Real Estate Selection & Strategy

Richard Matthews, Director of Real Estate Research

Hi, my name is Richard Matthews. I'm the Director of Real Estate Research at The Joint. I've been here for four years. My background is in academics. I was a geography professor at the University of South Carolina. My specialty in geography is economic geography, which is the science of the location of business. So they always say if you – those who can do are those who can't teach, so I moved from teaching to doing. And I worked at PetSmart for 10 years and helped open 700 clinics and developed their models. And I've been at The Joint for four years, and we've built 220 clinics in the time that I've been here.

So today, I'm going to talk about what we do in the real estate team, what our goals are; what our models are that we built and the tools that we use; what our deployment strategy is, where we look for clinics; what our location criteria is, what the kind of centers and sites we look for; how we go about getting a site accepted into our portfolio; and then kind of an expansion of new potential markets that Eric touched on briefly.

So what we do in the real estate team? The first thing I do is organize and describe real estate data. I have hundreds of thousands of patient information, patient points, patient data. I have 400 demographic criteria for every clinic. So the first thing I do is organize all that data into a big database. What does average look like for us? What does a standard deviation above and below look like for us? What does good look like? What does the challenge look like on all those data points? And that answers the question of what. What do we have? What kind of information do we have?

But that doesn't tell us anything about how or why, so the next step is to build explanatory models to help develop strategy. When I build an explanatory model, that's usually regression-based, and that helps us answer the question of why things happen, what is the relationship between certain demographics, certain site characteristics and our clinic performance. So by building explanatory models, we can understand why things happen. And once we understand the why of the data, then we can develop a strategy and replicate that criteria across different parts of the country.

So after we build those explanatory models, we communicate the results and best practices to our RD and franchisee community. We work with franchisees on opening clinics. I evaluate the sites using those tools – models that we build the explanatory tools on and so we use those tools to build the strategy and then to build our actual day-to-day operations. So in short, we want to understand the importance of location and apply those learnings to new centers.

So what – the first thing we do every January, I get very excited on January 1 to get new data. I go and ask our IT department to give me a list of all the patients and how much money they spent at any clinic that we visited. Last year, I had 557,000 patients from 430 units in 31 states. And I – and we have a lot more than that, but some of them didn't spend any money, some didn't have useable addresses, some aren't in the United States. But in the United States, this is a map of our 557,000 patients that came into our clinics last year, that gave us usable addresses and spent some money.

We had 31 – we have clinics in 31 states. We have patients from all 50 states, including Washington, D.C., Puerto Rico, all Canadian provinces and territories, so the Northwest Territories and Yukon they're coming now. We have patients from 24 countries on six continents. But this is a map of just the United States, and I get very excited when I see all this stuff. So we still have statistically 557,000, as Eric said, that's only 1% of the chiropractic universe. So we've got a huge runway even in places where we have a lot of patients currently, it's a huge runway potential for us right now.

So after I map the patients, I sign each patient to a zip plus 4 location. Zip plus 4, as you know, your zip code, every zip code has about 7,000 to 10,000 people in it. The four digits that are added on, no one really knows their nine-digit zip code, but everyone – somebody see it on a piece of mail. Zip plus 4 has 10 households, so that's essentially the number of houses on one side of one street for one block. So that's the kind of granularity we can apply our demographics to. So a lot of retailers use zip codes. You go to Home Depot, they ask you what your zip code is. They're trying to get the same information that we get from our intake – patient intake form.

The lowest level of geography that's in the census is the census block group, which is usually 1,000 to 3,000 people, so we get really granular information about our patients. And I divide that up by every clinic we have in the country. This is a map of our patients in an area of North Phoenix probably about 8 miles from where we are right now. We are right about here.

So this is a map of various clinic locations in North Phoenix and where their patients are. The different color dots are assigned to different clinics, so we can – by doing this every year, evaluating 400, 450 clinics, we really understand how our patients behave; how they react to things like interstate highway systems; how they react to natural barriers such as mountain ranges, which you see these green spots right down here show where there's mountains.

So the people – how do people interact? How do they interact to other clinics? We see one clinic, which has the dark blue dots, have patients that bypass other clinics. How? Why does that happen? And in this case, it might be that, that shopping center is a much more regional draw located on a highway system rather than a neighborhood location. And also, it shows the loyalty that our patients have.

