New market leaders emerge in elderly care
03 Healthcare market trends

Investment volumes over the course of Q1-17 appear to be ahead of 2016. Trade buyers remain active and there is renewed focus on long income.

04 Healthcare investment

Healthcare investment by investor type and some transaction highlights in Q4-16 to Q1-17.

05 Operator landscape

We analyse the corporate elderly care landscape that has changed markedly in a little over two years.

06-10 Interview with brighterkind

We interview Jeremy Richardson, CEO at Four Seasons Health Care’s brighterkind brand, to find out how product differentiation, investment and systems development are shaping strategy for care homes now and in the future.

We analyse the brighterkind portfolio using CBRE bespoke Analytics Software Pulse click here to find out more

11-12 2017 Lending trends

Lisa Attenborough, CBRE Director Debt Advisory, provides some insight into debt market trends over 2017 in the Healthcare sector.

13 Sector snapshots

We discuss key themes across some subsectors including care homes, hospitals, primary care and retirement villages.

14 CBRE Transactions

We summarise CBRE Healthcare transaction highlights.

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Our view of the Healthcare market pricing dynamics.

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Contact our Healthcare Team of specialists.
THE HEALTHCARE MARKET OVERVIEW

| Primary Care | 4.25% (4.50%) | Care Homes | 4.50% (4.50%) | Hospitals | 5.00% (5.00%) | Specialist | >5.50% (5.50%) |

*Arrows indicate yield direction. Previous quarter yields in brackets.

Photo 2: Helen McArdle – Fleming Court Care Home, Jesmond. Acquired by HC-One

HEALTHCARE MARKET TRENDS

- Multiple operational businesses changed hands towards the end of 2016; Lifestyle, Exemplar, Acer, Helen McArdle and Silk Healthcare are just a handful of examples, indicating that appetite amongst buyers remained healthy in spite of the events surrounding Brexit.

- Transactional activity in the Healthcare sector in Q1 2017 has been more varied and whilst a number of trade buyers such as Elysium have continued the spending spree, long income has once again been to the fore.

- The nature of investors appears to have changed, with UK trade buyers showing to be the dominant purchasing group for care homes. This suggests that good operators are managing in the face of sector headwinds and that the sector is more sustainable than some of the negative headlines would infer.

- Corporate activity in FY16 was very strong across the market, particularly in the specialist care sector where over £2.2bn transactions closed. Earnings multiples suggest that platform and bolt-on acquisitions remain keenly priced.

- Whilst healthcare real estate investment volumes were down markedly in FY16 relative to the period FY13-15, current investment activity indicates an uptick in volumes over 2017.

- CBRE estimate that transactions in the order of £850-£900m closed in 2016, with current investment volumes indicating half year 2017 will top £700m.

- Innovative real estate investors found new ways to deploy capital from NHS income strips to ground rent deals in the health and social care sectors.
HEALTHCARE TRANSACTION HIGHLIGHTS

Recent transactions of asset-backed health and social care investments have been dominated by major strategic acquisitions across the sectors, with Bupa’s acquisition of Oasis Dental, Acadia buying Priory and BC Partners backing of Elysium Healthcare. Activity was probably greater across a wider number of asset classes than at any time in the past 5 years. We highlight some of the deals in Q4-16 and into Q1-17 below.

- **November 2016 – Bright Horizons acquired Asquith Day Nurseries**. The portfolio comprised 90 day nurseries and the reported purchase price was in excess of £165m, reflecting a record multiple for this sector. CBRE provided real estate and strategic advice to the vendor.

- **December 2016 – Maria Mallaband**, supported by a US debt provider, acquired Acer Healthcare. The portfolio comprised 7 care homes located in southern England, all of which were purpose built. The purchase price was in excess of £100m and reflected values in excess of £200,000 per bed.

- **December 2016 – Cynnet acquired the adult services division of Cambian** for a reported £377m, representing an enterprise valuation of c.2.9x FY15 revenue of £129.5m. FY15 EBITDA for the adult services division was £24.1m.

- **January 2017 – Elysium Healthcare** was created from the spin-off of BC Partners’ acquisition of 22 Priory and PIC specialist care facilities from Acadia. The deal was part-funded via the creation of a ground rent worth c. £140m. CBRE advised the Fund.

