MEDICAL PROPERTIES TRUST INC
Form 10-K
March 31, 2006

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2005

or

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission file number 001-32559

Medical Properties Trust, Inc.
(Exact Name of Registrant as Specified in Its Charter)

Maryland	**20-0191742**
(State or Other Jurisdiction of Incorporation or Organization)	*(IRS Employer Identification No.)*
1000 Urban Center Drive, Suite 501 **Birmingham, AL** *(Address of Principal Executive Offices)*	**35242** *(Zip Code)*

(205) 969-3755
(Registrant s Telephone Number, Including Area Code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	**Name of Each Exchange on Which Registered**
Common Stock, par value $0.001 per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes o No þ

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes o No þ

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes þ No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of Registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment of this Form 10-K. o

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of accelerated filer and large accelerated filer in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer o Accelerated filer o Non-accelerated filer þ

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes o No þ

The aggregate market value of shares of the Registrant s common stock, par value $0.001 per share (Common Stock), held by non-affiliates of the Registrant as of March 24, 2006 was approximately $416,572,666. For purposes of the foregoing calculation only, all directors and executive officers of the Registrant have been deemed affiliates.

As of March 24, 2006, 40,055,064 shares of the Registrant s Common Stock were outstanding.

Portions of the Registrant s definitive Proxy Statement for the Annual Meeting of Stockholders to be held on May 18, 2006 are incorporated by reference into Part III, Items 10 through 14 of this Annual Report on Form 10-K.

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A WARNING ABOUT FORWARD LOOKING STATEMENTS

We make forward-looking statements in this Annual Report on Form 10-K that are subject to risks and uncertainties. These forward-looking statements include information about possible or assumed future results of our business, financial condition, liquidity, results of operations, plans and objectives. Statements regarding the following subjects, among others, are forward-looking by their nature:

- our business strategy;
- our projected operating results;
- our ability to acquire or develop net-leased facilities;
- availability of suitable facilities to acquire or develop;
- our ability to enter into, and the terms of, our prospective leases;
- our ability to use effectively the proceeds of our initial public offering;
- our ability to obtain future financing arrangements;
- estimates relating to, and our ability to pay, future distributions;
- our ability to compete in the marketplace;
- market trends;
- projected capital expenditures; and
- the impact of technology on our facilities, operations and business.

The forward-looking statements are based on our beliefs, assumptions and expectations of our future performance, taking into account all information currently available to us. These beliefs, assumptions and expectations can change as a result of many possible events or factors, not all of which are known to us. If a change occurs, our business, financial condition, liquidity and results of operations may vary materially from those expressed in our forward-looking statements. You should carefully consider these risks before you make an investment decision with respect to our common stock, along with, among others, the following factors that could cause actual results to vary from our forward-looking statements:

- the factors referenced in this Annual Report on Form 10-K, including those set forth under the sections captioned Risk Factors, Management s Discussion and Analysis of Financial Condition and Results of Operations; and Our Business .
- general volatility of the capital markets and the market price of our common stock;
- changes in our business strategy;
- changes in healthcare laws and regulations;

availability, terms and development of capital;

availability of qualified personnel;

changes in our industry, interest rates or the general economy; and

the degree and nature of our competition.

When we use the words believe, expect, may, potential, anticipate, estimate, plan, will, could, inter expressions, we are identifying forward-looking statements. You should not place undue reliance on these forward-looking statements. We are not obligated to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise.

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PART I

ITEM 1. *Business*

Overview

We are a self-advised real estate investment trust that acquires, develops, leases and makes other investments in healthcare facilities providing state-of-the-art healthcare services. We lease our facilities to healthcare operators pursuant to long-term net-leases, which require the tenant to bear most of the costs associated with the property. We also make long-term, interest only mortgage loans to healthcare operators, and from time to time, we also make operating, working capital and acquisition loans to our tenants.

We were formed as a Maryland corporation on August 27, 2003 to succeed to the business of Medical Properties Trust, LLC, a Delaware limited liability company, which was formed by one of our founders in December 2002. We conduct substantially all of our business through our wholly-owned subsidiaries, MPT Operating Partnership, L.P., MPT Development Services, Inc, and MPT Finance Company LLC. References in this Annual Report on Form 10-K to we, us, and our include Medical Properties Trust, Inc. and our wholly-owned subsidiaries.

In April 2004 we completed a private placement of 25,600,000 shares of common stock at an offering price of $10.00 per share. The total net proceeds to us, after deducting fees and expenses of the offering, were approximately $233.5 million. Until that time, our founders (Edward K. Aldag, Jr., William G. McKenzie, Emmett E. McLean and R. Steven Hamner) personally funded the cash requirements necessary to create a pipeline of potential acquisitions and to prepare MPT for its private offering. Between April 2004 and June 2005, we invested and committed to invest approximately $468 million in healthcare assets.

On July 13, 2005, we completed an initial public offering of 12,066,823 shares of common stock, priced at $10.50 per share. Of these shares of common stock, 701,823 shares were sold by selling stockholders (none of which were founders or officers of the Company) and 11,365,000 shares were sold by us. On August 5, 2005, the underwriters exercised an option to purchase an additional 1,810,023 shares of common stock to cover over-allotments. In total, we raised net proceeds of approximately $125.7 million pursuant to the offering after deducting the underwriting discount and offering expenses. As of December 31, 2005, we used net proceeds from the private and initial public offerings, together with borrowed funds, to invest and commit to invest a total of approximately $563 million in healthcare assets.