So by getting in in-depth at every clinic level, we're able to understand how that trade area operates, how our patients behave in various geographic settings, how far they're willing to travel, how likely they are to come to a clinic based on the types of centers they're in. So I have 400 demographic and psychographic and site characteristics for every clinic that we have. Demographics are measurable attributes of the population, things like age, income, education, number of people in a household, languages that people speak. All that information, that's measurable attributes of the population, and we get that from census information.

And then we have psychographic information. Psychoanalytic analytics came about 30 years ago, and that shows behavioral or aspirational attributes of the population, things like how people spend their money, not just how much money they make but what their lifestyles are, what their priorities are. And there are several different versions of it out there, but usually they have about 60 to 80 different clusters, psychographic clusters are the term. The one we use has about 70. And how they're divided, the companies that create these tools are marketing firms merged with credit bureaus to really evaluate how people spend their money.

And so one example of a cluster, cluster number one, is the wealthiest people in the United States. They account for about 1% of the population. They have graduate degrees. They're between the ages of 48 and 64. They're empty nesters. They drive German sports cars. They belong to country clubs. We know how many of that cluster goes to our clinics, and we know how many of – what their spending behavior is in our clinics.

Another clinic – another cluster is cluster number 49, American classics. These are downscale retirees aged 65 and above. Money is tight. They drive Chevy Malibus. They subscribe to Reader's Digest. And they go on gambling junkets to Atlantic City. We know how many of them are our patients and how they have spending habits for us. So we regress the demographics and psychographics against our sales, and our goal is to put a dollar value on every household in the United States as a potential customer for us.

So there are 70 clusters in the United States. I've sorted all our clusters on our most – our over- indexed customers, which is our most important cluster, and then I compare that to the U.S. population as a whole. The lower line, that orange-colored line, is the U.S. population as a whole based on sorting our best customers.

So about 25 clusters, where our most important customers come from, those 25 clusters account for about 45% of the U.S. population. Those same 25 clusters account for 70% of our patients. These are what we call our core customers. So the same is mapped with this dark blue color, that color, this say this is where our core customers are, those 25 psychographic clusters who have told us that they're our best patients and how they react to us and how they spend money and how far they're willing to travel and what their lifestyles are like, we can – we know who they are, and we know where they live across United States.

So we look for those people, those 25 clusters who account for 70% of our patients, we actively look to see where they live. Who are they? They make up a wide age range. We heard that millennials are 39% of our customers, our patients. Generation X is 34% of our patients, but we have baby boomers as well. So that's a wide age range. So we're not a niche market, we're really a wide mass market. We have a wide economic spectrum, both white collar and blue collar. White collar are good patients. They say sitting is the new smoking. So you got to get up and be active. And our – in the video that we showed, there's people coming into the clinics because they sat at a computer all day, so white-collar people are good patients for us.

Blue-collar patients are great patients for us because they're out working there body hard every day and need relief from us. And we have a median household income range, median is the better predictor for us than average because average tends to be skewed by some very high incomes. So our median household income range is between $50,000 and $100,000. Again, a very wide spectrum of the population, so we're not a really niche provider, we're a very mass provider. We have urbanicity, of a wide urbanicity too, smaller towns, suburbs, cities, most of the clinics though right now are in shopping centers in suburban locations of major cities.

And we have that large straight A database. Every time we open a new clinic, we add new information to our database, which is 400 different variables across 450 clinics and 500,000 patients. So we really know who our patient is. Our patients tell us who they are. All we have to do is listen to them and find out –

find more people like them. So here's our national build-out potential. This is the county map, you're seen this twice, I think, already today. Where you see the darker blue colors, those are where – those counties have a very high incidence of our core customers, those 25 psychographic groups.

We know where they live. We know every household in the United States, what their psychographic component is, and we just look for where our best customers live. And in those, we found where shopping centers are, the circles that Eric described. We found there's a shopping center in every one of those circles. And in that radius, about a distance of how far people are willing to travel because they've shown us how far they're willing to travel, we see a certain number of core customers. And if you have those – that number in that distance of traveling, we can put a clinic there that has enough core customers to support a clinic. And that's how we come up with these 1,700 right now.

And that's based on current usage and our current business model. So where do we put – where do we put clinics? What are we looking for? We want to be where people are. This is – we call this the little mermaid philosophy of site selection. The little mermaid sings a song, I want to be where the people are, and that's where I want to be, I want to be where the people are, too. So that's really where we want. We want to be where there's lots and lots of people because that's where it makes it convenient for them.