- **January 2017 – HC-One acquired Helen Mc Ardle Care**. The portfolio comprised 20 care homes located in north east England. The reported purchase price was £120m reflecting a price in the region of £90,000 per bed.

- **January 2017 – A UK based investor agreed to forward-fund a brand new, market leading Care Home**, opened in March 2017. The property will be let to The Orders of St John Care Trust on a new 40 year institutional FRI lease. The price was undisclosed. CBRE advised the purchaser.

- **February 2017 – St Cloud Care acquired LRH Homes**. The portfolio comprised 13 care homes located in London and south east England. The reported purchase price was in excess of £70m and reflected a value in the region of £95,000 per bed.

- **March 2017 – Impact Healthcare REIT raised £160m**, with a seed portfolio of 58 care homes to be leased to tenants for an initial term of 20 years on annually indexed, RPI linked leases.

- **March 2017 – Elysium closed the purchase of Badby Park** from Patron Capital.

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**Figure 1**: Distribution by buyer type of UK Healthcare transactions recorded by CBRE in 2016

- Overseas Real Estate Investors
- Private Equity
- UK Real Estate Investors
- UK Trade Buyers
- US Trade Buyers
- US Real Estate Investors

Source: CBRE
In spite of the 4 largest providers operating 1,150 homes and 68,000 beds between them (c.14% market total), the UK Elderly Care market remains fragmented. As the figures on this page show, whilst the top four providers have a degree of market concentration, this is declining and there is a remarkably even distribution after them. There has been some contraction in terms of market concentration since Q4-2014 but the largest 25 operators still provide in the order of 29% of total registered elderly care beds. Of more interest perhaps, are the changes within the corporate providers. Avery, Healthcare Homes and Quantum weren’t present in the top 25 in Q4-2014, whilst Anchor and Sanctuary have added over 2,000 beds in newer, larger homes. Operators such as HC-One and Minster have actively managed their estates and show net growth, whilst Four Seasons, Embrace and Orchard have focused on specific markets and show a net aggregate reduction of over 6,300.

Source: Care Markets (Laing Buisson)
Little did he know when he joined The Four Seasons Health Care Group in 2014 to develop and run a standalone private pay focused business, but Jeremy Richardson (JR) was moving into the Social Care sector at what would prove to be an unbelievably challenging juncture. Tom Morgan (TM), CBRE Senior Healthcare Director, discusses strategy, challenges and how the business that has become brighterkind is developing. Does the future look bright for brighterkind and the care sector?

Q1. TM: For those unfamiliar with brighterkind, could you briefly set the scene as to what the business model is and what you have been focused on over the last twenty four months?

JR: brighterkind was created in 2014 from a collection of former Four Seasons, Avery Healthcare and Majesticare homes. The new business was formed to focus on the private pay market and the initial strategy was to reposition a number of the homes through capital investment to attract this customer group.

Much of the last twenty four months has been focused on creating the business and the culture. We have really been going through a quasi start-up situation, albeit that we inherited a group of homes to give us a jump start. In the last two years we have moved brighterkind from being a subsidiary of Four Seasons to become an operationally standalone business.

The company has developed from a collection of disparate assets into a business with its own brand, culture, product proposition, leadership team, operations and risk & governance infrastructure. The central tenets of the product proposition are extraordinary care, a special dining experience and a recreation and activities programme called ‘Magic Moments’ that promotes physical, emotional and mental wellbeing but which, above all, is enjoyable.

Q2. TM: Lack of funding, compressed fee rates and rising costs. We read about these things almost daily in connection with social care in the UK but how would you describe the Elderly Care Home sector at the moment?

JR: It’s far too simplistic to tar the whole sector with the same brush. It is fair to say that many Local Authorities are not paying the true cost of care and that their fees have gone backwards in real terms.

At the same time, cost pressures on care home operators have escalated as a consequence of increased regulation and imposed legislation (National Minimum Wage, National Living Wage and the Apprentice Levy). This combination is not financially sustainable and is affecting certain parts of the country much more than others.

It is a challenging time for any care home business that is reliant on Local Authority funded residents and it is widely recognised that fees need to increase.

