a „picture book" rehabilitation clinic look like to you from an investor's point of view - in terms of the lease, operator, concept and the property from a structural point of view?

The lease should have a long remaining term of more than 12 years or be newly-concluded. Indexation linked to the consumer price index with a maximum 5% hurdle is advantageous. Sufficient collateral in the form of a bank guarantee and letter of comfort would also be agreed, as well as a regular reporting obligation on the most important key business performance indicators.

The tenant should have several properties in operation, not be a special purpose vehicle (SPV) and be secured by a strong and renowned parent company.

The specialised concept enables above-average rent cover.

The property should not be older than 10 years and be built specifically for clinic use. It should by located in a densely-populated region with a large catchment area and good accessibility.

Do you see consolidation tendencies in the operator market?

At present, the operator market for healthcare properties is generally very unconsolidated and often very small-scale, and this also applies to rehabilitation clinics. Nevertheless, we have seen an increasing professionalisation of all participants in the market in recent years and expect this trend to continue to intensify - similarly to developments in the hotel sector a few years ago. The increasing investor interest is leading to leases for development projects or new leases for existing properties being concluded in such a way that they meet the requirements of institutional investors. In addition to these aspects of the leases themselves, there is a particular demand for leases with established operators with strong credit ratings who can provide sufficient collateral in the event of insolvency.

We see the consolidation that had already begun as being further intensified by the current coronavirus pandemic and assume that it will progress more quickly than might have been the case in a normal market environment. For ourselves, as investors, this also means that we are scrutinising the underlying concepts, the operators themselves as well as their creditworthiness, the agreed collateral and operational performance indicators even more closely than was previously the case.

In your opinion, what are the greatest challenges / risks and opportunities that this segment could be confronted with in the future?

Many clinics have a rather patchwork structure and are managed without any real specialisation. If there is no rethinking on these points, there is a danger that a large number of clinics will no longer be economically viable in the long term. At the same time, demographic developments and the resulting increasing numbers of older people in our society are leading to an increased demand for clinic places. And these are not only occupied by older people, but are also required for families or younger adults.

An equally important point is the general shortage of staff and the lack of skilled workers in the healthcare market, which correspondingly also applies to on clinics.

Operators are faced with major problems here in achieving full operation if there is not a sufficient number of staff available. And this in an industry with increasing demand.

Where do you see a need for regulatory catch-up and adjustment?

The market for rehabilitation clinics is very lightly regulated compared to other healthcare real estate, such as nursing homes. At the moment, we do not expect that there will be any comprehensive adjustments on the part of the state. Many clinics are suffering as a result of the pandemic, which will also have a lasting impact on the profitability of the facilities and their operators. Therefore, we do not see there being any adjustments in the short term, especially when it comes to building structure requirements - as is the case, for example, with nursing homes regarding single room quota or room sizes. Therefore, the operator concept and the associated structural requirements for the property as well as their implementation must be examined more closely.

We do see a need for change regarding personnel and to address the lack of nursing staff. However, this is not limited to rehabilitation clinics, but applies to the health sector in general.

Are there any special features of a rehabilitation clinic that you look for, especially against the background of the current pandemic, when considering an acquisition?

Rehabilitation clinics were/are definitely affected by the current coronavirus pandemic, the occupancy rate has dropped significantly in some clinics because non-essential operations have been postponed. In the current situation, we are therefore looking in particular at rehabilitation clinics that specialise in the care of people who have to undergo emergency intervention and operations that cannot be postponed. In current transactions, we make sure that no short-term rent payment losses are to be expected. Appropriate arrangements are made with existing tenants, if necessary, which help operators economically during this exceptional period.

At BNP Paribas REIM, we have developed in-house pandemic scoring that screens every investment, regardless of the type of use, by sector income, asset and infrastructure. And in addition to assessing the risk of possible rent defaults, we also look at how day-to-day operations can be maintained in during the pandemic, particularly regarding the asset. In normal times, therapy programmes promote close contact with a high level of patient mixing, meals are taken communally and patients come together from very different regions - all these are pandemic-related risk situations have to be managed in the property and we scrutinize these closely. For a successful assessment via our scoring, sensible precautionary and countermeasures, i.e. rules of conduct and hygiene measures, must be implemented at this point. Digital service offers also comprise an important aspect in this regard.