Our three real estate pillars, when we evaluate a site, there's three components that we look for. First, the trade area demographics. Does that trade area have the components of the population that we're looking for? Does it have a group of those core customers? Does it have that mix of white-collar and blue-collar population? Does it have the age dynamic that we like? Does it have an income level that we like? So if that trade area isn't possible, we look for the centers. And we want to be in the centers that most people appear the most often, those busy centers. And then within the location of that center, we want to be in visible, accessible locations.

So we want those three things of what we consider when we evaluate the location. So when a franchisee says can we be into this center, those are the three components we're looking for. The first thing we really look for is the population, do we have enough people that can support a clinic because as we've seen, we are only doing – getting 1% of the population to come into our cities. So we want to avoid thinly populated areas. And clustering clinics help build the brand. Clustering, we've talked about this phrase before, is really locating clinics in adjacent trade areas. So we find it beneficial to locate in contiguous trade areas 1, 2, 3, 4 as opposed to putting one far away from the second, far away from the third. That helps us build our brand awareness, it helps us operationally, leveraging in markets.

So putting clinics in adjacent trade areas is really fundamentally important for us. And that income range matters. We talked about being between $50,000 and $100,000. We'll go above and beyond that or below that. We'll go into $40,000 income ranges or $125,000 income ranges if other characteristics apply. There's enough density to support a clinic or the kinds of centers that can draw enough people to us, we'll consider them. So the income range is not static. We can be very fluid in that income range. And still, that's most of the people in the United States.

These are our location-specific learnings for our site selection. A daytime workforce population helps. Our intake form people indicate where they live, so that's more of a residential approach to real estate. So we don't really know the impact of an all-workforce clinic where we have a lot of daytime work

population, we do see in those clusters, that master of patients of much more far-flung trade area because people are coming during the day to go to us, to visit us during the workday. But we don't know what it's all about in just an all-workforce and no residential population.

Convenience is the most important thing for us really. We want to be a part of the patient's daily activity space. And our mission says routine and affordable chiropractic care. We – the routine part of it is part of the real estate function. We want to be in the routine you're already on. We want to be in the places you're going to already: in the grocery centers, where you get your haircut, where the nail salon is, where you go for lunch. We want to be in those centers where you're already at.

We don't want to make it a different trip. We want to be just five minutes of your daily trip, which you're already taking. That's the kind of center we want to be in. So we want to be in those centers where the people appear the most often. Sometimes, you see a center that has a lot of people in it, but they're only going once a quarter, once a month. We want to be in those centers that people are going to twice a week, three times a week, every day for your coffee, for your lunch, those are the centers we want to be in as part of your daily routine. So we want to be in your routine space.

And we want to be best-in-class site characteristics. We want to be visible and accessible. Our clinic storefronts are 15 to 20 feet. We don't have a lot of space in our clinic storefront. It's our most important marketing tool, most important brand building tool that we have. So we want to be in a place that's visible and accessible. A lot of franchisees tell me what's the magic formula, and I say being visible and accessible to lots of your customers. There's not a scientific formula that can really get that really easily, but that's what we need, being visible and accessible to our patients.

We want to be in those centers that have daily drivers, things like top-tier grocers, multiple restaurant options, health care, beauty tenants. We can be in a – if a center has some kind of a regional mini – mid-box tenants, things like a Ross or Marshalls or it's a HomeGoods that people like to go more than once a week, more than once a month, we can be in those kind of centers as well but still visible and accessible. So we want to have smart growth as well. We just don't want to put 17 clinics out – 1,700 clinics or 1,000 clinics just for the sake of having 1,000 clinics or 1,700, we want all of them to be profitable.

And our franchisees sometimes get nervous. If one is located kind of close to where they are, they feel very protective of their space. So since I joined The Joint, I've been tracking all our clinics that locate within five miles of an existing clinic. Right now, we have 62 openings since the beginning of January 15, and what I'm trying to calculate and capture is the behavior of how patients move from one clinic to another. And it's far less in The Joint than other forms of retail. People – the patients that we have become emotionally attached to their doctors, then they're loyal to that doctor.

As opposed to, say, buying lumber or dog food, people don't have the same attachments to that provider. So people are willing to drive past one clinic to go to that patient, to go to that doctor that they trust. So we see far less patient interaction, patient movement than other traditional retail. But I track 62 cases, and we still have to keep track. Every month I'll keep adding to that. Our average revenue increase in the existing clinic has been 13% over the previous six months. That's because that clustering helps build brand awareness and because the franchisee, if they open both, can leverage marketing and leverage operations as well. And the new clinics that opened are 50% above historical ramps because they're entering a market that already has some existing brand awareness.