Continued on page 7
INTERVIEW WITH JEREMY RICHARDSON, CEO OF BRIGHTHERKIND

Continued from page 6

On the other hand, the privately funded market continues to represent an opportunity. Fee rates are more sensible and, with the appropriate level of funding, comes the opportunity to invest and innovate which is exactly what we are doing at brightherkind.

Q3. TM: The “true cost of care” has been described as being more comparable to the rate that self-funders pay than that paid by Local Authorities. What are you seeing across brightherkind?

JR: Self-funded residents tend to pay fees that are closer to the fair cost of the care being provided, while council fees on average are below the fair cost. One reason for a difference between standard council fee rates for care home places and the rates for self-funded residents is that councils are frequent repeat customers who purchase numerous beds, so helping operators to achieve the levels of occupancy they need and councils use this leverage to negotiate a lower fee rate.

Council fees have fallen by about 5% in real terms versus cost inflation over the past three or four years, before the effect of the introduction of the Living Wage, which in the first year added about another 5% to costs. Where councils have raised the social care precept and passed it on to front line care, it has helped to mitigate the additional costs, but in national terms this has not touched the existing under-funding.

Whilst I accept that Local Authority budgets are being squeezed, there is a moral and economic obligation for this precept to be passed onto operators to enable us to deliver the quality of care that older people deserve. There are some councils who have recognised the problems and are addressing fee rates, so the issue is not universal, but those that are not raising and passing on additional funding are letting down some of the most vulnerable in society.

Q4. TM: A closer relationship between the Social Care sector and the NHS has been talked about for years. Are you seeing signs that this is happening? How do you see social care evolving over the course of the next three to five years?

JR: There are one or two experiments going on to try and better link the two, Manchester being one but at the moment it is really tinkering around the edges. People far more qualified than me have been saying for many years that the two sectors (and budgets) need to be linked and I would strongly support that. What I have seen in my two and half years in the sector is a disorganised and chaotic structure where the left blames the right and vice versa. It’s slightly depressing to watch silo mentality and bureaucracy get in the way of patient and resident outcomes. Take the problem of delayed discharge, or so called bed-blocking, where predominantly elderly patients who have had their medical condition stabilised, remain in hospital for prolonged periods because they are not well enough to look after themselves at home. They could be cared for by qualified nurses in care homes, relieving pressure on hospital beds and saving the public purse.

Where this happens it is a success, so why is it still on such a small scale? Part of the problem is that the health sector is politicised.

Continued on page 8

Figure 5: CBRE Pulse – Manchester comparison between new-build care homes in the last two years and current live planning applications in the city

INTEGRATED CARE PROGRAMME STIMULATING ACTIVITY

BY COMPARING NEW BUILDS IN THE LAST TWO YEARS WITH LIVE PLANNING APPLICATIONS WE CAN SEE THAT THERE HAS BEEN A SIGNIFICANT UPTICK IN ACTIVITY WITHIN THE MANCHESTER AREA
INTERVIEW WITH JEREMY RICHARDSON, CEO OF BRIGTHERKIND

Continued from page 7

The NHS is revered in a way that is completely unhealthy and until there is a collective recognition that the NHS is not perfect and that change is needed from all sides of the political divide then we will continue to take one step forward and one step back.

Q5. TM: The CMA has launched a review into market practices within the care home sector. Is this something which you welcome as a major national provider?

JR: Yes, I do welcome the review. The CMA is looking at how the market functions, transparency of information and how the customer is communicated with. We are working closely with the review and welcome the opportunity to explain our processes and demonstrate how our business operates.

Q6. TM: Do you see the UK market becoming more specialist as it has in the US, with homes being either assisted living (residential care), skilled nursing or memory care (dementia)?

JR: Yes and No. I think that there will be an increase in specialisation. It makes sense for that to be the case, and you can already see that happening, but I am not sure that the demarcation in the UK will be quite as stark as it is in the US. We have less spare land to start with which makes the development of large specialist facilities much harder. I also think that labelling certain conditions runs the risk of over simplifying someone’s care needs. We have many residents with some form of dementia or cognitive impairment but most of these people have other nursing or residential needs as well. The key to running a successful service is to ensure that residents’ care needs are individually assessed and admissions aligned to the services being offered. Sometimes mixed communities can create atmospheres and environments that are far more energising than they would otherwise be.