05

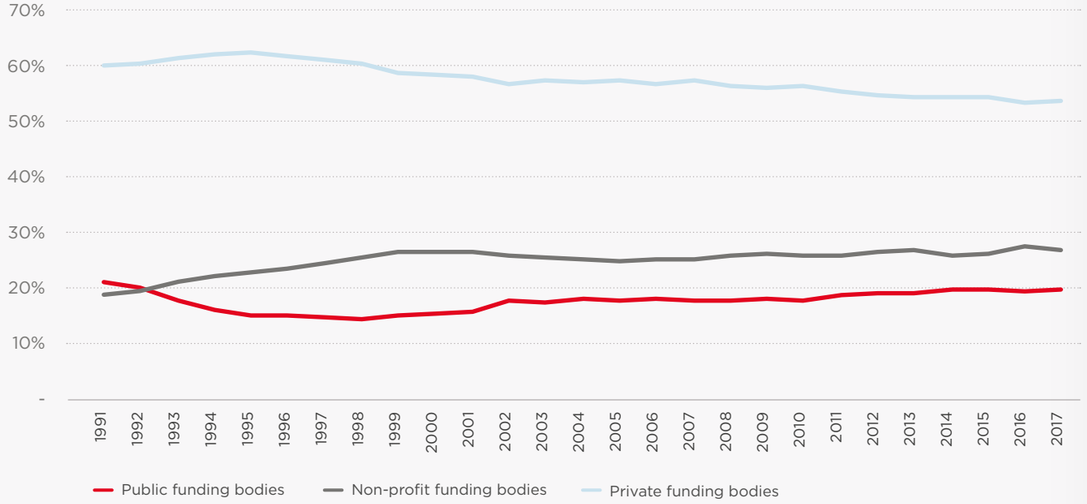
OPERATOR MARKET

OPERATOR MARKET

STRUCTURE OF OPERATOR MARKET

The Growth and Employment Promotion Act, which came into force in 1997, led to a market shakeout, which in particular led to a decline in the number of privately-owned rehabilitation clinics which has fallen by 28% since 1994, having increased by 19% between 1991 and 1997. Nevertheless, private operators still dominate the operator landscape, with 609 facilities, or 53%, in 2017. Despite the market power of private operators, the federal and state government pension insurance scheme, a public operator, is Germany's largest single operator of rehabilitation clinics with around 90 facilities. Nevertheless, public sector operators still only account for some 20% of the total market.

DEVELOPMENT OF PREVENTIVE AND REHABILITATION FACILITIES BY CATEGORY OF OPERATOR



Source: Gesundheitsberichterstattung des Bundes (GBE), Cushman & Wakefield, 2020

Consolidation in a fragmented market

Despite the market shakeout that began in the late 1990s, the rehabilitation facility operator market in Germany is still characterised by a highly fragmented structure, especially in the private sector. In recent years there has however been an increase in the number of consolidations in the private rehabilitation clinic operator sector. In 2014, Waterland acquired Advent and Macrol's shareholdings in Median Kliniken, before the latter was merged with RHM Klinik- und Altenheimbetriebe, which is also owned by Waterland. Median Kliniken later merged with AHG Allgemeine Hospitalgesellschaft, which had 45 facilities and outpatient clinics. There have since been further takeovers of individual clinics. In 2018, Helios' rehabilitation and care division was taken over by the Austrian healthcare property company Vamed. Due to the slight decline in the number of inpatient facilities, the market is not so much characterised by the entry of new operators and operator chains as by mergers and acquisitions of individual facilities by larger operator chains. The trend towards the purchase of individual facilities is supported by the generational change in owner-managed rehabilitation clinics, where there is often no suitable and financially liquid successor.

THE LARGEST OPERATORS OF REHABILITATION CLINICS

RANK	OPERATOR	NUMBER OF REHABILITATION FACILITIES
1	**Rentenversicherung des Bundes und der Länder**	90
2	**MEDIAN Unternehmensgruppe B.V. & Co. KG**	73
3	**Vamed (Germany, Austria, Switzerland & Czech Republic)**	33
4	**MediClin AG**	25
5	**Asklepios Kliniken GmbH**	17

Source: Cushman & Wakefield, 2020

OPERATOR MARKET

EXPERT INTERVIEW – DR. ANDRÉ M. SCHMIDT,
MEDIAN UNTERNEHMENSGRUPPE B.V. & CO. KG

Dr. André M. Schmidt

André M. Schmidt has been CEO of the clinic group, which today operates under the name MEDIAN Unternehmensgruppe GmbH & Co. KG since 2011. MEDIAN is the largest private operator of rehabilitation facilities in Germany and has around 120 rehabilitation clinics, acute hospitals, therapy centres, outpatient clinics and reintegration facilities.