Our investment in healthcare real estate, including mortgage loans and other loans to certain of our tenants, is considered a single reportable segment as further discussed in our Consolidated Financial Statements, Note 2 Summary of Significant Accounting Policies, in Part II, Item 8 of this Annual Report on Form 10-K. All of our investments are located in the United States, and we do not expect to invest in non-U.S. markets in the foreseeable future.

Portfolio of Properties

As of December 31, 2005, we owned 14 facilities which were being operated by four tenants; we had three facilities that were under development and leased to three additional tenants; and we had a mortgage loan to another operator.

Outlook and Strategy

We believe that the United States healthcare delivery system is becoming decentralized and is evolving away from the traditional one stop, large-scale acute care hospital. We believe that these changes are the results of a number of trends, including increasing specialization and technological innovation and the desire of both physicians and patients to utilize more convenient facilities. We also believe that demographic trends in the United States, including in particular an aging population, will result in continued growth in the demand for healthcare services, which in turn will lead to an increasing need for a greater supply of modern healthcare facilities. In response to these trends, we believe that healthcare operators increasingly prefer to conserve their capital for investment in operations and new technologies rather than investing in real estate and, therefore, increasingly prefer to lease, rather than own, their facilities.

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Our strategy is to lease the facilities that we acquire or develop to experienced healthcare operators pursuant to long-term net-leases. Alternatively, we have structured certain of our investments as long-term, interest only mortgage loans to healthcare operators, and we may make similar investments in the future. The market for healthcare real estate is extensive and includes real estate owned by a variety of healthcare operators. We focus on acquiring and developing those net-leased facilities that are specifically designed to reflect the latest trends in healthcare delivery methods. These facilities include:

Rehabilitation Hospitals: Rehabilitation hospitals provide inpatient and outpatient rehabilitation services for patients recovering from multiple traumatic injuries, organ transplants, amputations, cardiovascular surgery, strokes, and complex neurological, orthopedic, and other conditions. In addition to Medicare certified rehabilitation beds, rehabilitation hospitals may also operate Medicare certified skilled nursing, psychiatric, long-term, or acute care beds. These hospitals are often the best medical alternative to traditional acute care hospitals where under the Medicare prospective payment system there is pressure to discharge patients after relatively short stays.

Long-Term Acute Care Hospitals: Long-term acute care hospitals focus on extended hospital care, generally at least 25 days, for the medically-complex patient. Long-term acute care hospitals have arisen from a need to provide care to patients in acute care settings, including daily physician observation and treatment, before they are able to move to a rehabilitation hospital or return home. These facilities are reimbursed in a manner more appropriate for a longer length of stay than is typical for an acute care hospital.

Regional and Community Hospitals: We define regional and community hospitals as general medical/surgical hospitals whose practicing physicians generally serve a market specific area, whether urban, suburban or rural. We intend to limit our ownership of these facilities to those with market, ownership, competitive and technological characteristics that provide barriers to entry for potential competitors.

Women s and Children s Hospitals: These hospitals serve the specialized areas of obstetrics and gynecology, other women s healthcare needs, neonatology and pediatrics. We anticipate substantial development of facilities designed to meet the needs of women and children and their physicians as a result of the decentralization and specialization trends described above.

Ambulatory Surgery Centers: Ambulatory surgery centers are freestanding facilities designed to allow patients to have outpatient surgery, spend a short time recovering at the center, then return home to complete their recoveries. Ambulatory surgery centers offer a lower cost alternative to general hospitals for many surgical procedures in an environment that is more convenient for both patients and physicians. Outpatient procedures commonly performed include those related to gastrointestinal, general surgery, plastic surgery, ear, nose and throat/audiology, as well as orthopedics and sports medicine.

Other Single-Discipline Facilities: The decentralization and specialization trends in the healthcare industry are also creating demands and opportunities for physicians to practice in hospital facilities in which the design, layout and medical equipment are specifically developed, and healthcare professional staff are educated, for medical specialties. These facilities include heart hospitals, ophthalmology centers, orthopedic hospitals and cancer centers.

Medical Office Buildings: Medical office buildings are office and clinic facilities occupied and used by physicians and other healthcare providers in the provision of outpatient healthcare services to their patients. The medical office buildings that we target generally are or will be master-leased and adjacent to or integrated with our other targeted healthcare facilities.

Skilled Nursing Facilities: Skilled nursing facilities are healthcare facilities that generally provide more comprehensive services than assisted living or residential care homes. They are primarily engaged in providing skilled nursing care for patients who require medical or nursing care or rehabilitation services. Typically these services involve managing complex and serious medical problems such as wound care, coma care or intravenous therapy. They offer both short and long-term care options for patients with serious illness and medical conditions. Skilled nursing facilities also provide rehabilitation services that are typically utilized on a short-term basis after hospitalization for injury or illness.

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Our Leases

The leases for our facilities are net leases with terms requiring the tenant to pay all ongoing operating and maintenance expenses of the facility, including property, casualty, general liability and other insurance coverages, utilities and other charges incurred in the operation of the facilities, as well as real estate taxes, ground lease rent and the costs of capital expenditures, repairs and maintenance. Our leases also provide that our tenants will indemnify us for environmental liabilities. Our current leases range from 10 to 15 years and provide for annual rent escalation and, in some cases percentage rent.