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INTERVIEW WITH JEREMY RICHARDSON, CEO OF BRIGHTERKIND

Continued from page 8

Q7. TM: brighterkind operates from northern Scotland to the South Coast of England. What are the challenges and are they uniform across the portfolio?

JR: The challenges are really no different to those that any national multi-site business faces. To deliver consistency we need to develop a strong culture and way of working and we have strived hard to build that. The senior management team spends a lot of time in the business and I have committed to visiting every home at least once a year because it is so important to see the homes and support the teams.

We are a people business and our teams work unbelievably hard and deserve our support. We are investing heavily in training and people development and are always looking to strike the right balance between local autonomy and central control. It’s important to me that all of our homes, whatever their physical make up, offer the same quality of care and hospitality. I want all prospective service users to walk into a brighterkind home and be met with the strongest feeling of warmth, hospitality and genuine care.

An additional challenge is unique to the care sector is the need to manage third party relations at Local Authority and national regulator level across the country. One thing that I have observed is a lack of consistency of application which is perhaps not surprising given how the market is structured but which is time consuming and sometimes frustrating to manage.

Q8. TM: Many large national providers have been selling assets out of their estates indicating that some groups have become too large to manage. What has the situation been at brighterkind and is this likely to change in the short term?

JR: At the moment we are 70 homes in total. I want to grow the business but we have not set any arbitrary targets that we want to hit. What I would rather do is grow the business opportunistically by acquiring or developing homes that fit with the brighterkind model comprising of homes that have charm and character that predominantly cater for the private pay market or at least have the potential to do so. By definition this will mean that our growth is driven by demographics (location) and quality, or the potential of the home. I am certainly not averse to acquiring unloved assets, investing in them and repositioning them, provided that they are in the right place. The key is that whatever we add to brighterkind improves the business overall.

I am continually looking to improve in everything that we do. As for absolute size of estate, the only rule that I want to work to is that I don’t think we should ever be larger than a size that allows the senior management, and by that I mean Home Managers and above, to all get together in one room every year. We are a people business, the service that we provide is care delivered by our team, so if we cannot spend time together as one team and have to rely on spreadsheets and charts to run our business then we are rather missing the point aren’t we?

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Figure 6: CBRE Pulse – All non-purpose built, outstanding rated care homes in the UK’s most affluent areas

FOCUS ON QUALITY IN OLDER FACILITIES

There are opportunities to target older homes in pockets of affluence where care quality and fee are resilient

VIEW MAP IN PULSE
Q9. **TM:** What has your approach been to Capex across the estate and what returns are you seeing from it?

**JR:** Care homes are like most property intensive businesses, they are cash flow generative but capital consumptive. If you don't invest the capital then the cash flows soon dry up. We have invested heavily in the brighterkind estate over the last twenty four months (£13m and counting) and our plan is to continue investing to enable us to deliver our brand promise of ‘loving every day’. In general, where we have refurbished homes, we have seen very healthy returns and this has encouraged us to push forwards faster and as quickly as available capital permits.

Q10. **TM:** How do you see the ownership of real estate in brighterkind?

**JR:** At the moment brighterkind is a mixture of freeholds and leaseholds. As a rule I like freeholds and the control and flexibility that brings. Whilst capital is tied up in assets, it does allow greater flexibility to ride the economic cycle. It also gives greater control over absolute levels of gearing. There is nothing wrong with leaseholds ‘per se’ and if they are structured correctly they are a very effective way of deploying capital. The problem is that historically lease terms have been driven by the property owner with upward only rent reviews and rental levels that assume 35 years of optimistic trading performance. Once you get onto the thirty five year treadmill you can quickly find yourself saddled with liabilities not assets. I would like to see much greater flexibility attaching to lease structures but whilst the financing markets are organised in the way that they are this is unlikely to be the case.

Q11. **TM:** What does the future hold for brighterkind as part of the Four Seasons Health Care group?

**JR:** I am hugely optimistic about a brighterkind future. Two and a half years ago we did not exist. In the past thirty months we have developed a new standalone business with its own values, culture, ways of working and behaviours. We have recruited a first class leadership team and I believe that the quality of our senior management is as good as any in the industry. We have a very clear vision of what we are trying to achieve and have made excellent early progress. Our care quality has improved significantly over the time we have been independent, our financial performance has been very encouraging and residents’ feedback has been excellent. In two and a half years, we have gone from a good idea to a business that has been shortlisted for the Heath Investor Residential Care Provider of the Year.