Interview

You are the largest operator of rehabilitation clinics in Germany. From your point of view, how have the political-regulatory and operational framework conditions as well as the demand side changed in recent years? What has changed for the better and what has changed for the worse?

Rehabilitation in Germany has been very strong for many years and the general conditions are good. Politicians have recognised the importance of rehabilitation.

Due to the coronavirus crisis, rehabilitation has gained additional importance by taking on three important roles: firstly, as a place of after-care for post-Covid patients; secondly, as a support for acute hospitals by taking over patients at an earlier stage; and thirdly, by treating addiction and psychosomatic patients whose symptoms have intensified as a result of the pandemic and lockdown.

In this respect, rehabilitation has been and remains even more in demand during the crisis than previously. Even when it comes to financial support from politicians, we are no longer just forgotten.

What has changed is the increasing digitisation of rehabilitation, which was already one of the most important topics for us in the past three years. The coronavirus crisis has also acted as a catalyst for this development.

Digital tools are increasingly being used - both in the therapies in the clinics and in aftercare following a stay in a rehabilitation clinic. This makes it possible to ensure the success of rehabilitation even more sustainably.

This development has also further strengthened the role of rehabilitation in recent years. In this context, it is important for me to emphasise: We do not want to replace therapists, but apps and other tools should be used to treat patients even better and more sustainably and to put them on the path back to a healthy life. In the clinics, they learn the necessary know-how for this, and via digital aftercare, what they have learned is applied in everyday life. This actually strengthens the role of the clinics and avoids breaks in the care chain. Digital services such as DERENA continue to support patients after rehabilitation and enable them to monitor their progress, so that outpatient services can even be substituted in some cases.

MEDIAN clinics as a group offer a wide range of treatments for specific indications. In your opinion, which indications (symptom treatment focuses) have the greatest growth potential in the coming years and which will play a lesser role?

The four classic focus indications are neurology, follow-up treatments in the fields of orthopaedics and cardiology, the treatment of diseases of addiction and psychosomatics. The latter two have the greatest growth potential.

But basically all other indications beyond these particular areas are also growing, for example oncology, internal medicine as well as child and youth rehab. In all areas, there is a great need for after-care to support the recovery process as well as preventative measures to impede the chronification of disease - and rehabilitation provides both because it also gives patients the tools for a healthy life after their stay in hospital.

What will the modern rehabilitation clinic of the future look like in terms of therapy options and treatments, geographical location and structural requirements?

Ten or 15 years ago there was a discussion about whether rehabilitation facilities should not be geographically attached directly to hospitals. This is currently happening in Switzerland, for example. The idea is not wrong from the point of view of follow-up treatment, because in this way the treatment path from the acute hospital can be seamlessly continued directly into rehabilitation. The idea was based on the concept of optimising logistics, avoiding travel costs and reducing the length of stay in acute hospitals.

With regard to the role of rehabilitation, however, this approach falls short for several reasons, having originated in the world of acute medicine. Only 40 percent of our patients come directly from hospital to rehabilitation, 60 percent start their rehabilitation via a so-called curative procedure from home, independently of a stay in an acute hospital. In addition, the location of many rehabilitation clinics in beautiful surroundings sustainably strengthens the recovery effect; people get out of their everyday lives.

Another point is the dramatic rise in property prices in the major cities. The construction and operation of a rehabilitation clinic in an urban area would not be at all feasible in view of the current level of care rates (Pflegesätze – the rates paid by health insurers for care). We are seeing this in an exemplary way with regard to outpatient rehabilitation facilities.

In addition, spatial proximity does not automatically mean temporal proximity. Anyone who lives in a large city knows that journeys within the urban area are also time-consuming and stressful. Here, too, you can easily spend two hours a day on the road to your rehabilitation treatment, which is not exactly conducive to recovery.

Finally, as described at the beginning, digitisation will also contribute to rural clinic locations with short distances gaining in importance again. Thus, inpatient rehabilitation in pleasant surroundings will shift seamlessly to digital aftercare that is not tied to a specific location.