So we want to have smart growth, and this is how we capture that with our encroachment policy to ensure that franchisees maintain their existing patient base. We have a site acceptance committee, sometimes called a real estate committee. We try to meet weekly to review and evaluate new sites for clinic development. A lot of retailers meet once a month for a real estate committee. We try to meet once a week, and that is so that we can get that engine moving faster and get clinics to open faster. More clinics open faster by meeting more often.

The site committee is made up of senior team members. So we provide due diligence from multiple frameworks. We get inputs from marketing and operations and their experience. And the purpose is to accelerate that clinic opening process. That regional developer in their territory really is – plays a crucial role because I can't get out to look at every site so that regional developer has to be our eyes and ears on the ground because they want to open strong, successful clinics as well. So they are – I train them in what to look for, and they're out looking for us.

And the result since we established our site acceptance committee, 88% of the clinics we evaluate are above average. So we've had great strides in marketing and in operations. But the real estate, the due diligence that we apply through the site committee has helped build a brand as well. And the new clinics that we open are 104% above historical ramps, so that 88% means – of the universe of clinics that we've opened, 88% are above historical ramp, and what they average is 104% better than historical averages.

So we eventually – we are beginning to get into new markets. We've seen our universe kind of expand. Our typical suburban shopping center is moving in both directions on the urban hierarchy into small markets. We have seen some recent openings in small markets that are in the orbit of larger cities but sort of at a distance, and we've seen some successful smart markets opening. And that gives us great encouragement as to where we can go in the future. We're also looking at a more urban focus. And what we're seeing in every city in the United States is that people are moving back to cities.

The move from suburb to suburbs that began 60 years ago is now going back particularly amongst younger generations. Millennials love to live in cities. They are great patients of ours. So they're living in cities, and we're going to have move back into the – we're going to have to find those cities. But those cities don't have a lot of traditional daily-use, automobile-focused shopping centers. So as time develops, we're going to have to move into those markets as well. And we're looking at non-traditional airports, dual concepts and university locations as well.

We have another growth source, and that's infill. We've seen recently, beginning in the fall, two clinics that were doing really well, two of our top 10 clinics really said, we're doing so well, we can't handle how great we're being right now. So they had to – they opened in non-adjacent trade areas. They weren't clustering by moving into the next trade area over. They open the second clinic in the same trade area where we already had the strength. These two clinics, both of them opened around September or October of last year. Six months later, they're doing 38% better in the market. So they've gone from two clinics to four clinics and, in six months, we've added 38% to the overall marketing.

So we think this can happen in many, many more of our best markets. This top – for instance, our top 50 clinics are now 87% above the chain average, and they're comping at 24%. So at some point, we should think about what our strategy might be into developing an infill characteristic for development. So our

takeaways for today are that our core customers come from a broad spectrum of the U.S. population, and that gives us the ability to go into a wide variety of markets.

Our sales forecasting tool and our build-out potential is based on reliable and proprietary analytics. Our current database has 400 predictive variables and our model and data is used throughout the business. Our operators, and our marketing team and our finance teams uses that same data structure that we've created. And we want to optimize the growth based on expanding brand and industry awareness. Our patients tell us who they are, they do a great job of telling us who they are, and we just want to find more people exactly like them because they've told us who they are. Al right, any questions?

<Q>: [Question Inaudible]

<A – Eric Simon>: I was prepared to repeat the question. What are the common things that the top-50 clinics share, that you think might be driving that big outperformance versus the average unit volume?

<A – Richard Matthews>: That's a good question. I think it's dense population and maybe a skewing towards a younger work – a younger population. So – and we tend to be – most of our clinics are in Sun Belt cities we started there, that are older for us so we've had time to build that brand awareness. But density and a little – and a shift towards that younger population.

<Q>: How are you seeing the earnings or property earnings give you either more incentives or fill you into Tier 1 to Tier 3 kind of locations? How has that changed over the past few years?