Significant Tenants

We have leases with seven hospital operating companies (including the three properties currently under development) covering 17 facilities and we have one mortgage loan to another hospital operating company. Vibra Healthcare, LLC (Vibra) has leases on seven of our facilities that represent 50% of the original total cost of our operating facilities and mortgage loan as of December 31, 2005. Total revenue from Vibra in 2005, including rent, percentage rent and interest on our acquisition loan to Vibra was approximately $26.2 million, or 83% of total revenue in 2005. We expect that the percentage of revenue we earn from Vibra in 2006 will be substantially less than that in 2005 because we expect Vibra s interest and percentage rent to decline as the acquisition loan is repaid and because our recent and anticipated near-term future acquisitions and investments do not include transactions with Vibra.

Notwithstanding our plans to reduce the percentage of our revenue earned from Vibra, its financial performance and resulting ability to satisfy its lease and loan obligations to us are material to our financial results and our ability to service our debt and make distributions to our stockholders. We discuss the risks related to our Vibra relationship in Item 1.A of this Annual Report on Form 10-K Risk Factors.

Environmental Matters

Under various federal, state and local environmental laws and regulations, a current or previous owner, operator or tenant of real estate may be required to investigate and clean up hazardous or toxic substances or petroleum product releases or threats of releases at such property and may be held liable to a government entity or to third parties for property damage and for investigation, clean-up and monitoring costs incurred by such parties in connection with the actual or threatened contamination, including substances currently unknown, that may have been released on the real estate. These laws may impose clean-up responsibility and liability without regard to fault, or whether or not the owner, operator or tenant knew of or caused the presence of the contamination. The liability under these laws may be joint and several for the full amount of the investigation, clean-up and monitoring costs incurred or to be incurred or actions to be undertaken, although a party held jointly and severally liable might be able to obtain contributions from other identified, solvent, responsible parties of their fair share toward these costs. Investigation, clean-up and monitoring costs may be substantial and can exceed the value of the property. The presence of contamination, or the failure to properly remediate contamination, on a property may adversely affect the ability of the owner, operator or tenant to sell or rent that property or to borrow funds using such property as collateral and may adversely impact our investment in that property. In addition, if hazardous substances are located on or released from our properties, we could incur substantial liabilities through a private party personal injury claim, a property damage claim by an adjacent property owner, or claims by a governmental entity or others for other damages, such as natural resource damages. This liability may be imposed under environmental laws or common-law principles.

Federal regulations require building owners and those exercising control over a building s management to identify and warn, via signs and labels, of potential hazards posed by workplace exposure to installed asbestos-containing materials and potentially asbestos-containing materials in their building. The regulations also set forth employee training, record

keeping and due diligence requirements pertaining to asbestos-containing materials and potentially asbestos-containing materials. Government entities can assess significant fines for violation of these regulations. Building owners and those exercising control over a building s management may be subject to an increased risk of personal injury lawsuits by workers and others exposed to asbestos-containing materials and potentially asbestos-containing materials as a result of these regulations. The regulations may affect the value of a

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building containing asbestos-containing materials and potentially asbestos-containing materials in which we have invested. Federal, state and local laws and regulations also govern the removal, encapsulation, disturbance, handling and disposal of asbestos-containing materials and potentially asbestos-containing materials when such materials are in poor condition or in the event of construction, remodeling, renovation or demolition of a building. Such laws and regulations may impose liability for improper handling or a release to the environment of asbestos-containing materials and potentially asbestos-containing materials and may provide for fines to, and for third parties to seek recovery from, owners or operators of real property for personal injury or improper work exposure associated with asbestos-containing materials and potentially asbestos-containing materials.

Prior to closing any facility acquisition, we obtain Phase I environmental assessments in order to attempt to identify potential environmental concerns at the facilities. These assessments are carried out in accordance with an appropriate level of due diligence and generally include a physical site inspection, a review of relevant federal, state and local environmental and health agency database records, one or more interviews with appropriate site-related personnel, review of the property s chain of title and review of historic aerial photographs and other information on past uses of the property. We may also conduct limited subsurface investigations and test for substances of concern where the results of the Phase I environmental assessments or other information indicates possible contamination or where our consultants recommend such procedures.

While we may purchase many of our facilities on an as is basis, we intend for all of our purchase contracts to contain an environmental contingency clause, which permits us to reject a facility because of any environmental hazard at the facility.

Competition

We compete in acquiring and developing facilities with financial institutions, institutional pension funds, real estate developers, other REITs, other public and private real estate companies and private real estate investors. Among the factors adversely affecting our ability to compete are the following:

- we may have less knowledge than our competitors of certain markets in which we seek to purchase or develop facilities;
- many of our competitors have greater financial and operational resources than we have; and
- our competitors or other entities may determine to pursue a strategy similar to ours.

To the extent that we experience vacancies in our facilities, we will also face competition in leasing those facilities to prospective tenants. The actual competition for tenants varies depending on the characteristics of each local market. Virtually all of our facilities operate in a competitive environment, and patients and referral sources, including physicians, may change their preferences for a healthcare facilities from time to time.