To what extent does the issue of comfort and additional services play a role in the operation of a rehabilitation clinic?

This is definitely an issue, but only a subordinate one. Unlike the acute sector, where private patients play a greater role, the majority of rehabilitation patients come to us via the German statutory pension insurance provider (DRV) who, as the cost bearer, expressly prohibits additional services. Supplementary services, which are primarily relevant for private patients or patients with supplementary insurance from the statutory health insurer, are therefore not of such great importance per se in our clinics and facilities.

Nevertheless, the topic should not be underestimated. With our MEDIAN premium offer, we cater to this target group and provide patients who are willing to pay more for their rehabilitation, even out of their own pocket, with corresponding offers providing increased comfort at selected locations. Of course, this only plays a role in individual indications, especially in follow-up treatment (AHB), but much less so in addiction rehabilitation or neurology, where the expense - for example for ventilating patients - is so enormous that the distinction between private and statutory health insurance patients makes no difference at all to the property.

In the care market, the politically motivated approach of „outpatient before inpatient“ applies. Do you also see comparable developments in the market for rehabilitation services?

This approach has basically applied to the entire health care system for more than 25 years. The outpatient sector is also growing more strongly than the inpatient sector, but at a low level in terms of overall share. However, there is one major difference: outpatient nursing/care provision comes to the people, whereas in rehabilitation, the person has to come to the outpatient facility. Here, too, I therefore see digitisation as an important driver. In the course of the demographic shift, patients are getting older and more multimorbid, i.e. they come to us with several, sometimes serious illnesses. The ever-improving digital aftercare gives us the opportunity to increasingly treat them at home and thus gradually replace outpatient rehabilitation.

How does the shortage of skilled workers in the rehabilitation sector affect your company? Do you feel any geographical differences here and how do you address this issue?

We are also feeling the shortage of skilled workers in the rehabilitation sector, but mainly in nursing - the area that is also discussed the most politically. In the medical, therapeutic and psychological services, on the other hand, we do not experience a dramatic shortage of qualified staff and manage to fill all vacancies, even if it sometimes takes a little longer.

When recruiting nursing staff, we benefit from the fact that rehabilitation offers better working conditions than, for example, acute hospitals or nursing facilities, such as shifts which are family-friendly and less time pressure. Many colleagues also appreciate the closer relationships with the patients, who usually stay with us for several weeks. Finally, as an employer we benefit from the fact that in Germany, for example, half of all psychologists are trained in rehabilitation clinics.

There is, however, one exception: in the field of neurological early rehabilitation and acute medical care, which is very demanding in terms of nursing, there is a great shortage of intensive care nurses. Here we could offer significantly more ventilation and ventilation-weaning beds if we had more qualified staff.

What are the biggest challenges for the rehabilitation clinic market?

I see the shortage of specialists in acute neurology, which I just mentioned, as a major challenge. So is the transformation towards digital rehabilitation services. This process will relieve the burden on social insurance providers, as care can be provided more cost-effectively, and also offer advantages for patients, because the quality of treatment will increase and we will be able to provide a continuous treatment path. In order for this change to be successful for the benefit of all, however, it is essential that it is accompanied by scientific and political measures.

In many sectors, the coronavirus pandemic is acting as an accelerator for change. What influence does the pandemic have on the operation of a rehabilitation clinic?

An immense influence, especially with regard to the increased requirements in the area of hygiene and the entire processes in the clinics and facilities. At the very beginning of the pandemic, we already further strengthened our already high hygiene standards and developed a comprehensive hygiene concept. As the most important individual measure, every newly-admitted patient is examined for the presence of coronavirus infection by means of a PCR test, initially isolated and only start their rehabilitation after a negative result. Since October, this testing concept has been supplemented by regular preventive antigen tests for patients and staff.

Wherever possible, treatments and therapy sessions take place individually or in small groups. Wearing protective masks is mandatory in all public clinic areas. Protective distancing and special regulations apply to shared areas such as the restaurants, and care is taken to ensure regular, extensive ventilation. In addition, a comprehensive ban on visitors has been in place since May - to name just the most important protective measures.

Despite all this, MEDIAN has shown that we have been able to maintain our quality points even during the coronavirus pandemic and with a high level of occupancy; this clearly distinguishes us from our competitors.

Our analyses for 2020 show that we were, and continue to be, able to provide patients with a comprehensive range of therapies even under high-level protective measures and strict hygiene standards.