<A – Richard Matthews>: Well, commercial real estate is really competitive now. There's a theme that's out there, that's we're over retailed. And I'm in a group that advises the International Council of Shopping Centers, accompanied – among the North American Research task force and the ICSC, the International Council of Shopping Centers is sort of the shopping center lobbying group has – is constantly worried about that message that we're overbuilt. Not a lot of retailers – new centers are being built now. So we're competitive for these new kinds – for the small-box space in good centers, we're not the only one looking for them.

We are desirable for owners of space, for landlords and developers because we have a very easy buildout. We don't take up a lot of space. We turn over in parking very quickly. So landlords like us now. Five years ago, we weren't all that – the service sector, which has a different tax for a lot of municipalities, is different than retail. So we have shifted from being sort of a questionable tenant to really a desirable tenant now.

<Q>: Do you find that your store footprint, while I know it's attractive from a small size perspective, but do you think it is big enough and attractive enough to really drive patient traffic over time in that key variable of, sort of, awareness and visibility?

<A – Richard Matthews>: Yes. If you take an idea that you get large, it should get larger and larger. And this is some of the big box retail stuff. If you get larger, then let's build a 100,000 foot box somewhere because we could put more items on the shelf as opposed to 3,000-foot items, and you see some retailers like tenant – like target for instance, got bigger and bigger and bigger, 100,000 feet, 125,000 feet, and now the targets are opening 10,000-foot stores.

So the rent structure for us then going from 1,000 feet to 2,000 feet gets a little – we prefer that 1,000-foot box. And if we have to – we have some clinics that are 1,800 feet, 2,000 feet but they don't do the size of the box doesn't do – isn't a variable that is a good predictor of sales unlike a – the number of a retailer that can put more product on the shelf. So just this becomes – we're not – we're getting less return on that investment. So we really have to have good visibility and accessibility of that 15 feet. That 15 feet to 20 feet has to be in the line of sight when you come in that center. We don't like being around the corner in the elbow of places. So while 15 feet doesn't give us a lot of flexibility, we really want to be in those. We really have – we have to maximize that visibility and accessibility.

<Q>: It's terrific that you have embraced the clustering strategy. Just wondering what it looks like, I guess what the metrics will look like, when you go into a more virgin market? And then also, if you could just touch on the traffic stats for the type of centers that you typically go in to?

<A – Richard Matthews>: Yes. The second question first. If we get average daily traffic counts are, sort of, divider between weak and strong, is 20,000. So if you're below 20,000, that's – we're going to need some extra incentive. But 20,000 is the sort of the key that we're looking for there. We've seen some good openings, some strong openings in newer territories in the past 1.5 years or so. So I have every confidence that, that cluster – that clustering is going to just add onto that.

So our – sort of our marketing tool or marketing team has helped get that initial up – that initial sales up in those new territories. And then when we cluster, it's going to be an exponential effect. Yes, the ramp – our ramp in new territories is really strong as well now.

<Q>: I was curious just may be a history lesson on the initial corporate buildout in Illinois and New York that was unsuccessful. What were some of the characteristics of that lack of success and what are some of the learnings on that front?

<A – Richard Matthews>: Do you want to handle that?

<A – Peter Holt>: The short answer is, I think it was – Chicago was an amazing market. We opened up those 11 clinics in a relatively short period of time, and that was just the time when we got over our scheme. And that was the time when our breakeven was running between 18 and 24 months. That wasn't what was expected. And so as those clinics were underperforming and putting financial pressure on the company, that's when I was coming on board and looking at it, okay, that's underperforming, that's why it was bought in the first place.

And so what's the most effective way to deal with this? And that – the sizes were all okay, they – yes, some could be better than others, but there was reasonable size, it was an amazing market. Illinois is an absolutely chiropractic market. And I would say the issue with Chicago more than anything else was our former management did a great job of opening up very quickly about 61 corporate clinics, half built, half bought. And we weren't putting enough time on the operations side of it, which was putting that financial pressure on.

And then we now have our deal in the Chicago market, they took six of those 11 clinics. They have been turning it around and being successful. There's still room to improve, of course, but it's not a Chicago

market. I really think it was, more than anything else, it wasn't a site issue, it's probably more than anything else, it was the over site that we had put in place to support those brand-new clinics in a brand-new market, where we opened them up in the middle of the winter without a marketing campaign behind it.

You're going to hear from Jorge Armenteros, our VP of Operations, who really came in, completely restructured our oversights and support of the clinics, and you'll see the – and you've seen the results every quarter about the impact that's had on overseeing the clinics.

Anything else? Okay, I think we're on time for a break and then lunch.