Healthcare Regulatory Matters

The following discussion describes certain material federal healthcare laws and regulations that may affect our operations and those of our tenants. However, the discussion does not address state healthcare laws and regulations, except as otherwise indicated. These state laws and regulations, like the federal healthcare laws and regulations, could affect our operations and those of our tenants. Moreover, the discussion relating to reimbursement for healthcare services addresses matters that are subject to frequent review and revision by Congress and the agencies responsible for administering federal payment programs. Consequently, predicting future reimbursement trends or changes is inherently difficult.

Ownership and operation of hospitals and other healthcare facilities are subject, directly and indirectly, to substantial federal, state and local government healthcare laws and regulations. Our tenants failure to comply with these laws and regulations could adversely affect their ability to meet their lease obligations. Physician investment in us or in our facilities also will be subject to such laws and regulations. We intend for all of our business activities and operations to conform in all material respects with all applicable laws and regulations.

Anti-Kickback Statute. 42 U.S.C. §1320a-7b(b), or the Anti-Kickback Statute, prohibits, among other things, the offer, payment, solicitation or acceptance of remuneration directly or indirectly in return for referring an

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individual to a provider of services for which payment may be made in whole or in part under a federal healthcare program, including the Medicare or Medicaid programs. Violation of the Anti-Kickback Statute is a crime and is punishable by criminal fines of up to $25,000 per violation, five years imprisonment or both. Violations may also result in civil sanctions, including civil penalties of up to $50,000 per violation, exclusion from participation in federal healthcare programs, including Medicare and Medicaid, and additional monetary penalties in amounts treble to the underlying remuneration.

The Anti-Kickback Statute defines the term remuneration very broadly and, accordingly, local physician investment in our facilities could trigger scrutiny of our lease arrangements under the Anti-Kickback Statute. In addition to certain statutory exceptions, the Office of Inspector General of the Department of Health and Human Services, or OIG, has issued Safe Harbor Regulations that describe practices that will not be considered violations of the Anti-Kickback Statute. These include a safe harbor for space rental arrangements which protects payments made by a tenant to a landlord under a lease arrangement meeting certain conditions. We intend to use our commercially reasonable efforts to structure lease arrangements involving facilities in which local physicians are investors and tenants so as to satisfy, or meet as closely as possible, the conditions for the safe harbor for space rental. We cannot assure you, however, that we will meet all the conditions for the safe harbor, and it is unlikely that we will meet all conditions for the safe harbor in those instances in which percentage rent is contemplated and we have physician investors. In addition, federal regulations require that our tenants with purchase options pay fair market value purchase prices for facilities in which we have physician investment. We intend our lease agreement purchase option prices to be fair market value; however, we cannot assure you that all of our purchase options will be at fair market value. Any purchase not at fair market value may present risks of challenge from healthcare regulatory authorities. The fact that a particular arrangement does not fall within a statutory exception or safe harbor does not mean that the arrangement violates the Anti-Kickback Statute. The statutory exception and Safe Harbor Regulations simply provide a guaranty that qualifying arrangements will not be prosecuted under the Anti-Kickback Statute. The implication of the Anti-Kickback Statute could limit our ability to include local physicians as investors or tenants or restrict the types of leases into which we may enter if we wish to include such physicians as investors having direct or indirect ownership interests in our facilities.

Federal Physician Self-Referral Statute. Any physicians investing in our company or its subsidiary entities could also be subject to the Ethics in Patient Referrals Act of 1989, or the Stark Law (codified at 42 U.S.C. §1395nn). Unless subject to an exception, the Stark Law prohibits a physician from making a referral to an entity furnishing designated health services paid by Medicare or Medicaid if the physician or a member of his immediate family has a financial relationship with that entity. A reciprocal prohibition bars the entity from billing Medicare or Medicaid for any services furnished pursuant to a prohibited referral. Financial relationships are defined very broadly to include relationships between a physician and an entity in which the physician or the physician s family member has (i) a direct or indirect ownership or investment interest that exists in the entity through equity, debt or other means and includes an interest in an entity that holds a direct or indirect ownership or investment interest in any entity providing designated health services; or (ii) a direct or indirect compensation arrangement with the entity.

The Stark Law as originally enacted in 1989 only applied to referrals for clinical laboratory tests reimbursable by Medicare. However, the law was amended in 1993 and 1994 and, effective January 1, 1995, became applicable to referrals for an expanded list of designated health services reimbursable under Medicare or Medicaid.

The Stark Law specifies a number of substantial sanctions that may be imposed upon violators. Payment is to be denied for Medicare claims related to designated health services referred in violation of the Stark Law. Further, any amounts collected from individual patients or third-party payors for such designated health services must be refunded on a timely basis. A person who presents or causes to be presented a claim to the Medicare program in violation of the Stark Law is also subject to civil monetary penalties of up to $15,000 per claim, civil money penalties of up to $100,000 per arrangement and possibly even exclusion from participation in the Medicare and Medicaid programs.