Due to the pandemic, we have pushed ahead even more with digitisation in order to be able to offer our patients therapies without personal contact with the help of digital tools.

Finally, the role of rehabilitation within the health care system has been strengthened and political acknowledgement has once again increased. An example from Mecklenburg-Western Pomerania makes this clear: while at the beginning of the pandemic we were lumped together with hotel businesses and day-trip organisers by the state government and our patients were refused entry to the state, our clinics are now being called upon by the Ministry of Health in the second wave of the pandemic to stand by the acute hospitals as auxiliary clinics and to take patients. So the political leaders have understood.

In your opinion, what are the decisive factors that distinguish a successful from a less successful facility?

Successful facilities are fully occupied and achieve 100 points in the German Pension Insurance's quality audit. Success is also measured by high patient satisfaction. Here, the patients themselves confirm in a questionnaire that they have achieved their rehabilitation goals. At MEDIAN, we continuously track all of these parameters with the help of analysis via our Business Intelligence tool (BI) for quality indicators, in which all of the performance data of our clinics regarding their discharged patients converge on a daily basis.

Please give us a little insight into your success story. How have you managed to establish MEDIAN Kliniken as the market leader in Germany?

For us, rehabilitation is not a „business". Of course we want to earn money. However, as an operator of clinics and rehabilitation facilities, we see ourselves much more as a service provider with medical responsibility for our patients - and, due to our market share, also with a relevant obligation towards the healthcare system.

MEDIAN pursues a clear quality strategy and constantly puts its own services under critical scrutiny. With this internal quality control, we supplement external audits, in particular by the DRV. Our quality can be measured objectively, which distinguishes us from many of our competitors. Even and especially during the crisis, we have continued this quality measurement, because here and now a successful rehabilitation company has to prove its efficiency - despite the currently challenging framework conditions.

Via this quality strategy, we will continue to keep our occupancy rates high in the future, and that is what makes MEDIAN successful. However, it is only possible with a common vision that the entire company shares and lives by: all of our approximately 120 clinics and facilities benefit from each other, as they can orient themselves to each other, compare themselves with each other and learn from each other.

06

REHABILITATION CLINICS AS AN ASSET CLASS

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PROPERTY STRUCTURE AND FAVOURED LOCATIONS

As described earlier in greater detail, inpatient rehabilitation in Germany experienced its zenith between the late 1980s and the mid-1990s. In order to meet the demand, numerous rehabilitation clinics were built during this period, many of which are still in operation today. With the introduction of the more restrictive allocation of rehabilitation treatment in the mid-1990s, construction activity in the sector also declined. This has resulted in the rehabilitation clinic sector having a relatively old building stock; many of the facilities currently in operation are 35 years old or more. This results in high investment requirements, on the one hand in renovation measures to maintain the building fabric, and on the other hand in improving their equipment to maintain and improve their competitiveness. Especially for independent, owner-managed rehabilitation clinics, it is often difficult to raise the necessary investment capital.

Building requirements

The building standards for rehabilitation clinics are determined by the German Statutory Pension Insurance, while their equipment features may vary depending on the treatment focus of the facilities. For example, depending on the main focus of treatment, rehabilitation clinics must have training and functional rooms such as training kitchens, exercise rooms and baths, rooms for individual discussions and individual treatments, as well as rooms for group activities. Irrespective of the treatment focus of the facilities, barrier-free access must be ensured without restriction in every rehabilitation clinic in accordance with the Equal Opportunities for Disabled Persons Act (§ 4 BGG), so that people with disabilities can make full use of all structural facilities and other equipment and systems.