I am excited about using the platform that we have created to continue developing the business. I am making no apologies about aspiring to be the ‘Best Care Home business in the UK’ and with the right support and a lot of hard work I am confident that we can achieve this. I am proud of what we have done thus far but this is just the start.

**TM:** Thank you very much indeed Jeremy.
2017 LENDING TRENDS IN THE HEALTHCARE SECTOR

ALTERNATIVE LENDERS SEEK ALTERNATIVE ASSETS

Debt pricing has plateaued in the second half of 2016 following an increase after the referendum. There will be more political and economic uncertainty as 2017 unfolds, so the expectation is that pricing will only go one way. We have seen an increasing spread of terms emerging as lenders dip in and out of the market and come up against allocation constraints. Market coverage has never been more important when considering debt solutions.

Figures 7 and 8 show the variations in margins and LTVs for five different types of lending for the 2007-2015 period, as reported by De Montfort University’s Commercial Property Lending Report.

As would be expected, margins rise and LTVs fall as one moves up the risk curve from prime to secondary investment and from fully- to partially prelet to speculative development. As might also be expected, during periods when debt availability was falling, the variation in margin and LTV across the five types widened (with debt drying up entirely in one case, as indicated by the dotted lines).

Over the nine year period for which data is available speculative development lending has been most volatile, requiring us to infer terms for the years 2011-13. Accordingly the average LTV figure of 48% against a margin of 413bps has a wider margin of error than other lending types.

In 2017 there will be an increasing demand for development finance in the Healthcare sector. Savvy alternative lenders who are comfortable with the sector risks could capitalise on mainstream lenders’ limitations. By lending at appropriate leverage and structuring a facility that is protected in downside scenarios, there is an opportunity to back a range of high quality sponsors and support growth in the sector.

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COMMERCIAL REAL ESTATE DEBT PROSPECTS

Commercial real estate debt has for some time comfortably offered a premium of more than 2% to Gilts. Q1 2017 was the fifth successive quarter when the premium offered by CRE debt to Gilts exceeded 2.5% on a gross return basis; indeed, the premium of 2.9% at the end of Q1 2017 is the highest since Q4 2014. Just as noteworthy perhaps - and increasingly an important driver of allocation from fixed income investors – is the scale of return relative to corporate bonds, this premium was above 1.5% for the fifth successive quarter, standing at 1.7% in Q1 2017 as shown in Figure 9. It is this premium that is driving alternative lenders into the sector to absorb demand left by the clearing banks.

Looking at the Healthcare sector, senior debt appetite is mixed. Mainstream corporate banks have well-established industry teams who understand the market and focus on operator quality and existing relationships. Their appetite for standalone development finance is limited. Access to alternative lenders will be the key to unlocking debt requirements in 2017. CBRE Debt Advisory has relationships with all major lenders in the sector.

“Access to alternative lenders will be the key to unlocking debt requirements in 2017”

Figure 9: Senior CRE lending returns, premium versus other forms of fixed income, Q1 2016, Q4 2016 and Q1 2017

Source: Bank of England, BofAML, CBRE, Macrobond, Q1 2017

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HEALTHCARE SECTOR SNAPSHOTS

CARE HOMES

The sector has seen increasing inflow of capital with activity at portfolio level and in new developments in particular. Buoyed by the increased funding from the council tax precept and Funded Nursing Care Contribution (FNCC) this has boosted income streams. However, it is only papering the cracks as the underfunding remains and in many parts of the country, it costs less to stay in a hotel than to provide 24 hour care in a home. However, the £2bn additional funding for social care announced in the Spring budget is a welcome boost. The number of homes closing is accelerating and there is a widening polarisation between modern homes in affluent areas and those reliant on funded places. For “best in class” self-pay homes pricing is at an all time high but for the majority, buyer interest is more muted and selective. Arguably this offers opportunity to groups and private equity looking for operational platforms that can be improved and upgraded.