Final regulations applicable only to physician referrals for clinical laboratory services were published in August 1995. A proposed rule applicable to physician referrals for all designated health services was published in January 1998. In January 2001, CMS published the Phase I final rule, which finalized a significant portion of the 1998 proposed rule. On March 26, 2004, CMS issued the second phase of its final regulations addressing physician

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referrals to entities with which they have a financial relationship (the Phase II rule). The Phase II rule addresses and interprets a number of exceptions for ownership and compensation arrangements involving physicians, including the exceptions for space and equipment rentals and the exception for indirect compensation arrangements. The Phase II rule also includes exceptions for physician ownership and investment, including physician ownership of rural providers and hospitals. The new regulation revised the hospital ownership exception to reflect the 18-month moratorium that began December 8, 2003 on physician ownership or investment in specialty hospitals, which was enacted in Section 507 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The Phase II rule became effective on July 26, 2004. The moratorium imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 expired on June 8, 2005. However, that moratorium was retroactively extended by the passage of the Deficit Reduction Act of 2005 (the DRA) which requires the Secretary of Health and Human Services to develop a strategic and implementing plan for physician investment in specialty hospitals that addresses the issues of proportionality of investment return, bona fide investment, annual disclosure of investments, and the provision of medical assistance (Medicaid) and charity care. The report is due six months after the date of enactment, but this deadline may be extended by two months. The DRA also directs CMS to continue the moratorium on enrollment of specialty hospitals until the earlier of the date the report is submitted or six months after enactment of the DRA.

In those cases where physicians invest in our subsidiaries or our facilities, we intend to fashion our lease arrangements with healthcare providers to meet the applicable indirect compensation exceptions under the Stark Law, however, no assurance can be given that our leases will satisfy these Stark Law exception requirements. Unlike the Anti-Kickback Statute Safe Harbor Regulations, a financial arrangement which implicates the Stark Law must meet the requirements of an applicable exception to avoid a violation of the Stark Law. This may lead to obstacles in permitting local physicians to invest in our facilities or restrict the types of lease arrangements we may enter into if we wish to include such physicians as investors.

State Self-Referral Laws. In addition to the Anti-Kickback Statute and the Stark Law, state anti-kickback and self-referral laws could limit physician ownership or investment in us, restrict the types of leases we may enter into if such physician investment is permitted or require physician disclosure of our ownership or financial interest to patients prior to referrals.

Recent Regulatory and Legislative Developments. The DRA was signed by President Bush on February 8, 2006, and is expected to reduce Medicare spending by $6.0 billion over the next five years and cut Medicaid spending by $5.0 billion over the same time frame. A clerical error during the legislative process, however, raises some concerns over the validity of the DRA because the United States House of Representatives never voted on the version approved by the Senate and ultimately signed by the President. Legal challenges may arise as a result of this technicality, challenging the DRA. Nonetheless, CMS has already begun implementing portions of the DRA. Medicare Part A pays for hospital inpatient operating and capital related costs associated with acute care hospital inpatient stays on a prospective basis. Pursuant to this inpatient prospective payment system, or IPPS, CMS categorizes each patient case according to a list of diagnosis-related groups, or DRGs. Each DRG has an assigned payment that is based upon the expected amount of hospital resources necessary to treat a patient in that DRG. On August 12, 2005, CMS published a Final Rule for IPPS for fiscal year 2006. The Final Rule includes a 3.7% increase in payment rates, a number of changes to the DRGs and enhancements to the voluntary quality reporting program. Hospitals are required to submit certain clinical data on ten quality measures in order to receive full payment for fiscal year 2006. CMS expects aggregate payments to IPPS hospitals to increase by $3.3 billion over the previous year.

On August 1, 2003, CMS published the fiscal year 2004 Final Rule for inpatient rehabilitation facilities, or IRFs. Under the Final Rule, all IRFs have received an increase in their prospective payment system rate for fiscal year 2004 due to an across the board 3.2% IRF market basket increase. On August 15, 2005, CMS published the fiscal year 2006 Final Rule for inpatient rehabilitation facilities, or IRFs. The Final Rule adopts a number of refinements to the IRF

prospective payment system, including an across-the-board 1.9% decrease in the standard payment amount based on evidence that coding increases instead of increases in patient acuity have led to increased payments to IRFs. The Final Rule also includes a 3.6% market basket increase and increases from 19.1% to 21.3% the payment rate adjustment for IRFs located in rural areas. Further, the Final Rule reduces the outlier threshold for cases with unusually high costs from $11,211 to $5,132. In addition, the Final Rule contains policy changes

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including the adoption of new labor market area definitions which are based on the new Core Based Statistical Areas announced by the Office of Management and Budget, or OMB, late in 2000. These increases are expected to benefit those tenants of ours who operate IRFs. These increases benefit those tenants of ours who operate IRFs.

On May 7, 2004, CMS issued a Final Rule to revise the classification criterion, commonly known as the 75 percent rule, used to classify a hospital or hospital unit as an IRF. The compliance threshold is used to distinguish an IRF from an acute care hospital for purposes of payment under the Medicare IRF prospective payment system. The Final Rule implements a three-year period to analyze claims and patient assessment data to determine whether CMS will continue to use a compliance threshold that is lower than 75% or not. For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the compliance threshold will be 50% of the IRF s total patient population. The compliance threshold will increase to 60% of the IRF s total patient population for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2006, to 65% for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007, and to 75% for cost reporting periods after July 1, 2007. The Deficit Reduction Act of 2005 extends the phase-in period of the 75 percent rule for one additional year. The 60% threshold remains in effect until June 30, 2007. In fiscal year 2007, the threshold is 65% and beginning in fiscal year 2008, the threshold is 75%.