The climate has to fit

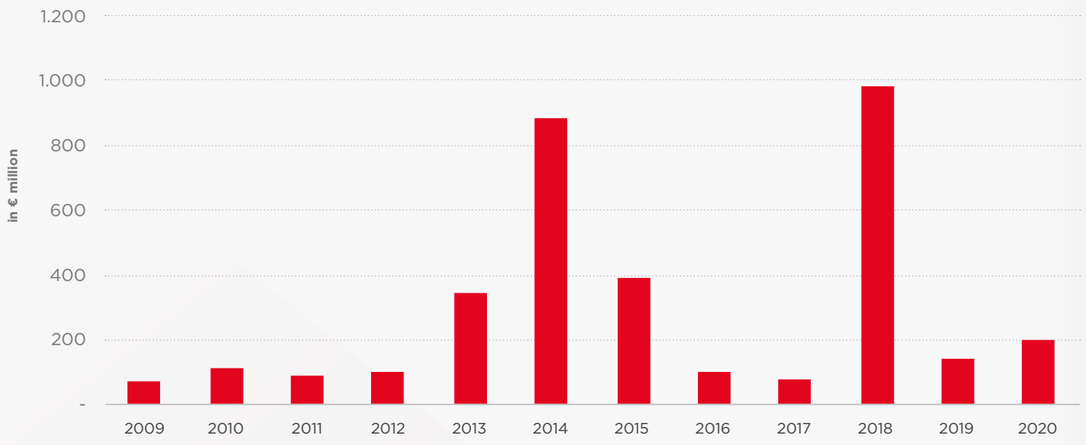
Rehabilitation clinics are often located in scenic rural areas, with a simultaneous relative lack of rehabilitation facilities in the urban centres. In addition, there is an increased density of rehabilitation clinics in regions with a bracing climate, which is considered to be a therapeutic factor, especially for respiratory and skin diseases. These regions include above all the seaside resorts on the North and Baltic Seas and climatic health resorts in the mountains. Due to the average construction age of the facilities, there is also a difference between the old and new federal states in terms of the number of rehabilitation clinics. The federal state of Mecklenburg-Western Pomerania is an exception, due to the bracing climate on the Baltic Sea coast.

REHABILITATION CLINICS AS AN ASSET CLASS

LETTING AND INVESTMENT MARKET

As previously described, rehabilitation clinics are run by operators in the private, public or non-profit sectors. These operators either hold the real estate in their own portfolio or sign a general lease agreement with its owner. As with other health care properties, such a general lease is often indexed based on the CPI, and with maintenance and repair structured as double or triple net. General leases are agreed on a long-term basis due to the planning horizon, which ensures a relatively secure and long-term cash flow for the owner of the property.

DEVELOPMENT OF TRANSACTION VOLUME REHABILITATION CLINICS



Source: Cushman & Wakefield, 2021

Significantly more demand than supply

Rehabilitation clinic transactions have enjoyed increasing interest in recent years, while transaction volume has also developed dynamically. Nevertheless, this asset class is less established than others in the healthcare segment, such as nursing home properties, whereby the two share economic similarities in addition to increasing demand due to demographic change. Due to general leases with long term periods, both property types are core products that guarantee long-term cash flow stability.

Clinic properties, as classic operator properties, are attractive above all to the operator chains themselves as well as for investors with a relevant track record in the healthcare segment. The dynamic transaction activity involving individual clinics is largely due to uncertainty regarding successorship in operating independent owner-managed rehabilitation clinics as well as the increasing cost pressure on private operators. It is to be expected that clinics whose treatment focus has seen a strong increase in the number of patients in recent years will become increasingly popular with investors. These include specialist clinics in the fields of psychosomatics, orthopaedics, cardiovascular diseases and oncology.

In addition to location, building quality and the key conditions of the general lease, net initial yields for such operator properties are heavily dependent on the creditworthiness of the operator and the sustainability of the treatment concept, and range between 4.3% and 4.8% for core investment opportunities.

It can be assumed that a large part of the rehabilitation measures will continue to be carried out in inpatient treatment in the future. There are many reasons for this. For example, it is very easy to bundle different forms of treatment in an inpatient setting without the patient having to commute between different locations and their place of residence every day. In addition, group treatments are easily carried out by all participants without having to consider the personal obligations of the patients, and especially in the treatment of psychosomatic illnesses, a therapy far away from the patient‘s own residence is often more promising. Furthermore, patients with lung and respiratory tract diseases often require a stay in a stimulating climate zone to achieve the desired treatment success.

As in many areas, the Coronavirus pandemic has also had an impact on rehabilitation in Germany. Thus, inpatient rehabilitation stays are still possible, but take place under strict hygiene measures. In addition, patients with lung and respiratory diseases in particular are reluctant to start rehabilitation stays in order to prevent a possible infection. However, experts point out that the risk of infection in a rehabilitation facility with a hygiene concept is by no means higher than at home. Like so many areas of everyday life, rehabilitation has had to adapt to the “new normal”.