HOSPITALS

Circle Health has announced a joint venture with Fresenius subsidiary Vamed to develop European-style inpatient rehabilitation services initially within its Reading Hospital (20 beds) and then within its Birmingham hospital development. Vamed is an international healthcare management and construction organisation that covers acute, rehabilitation and nursing care and a credible partner that could bring the European model into the UK. Is this a serious attempt by the independent sector to bridge the gap between inpatient medical care and elderly social care helping to alleviate NHS beds crises? That will depend on the target patient group, which is likely to include private payers such as big corporates with working-age cohort. A buy-in from the public sector may also depend on which budget, NHS or social, is prepared to foot the bill. Nevertheless, the acute sector will be following this innovative development closely. New developments in Birmingham, Manchester, Nottingham and London suggests the market is confident the role of private sector provision alongside public sector services.

PRIMARY CARE

The dynamics of the sector remain compelling for long-term investors seeking secure asset backed income. The lack of a development pipeline continues and the promised £1bn of grants to improve the primary care estate is not being fully utilised and is piecemeal on small projects. NHS England has still not released the updated Premises Cost Directions controlling rent reimbursement and rental growth is currently muted despite most other sectors showing uplifts. The dichotomy remains that we have a dated stock, half of which has seen no investment for ten years, and ready and willing investors looking to reprovide but a current reluctance from NHS England to support the level of rent reimbursements necessary to make these economic.

RETIREMENT VILLAGES

There is widespread awareness that well designed, good quality retirement housing with care can make a positive contribution towards maintaining the physical and mental health of older people (thereby reducing hospital admissions) and releasing under-occupied housing. Over the last ten years, the majority of schemes in low and middle income areas have been delivered by housing associations and there is now serious concern from this segment of the market that the forthcoming cap on housing benefits will have major financial implications for existing and planned schemes. In order to ensure financial viability, a number of housing associations are considering developing new schemes with a greater proportion available for the private market. However, simply offering more units to purchase or for private rent will not necessarily result in financial success. Many schemes fail because they do not offer what older people want. Research by Demos has found that 33% of older people would consider downsizing, but only 7% do because there is nothing suitable. The Communities and Local Government Select Committee has recognised this problem and announced an inquiry into whether the housing on offer for older people in England is sufficiently available and suitable for their needs. The St Monica Trust found that the current cohort of older people have different aspirations than the previous generation and these wishes have been incorporated into the planning of the Chocolate Quarter at the former Cadbury factory in Keynsham, due to open in Summer 2017. The new retirement village will have 136 stylish apartments and a 93-bed care home, as well as office space, retail outlets and leisure facilities for the local community, including a 50 seat cinema, swimming pool, dance studio and pizza restaurant. The result has been a significant lowering in the average age of people expressing an interest and 33% of apartments being sold off plan within two months of the launch.
CBRE HEALTHCARE TRANSACTION HIGHLIGHTS 2016

SIGNATURE LUXURY CARE HOMES
Vendor: DPI, a Consortium led by CBRE Global Investment Partners and Church Commissioners
Purchaser: Welltower Inc and Revera Inc
Detail: Market leading sale of 4 luxury care homes under a sale and manage back structure
CBRE Role: CBRE provided sell-side brokerage services to the vendor

PRIME DEVELOPMENT SITE - DIDSBURY
Vendor: Circle Health
Purchaser: Confidential
Detail: Sale of a development site with planning permission for an independent hospital.
CBRE Role: CBRE acted on behalf of the vendor

SIGNATURE LUXURY CARE HOMES
Vendor: DPI, a Consortium led by CBRE Global Investment Partners and Church Commissioners
Purchaser: Welltower Inc and Revera Inc
Detail: Market leading sale of 4 luxury care homes under a sale and manage back structure
CBRE Role: CBRE provided sell-side brokerage services to the vendor

RAMSAY HEALTHCARE PRIVATE HOSPITAL
Vendor: WW Medical Properties
Purchaser: Confidential
Detail: Forward-funding of a brand new market leading Ramsey Healthcare private hospital
CBRE Role: CBRE provided sell-side brokerage services to the vendor

ELYSIUM HOSPITALS GROUND RENT
Vendor: BC Partners
Purchaser: Alpha Real Capital
Detail: Ground rent acquisition, structured for 22 Priory and PIC hospitals
CBRE Role: CBRE provided buy-side due diligence valuation advisory