On December 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or the Act, which contains sweeping changes to the federal health insurance program for the elderly and disabled. The Act includes provisions affecting program payment for inpatient and outpatient hospital services. In total, the Congressional Budget Office estimates that hospitals will receive $24.8 billion over ten years in additional funding due to the Act.

Rural hospitals, which may include regional or community hospitals, one of our targeted types of facilities, will benefit most from the reimbursement changes in the Act. Some examples of these reimbursement changes include (i) providing that payment for all hospitals, regardless of geographic location, will be based on the same, higher standardized amount which was previously available only for hospitals located in large urban areas, (ii) reducing the labor share of the standardized amount from 71% to 62% for hospitals with an applicable wage index of less than 1.0, (iii) giving hospitals the ability to seek a higher wage index based on the number of hospital employees who take employment out of the county in which the hospital is located with an employer in a neighboring county with a higher wage index, and (iv) improving critical access hospital program conditions of participation requirements and reimbursement. Medicare disproportionate share hospital, or DSH, payment adjustments for hospitals that are not large urban or large rural hospitals will be calculated using the DSH formula for large urban hospitals, up to a 12% cap in 2004 for all hospitals other than rural referral centers, which are not subject to the cap. The Act provides that sole community hospitals, as defined in 42 U.S.C. § 1395 ww(d)(5)(D)(iii), located in rural areas, rural hospitals with 100 or fewer beds, and certain cancer and children s hospitals shall receive Transitional Outpatient Payments, or TOPs, such that these facilities will be paid as much under the Medicare outpatient prospective payment system, or OPPS, as they were paid prior to implementation of OPPS. As of January 1, 2004 all TOPs for community mental health centers and all other hospitals were otherwise discontinued. The hold harmless TOPs provided for under the Act will continue for qualifying rural hospitals for services furnished through December 31, 2005 and for sole community hospitals for cost reporting periods beginning on or after January 1, 2004 and ending on December 31, 2005. Hold harmless TOPs payments continue permanently for cancer and children s hospitals.

The Act also requires CMS to provide supplemental payments to acute care hospitals that are located more than 25 road miles from another acute care hospital and have low inpatient volumes, defined to include fewer than 800 discharges per fiscal year, effective on or after October 1, 2004. Total supplemental payments may not exceed 25% of the otherwise applicable prospective payment rate.

Finally, the Act assures inpatient hospitals that submit certain quality measure data a full inflation update equal to the hospital market basket percentage increase for fiscal years 2005 through 2007. The market basket percentage increase

refers to the anticipated rate of inflation for goods and services used by hospitals in providing services to Medicare patients. For fiscal year 2005, the market basket percentage increase for hospitals paid under the inpatient prospective payment system is 3.3%. For those inpatient hospitals that do not submit such quality data, the Act provides for an update of market basket minus 0.4 percentage points. The DRA expands the provision of the Act

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tying inpatient reimbursement to hospitals reporting on certain quality measures. Hospitals not submitting the data will not receive the full market basket update. The DRA requires the Secretary of Health and Human Services to add other quality measures to be reported on by hospitals. Beginning in fiscal year 2007, the market basket updates for hospitals that fail to provide the quality data will be reduced by 2%.

The Act also imposed an 18 month moratorium limiting the availability of the whole hospital exception, or Whole Hospital Exception, under the Stark Law for specialty hospitals and prohibited physicians investing in rural specialty hospitals from invoking an alternative Stark Law exception for physician ownership or investment in rural providers. The moratorium began upon enactment of the Act and expired June 8, 2005. Under the Whole Hospital Exception, the Stark Law permits a physician to refer a Medicare or Medicaid patient to a hospital in which the physician has an ownership or investment interest so long as the physician maintains staff privileges at the hospital and the physician s ownership or investment interest is in the hospital as a whole, rather than a subdivision of the facility. Following expiration of the moratorium, CMS issued a statement that it will not issue provider agreements for new specialty hospitals or authorize initial state surveys of new specialty hospitals while it undertakes a review of its procedures for enrolling such facilities in the Medicare program. CMS anticipates completing this review by January 2006. The suspension on enrollment does not apply to specialty hospitals that submitted enrollment applications prior to June 9, 2005 or requested an advisory opinion about the applicability of the moratorium.

The moratorium imposed by the Act expired on June 8, 2005. However, that moratorium was retroactively extended by the passage of the DRA which requires the Secretary of Health and Human Services to develop a strategic and implementing plan for physician investment in specialty hospitals that addresses the issues of proportionality of investment return, bona fide investment, annual disclosure of investments, and the provision of medical assistance (Medicaid) and charity care. The report is due six months after the date of enactment, but this deadline may be extended by two months. The DRA also directs CMS to continue the moratorium on enrollment of specialty hospitals until the earlier of the date the report is submitted or six months after enactment of the DRA.