07
SOURCES

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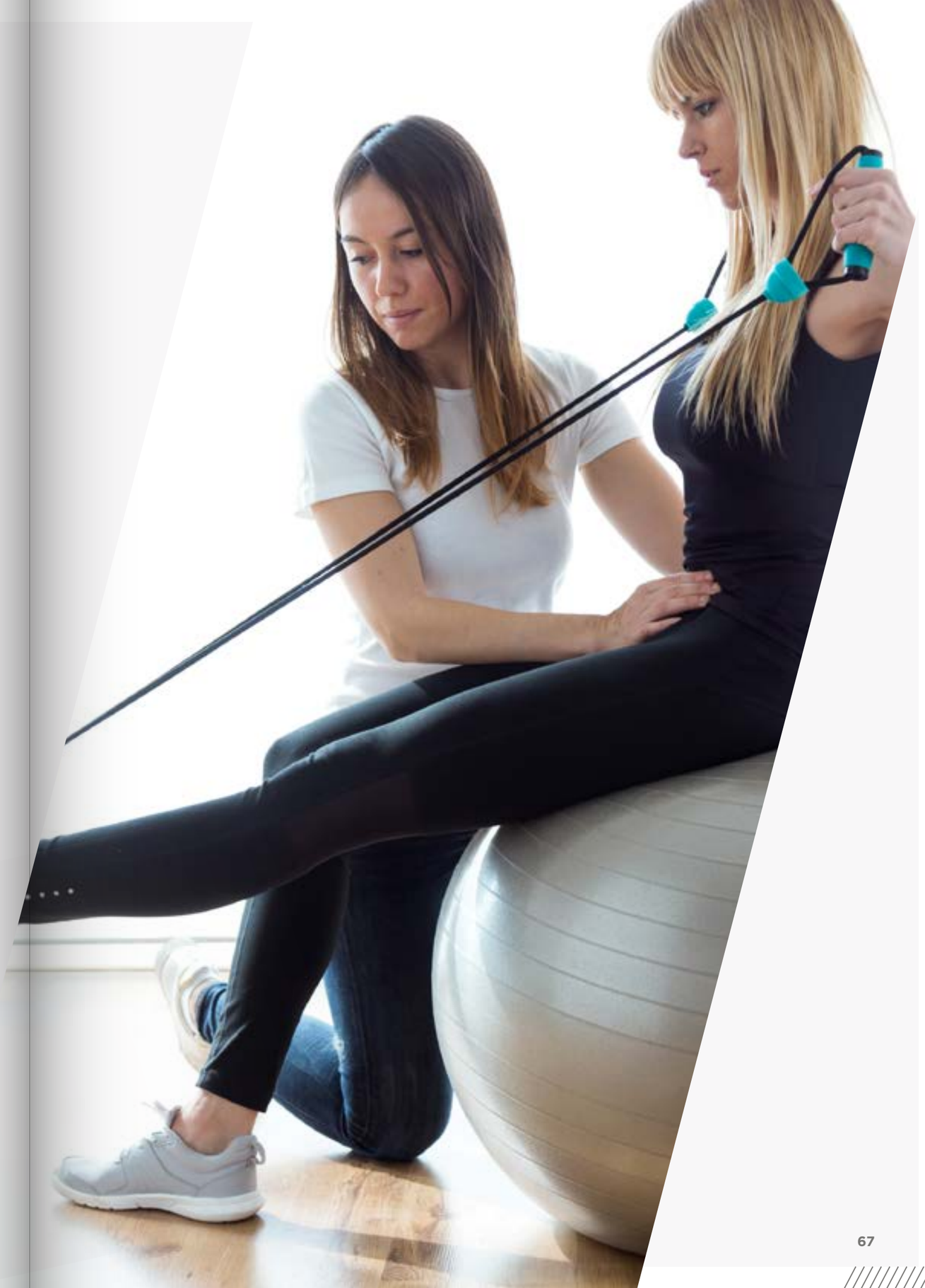

08

CONTACT & DISCLAIMER

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Jan-Bastian Knod

ASSOCIATE
INVESTMENT ADVISORY

+49 (0) 69 50 60 73 261

jan-bastian.knod@cushwake.com

Simon Jeschioro

INTERNATIONAL PARTNER
HEAD OF INVESTMENT ADVISORY

+49 (0) 69 50 60 73 260

simon.jeschioro@cushwake.com

Marie Stammer

CONSULTANT
INVESTMENT ADVISORY

+49 (0) 49 69 50 60 73 265

marie.stammer@cushwake.com