THE CAMBRIAN CARE FACILITY - BUCKNALL
Vendor: Wrekin Housing Trust
Purchaser: The Aurora Group
Detail: Sale of a purpose built facility to provide education and care for children and young people with special needs
CBRE Role: CBRE acted on behalf of the vendor

BADBY PARK - DARLINGTON
Vendor: On behalf of administrators
Purchaser: Badby Park Ltd on behalf of Patron Capital
Detail: Acquisition of a 67 bed purpose-built care home with vacant possession to be converted into a rehabilitation centre
CBRE Role: CBRE acted on behalf of the purchaser
HEALTHCARE PRICING DYNAMICS MARCH 2017

In the tables below, we summarise our view of current pricing dynamics. After a stalling in the market following the referendum in June 2016, there has been investment from around the globe into UK Healthcare. This demonstrates the attraction of quality assets with secure cash flow and only secondary stock showing a weakening trend.

### Care Homes, Hospitals and Specialist Care Parameters

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Price Per Bed</th>
<th>Multiple Range</th>
<th>Yield Range</th>
<th>Yield Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Super Prime</td>
<td>Best in class, high value location</td>
<td>&gt;£200k</td>
<td>&gt;11</td>
<td>4.50% – 5.25%</td>
<td>Stable</td>
</tr>
<tr>
<td>Prime</td>
<td>Modern purpose build, fully compliant</td>
<td>&gt;£100k</td>
<td>&gt;9.0</td>
<td>5.25% – 6.50%</td>
<td>Stable</td>
</tr>
<tr>
<td>Tier 1</td>
<td>Older purpose built, single en-suite</td>
<td>&gt;£70k</td>
<td>&gt;7.0</td>
<td>6.50% – 8.00%</td>
<td>Weaker</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Mixed converted/extended, part en-suite</td>
<td>&gt;£40k</td>
<td>&gt;6.0</td>
<td>9.00% – 10.00%</td>
<td>Weaker</td>
</tr>
<tr>
<td>Obsolete</td>
<td>Small low value conversions, compliance issues</td>
<td>Up to £40k</td>
<td>&gt;5.0</td>
<td>No market</td>
<td>Weaker</td>
</tr>
<tr>
<td>Specialist Care</td>
<td>Best in class, high fees</td>
<td>N/A</td>
<td>&gt;8.0</td>
<td>&gt;5.50%</td>
<td>Stable</td>
</tr>
<tr>
<td>Hospitals - Prime</td>
<td>Modern, private sector</td>
<td>N/A</td>
<td>&gt;10</td>
<td>5.00% – 5.75%</td>
<td>Stable</td>
</tr>
</tbody>
</table>

Note: Prime yields refer to rack rented care homes let to financially strong tenants, but not charitable, on a lease with a minimum of 25 years unexpired and index linked rent reviews. The above details are indicative only and will vary by property and location.

### Care Home Development Land Values

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Price Per Bed</th>
<th>Price Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top-tier</td>
<td>Mostly located within Greater London and the South East of England in recognised affluent locations</td>
<td>£40k – £70k+</td>
<td>Stronger</td>
</tr>
<tr>
<td>Mid-tier</td>
<td>Regional affluent locations with small care catchments and recognised retirement towns with high elderly populations</td>
<td>£25k – £40k</td>
<td>Stable</td>
</tr>
<tr>
<td>Lower-tier</td>
<td>Regional/provincial, less affluent locations</td>
<td>&lt;£20k</td>
<td>Weaker</td>
</tr>
</tbody>
</table>

### GP/ Medical Centres

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Yield Range</th>
<th>Yield Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Super Prime</td>
<td>Best in class, large lots, long leases</td>
<td>4.25% – 4.75%</td>
<td>Stronger</td>
</tr>
<tr>
<td>Prime</td>
<td>Modern, mid size</td>
<td>4.75% – 5.50%</td>
<td>Stable</td>
</tr>
<tr>
<td>Secondary</td>
<td>Older, purpose built, 10+ years unexpired</td>
<td>5.50% – 7.00%</td>
<td>Weaker</td>
</tr>
<tr>
<td>Tertiary</td>
<td>Converted, short leases, obsolescence risk</td>
<td>7.00% – 9.00%</td>
<td>Weaker</td>
</tr>
</tbody>
</table>

Source: CBRE
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