Any acquisition or development of specialty hospitals must comply with the current application and interpretation of the Stark Law. CMS may clarify or modify its definition of specialty hospital, which may result in physicians who own interests in our tenants being forced to divest their ownership or the enrollment of the hospital for participation in the Medicare Program may be delayed. Although the specialty hospital moratorium under the Act limited, and the proposed Budget Reconciliation Conference Agreement would have limited physician ownership or investment in specialty hospitals as defined by CMS, they do not limit a physician s ability to hold an ownership or investment interest in facilities which may be leased to hospital operators or other healthcare providers, assuming the lease arrangement conforms to the requirements of an applicable exception under the Stark Law. We intend to structure all of our leases, including leases containing percentage rent arrangements, to comply with applicable exceptions under the Stark Law and to comply with the Anti-Kickback Statute. We believe that strong arguments can be made that percentage rent arrangements, when structured properly, should be permissible under the Stark Law and the Anti-Kickback Statute; however, these laws are subject to continued regulatory interpretation and there can be no assurance that such arrangements will continue to be permissible. Accordingly, although we do not currently have any percentage rent arrangements where physicians own an interest in our facilities, we may be prohibited from entering into percentage rent arrangements in the future where physicians own an interest in our facilities. In the event we enter into such arrangements at some point in the future and later find the arrangements no longer comply with the Stark Law or Anti-Kickback Statute, we or our tenants may be subject to penalties under the statutes.

The California Department of Health Services recently adopted regulations, codified as Sections 70217, 70225 and 70455 of Title 22 of the California Code of Regulations, or CCR, which establish minimum, specific, numerical licensed nurse-to-patient ratios for specified units of general acute care hospitals. These regulations are effective January 1, 2004. The minimum staffing ratios set forth in 22 CCR 70217(a) co-exist with existing regulations requiring that hospitals have a patient classification system in place. 22 CCR, 70053.2 and 70217. The licensed

nurse-to-patient ratios constitute the minimum number of registered nurses, licensed vocational nurses, and, in the case of psychiatric units, licensed psychiatric technicians, who shall be assigned to direct patient care and represent the maximum number of patients that can be assigned to one licensed nurse at any one time. Over the past several years many hospitals have, in response to managed care reimbursement contracts, cut costs by reducing their licensed nursing staff. The California Legislature responded to this trend by requiring a minimum number of

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licensed nurses at the bedside. Due to this new regulatory requirement, any acute care facilities we target for acquisition or development in California may be required to increase their licensed nursing staff or decrease their admittance rates as a result. Governor Schwarzenegger issued two emergency regulations in an attempt to suspend the ratios in emergency rooms and delay for three years staffing requirements in general medical units. However, this action was appealed and on June 7, 2005, the Superior Court overturned the two emergency regulations. The Schwarzenegger administration appealed that ruling; however, the Governor withdrew the appeal in November 2005.

On May 7, 2004, CMS issued a Final Rule to update the annual payment rates for the Medicare prospective payment system for services provided by long term care hospitals. The rule increased the Medicare payment rate for long-term care hospitals by 3.1% starting July 1, 2004. On May 6, 2005, CMS issued a Final Rule to update the annual payment rates for 2006. Beginning July 1, 2005, the Medicare payment rate for long-term care hospitals will increase by 3.4% for patient discharges through June 30, 2006. Medicare expects aggregate payment to these hospitals to increase by $169 million during the 2006 long-term care hospital rate year compared with the 2005 rate year. Long-term care hospitals, one of the types of facilities we are targeting, are defined generally as hospitals that have an average Medicare inpatient length of stay greater than 25 days. In addition, the final rule contains policy changes including the adoption of new labor market area definitions for long-term care hospitals which are based on the new Core Based Statistical Areas announced by the Office of Management and Budget, or OMB, late in 2000. On January 27, 2006, CMS published a proposed rule provides for no increase in the Medicare payment rates for long-term care hospitals for patient discharges between July 1, 2006 and June 30, 2007. CMS is also proposing to adopt the Rehabilitation, Psychiatric and Long-Term Care (RPL) market basket to replace the excluded hospital with capital market basket that is currently used as the measure of inflation for calculating the annual update to the long-term care hospital prospective payment rate. The RPL market basket is based on the operating and capital costs of inpatient rehabilitation facilities, inpatient psychiatric facilities, and long-term care hospitals. CMS is also proposing to revise the labor-related share based on the RPL market basket from 72.855% (based on the excluded hospital with capital market basket) to 75.923%. CMS is accepting comments on the proposed rule until March 20, 2006. We do not know whether the proposed rule will be adopted without change.

The Balanced Budget Act of 1997, or BBA, mandated implementation of a prospective payment system for skilled nursing facilities. Under this prospective payment system, and for cost reporting periods beginning on or after July 1, 1998, skilled nursing facilities are paid a prospective payment rate adjusted for case mix and geographic variation in wages formulated to cover all costs, including routine, ancillary and capital costs. In 1999 and 2000 the BBA was refined to provide for, among other revisions, a 20% add-on for 12 high acuity non-therapy Resource Utilization Grouping categories, or RUG categories, and a 6.7% add-on for all 14 rehabilitation RUG categories. These categories may expire when CMS releases its refinements to the current RUG payment system. On August 4, 2005, CMS published a Final Rule updating skilled nursing facility payment rates for fiscal year 2006. The Final Rule eliminates the temporary add-on payments that Congress directed in the Balanced Budget Refinement Act of 1999 and introduces nine (9) new payment categories. The Final Rule also permanently increases rates for all RUGs to reflect variations in non-therapy ancillary costs. Further, fiscal year 2006 payment rates include a market basket update increase of 3.1%, a slight increase over what had been anticipated in the Proposed Rule. In addition, the Final Rule contains policy changes including the adoption of new labor market area definitions which are based on the new Core Based Statistical Areas announced by the Office of Management and Budget, or OMB, late in 2000. The Deficit Reduction Act of 2005 reduces payments to skilled nursing faculties for certain bad debt attributable to Medicare coinsurance for beneficiaries who are not dual eligibles.

Beginning January 1, 2007, the Deficit Reduction Act of 2005 caps payment rates for services provided in ambulatory surgery centers at the amounts paid for the same services in hospital outpatient departments under the OPPS. This provision is effective until the Secretary of Health and Human Services establishes a revised payment system for ambulatory surgery centers as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

In addition to the legislation and regulations discussed above, on January 12, 2005, the Medicare Payment Advisory Committee, or MedPAC, made extensive recommendations to Congress and the Secretary of HHS including proposing revisions to DRG payments to more fully capture differences in severity of illnesses in an attempt to more equally pay for care provided at general acute care hospitals as compared to specialty hospitals.

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Furthermore, MedPAC made significant recommendations regarding paying healthcare providers relative to their performance and to the outcomes of the care they provided. MedPAC recommendations have historically provided strong indications regarding future directions of both the regulatory and legislative process.

Insurance

We have purchased general liability insurance (lessor s risk) that provides coverage for bodily injury and property damage to third parties resulting from our ownership of the healthcare facilities that are leased to and occupied by our tenants. Our leases with tenants also require the tenants to carry general liability, professional liability, all risks, loss of earnings and other insurance coverages and to name us as an additional insured under these policies. We expect that the policy specifications and insured limits will be appropriate given the relative risk of loss, the cost of the coverage and industry practice.

Employees

We employ 19 full-time employees and one part-time employee as of March 15, 2006. We anticipate hiring approximately four to six additional full-time employees during the next 12 months, commensurate with our growth. We believe that our relations with our employees are good. None of our employees is a member of any union.

ITEM 1.A. ***Risk Factors***

Risks Relating to Our Business and Growth Strategy

We were formed in August 2003 and have a limited operating history; our management has a limited history of operating a REIT and a public company and may therefore have difficulty in successfully and profitably operating our business.

We have only recently been organized and have a limited operating history. We are subject to the risks generally associated with the formation of any new business, including unproven business models, untested plans, uncertain market acceptance and competition with established businesses. Our management has limited experience in operating a REIT and a public company. Therefore, you should be especially cautious in drawing conclusions about the ability of our management team to execute our business plan.

We may not be successful in deploying the net proceeds of our initial public offering for their intended uses as quickly as we intend or at all, which could harm our cash flow and ability to make distributions to our stockholders.

Upon completion of our initial public offering, we experienced a capital infusion from the net offering proceeds, which we have used or intend to use to develop additional net-leased facilities and to make a loan to an affiliate of one of our prospective tenants. If we are unable to use the net proceeds in this manner, we will have no specific designated use for a substantial portion of the net proceeds from our initial public offering. In that case, or in the event we allocate a portion of the net proceeds to other uses during the pendency of the developments, you would be unable to evaluate the manner in which we invest the net proceeds or the economic merits of the assets acquired with the proceeds. We may not be able to invest this capital on acceptable terms or timeframes, or at all, which may harm our cash flow and ability to make distributions to our stockholders.

We may be unable to acquire or develop any of the facilities we have identified as potential candidates for acquisition or development, which could harm our future operating results and adversely affect our ability to make distributions to our stockholders.

We have identified numerous other facilities that we believe would be suitable candidates for acquisition or development; however, we cannot assure you that we will be successful in completing the acquisition or development of any of these facilities. Consummation of any of these acquisitions or developments is subject to, among other things, the willingness of the parties to proceed with a contemplated transaction, negotiation of mutually acceptable definitive agreements, satisfactory completion of due diligence and satisfaction of customary

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closing conditions. If we are unsuccessful in completing the acquisition or development of additional facilities in the future, our future operating results will not meet expectations and our ability to make distributions to our stockholders will be adversely affected.

We expect to continue to experience rapid growth and may not be able to adapt our management and operational systems to integrate the net-leased facilities we have acquired and are developing or those that we may acquire or develop in the future without unanticipated disruption or expense.

We are currently experiencing a period of rapid growth. We cannot assure you that we will be able to adapt our management, administrative, accounting and operational systems, or hire and retain sufficient operational staff, to integrate and manage the facilities we have acquired and are developing and those that we may acquire or develop. Our failure to successfully integrate and manage our current portfolio of facilities or any future acquisitions or developments could have a material adverse effect on our results of operations and financial condition and our ability to make distributions to our stockholders.

We may be unable to access capital, which would slow our growth.

Our business plan contemplates growth through acquisitions and developments of facilities. As a REIT, we are required to make cash distributions which reduces our ability to fund acquisitions and developments with retained earnings. We are dependent on acquisition financings and access to the capital markets for cash to make investments in new facilities. Due to market or other conditions, there will be times when we will have limited access to capital from the equity and debt markets. During such periods, virtually all of our available capital will be required to meet existing commitments and to reduce existing debt. We may not be able to obtain additional equity or debt capital or dispose of assets, on favorable terms, if at all, at the time we need additional capital to acquire healthcare properties on a competitive basis or to meet our obligations. Our ability to grow through acquisitions and developments will be limited if we are unable to obtain debt or equity financing, which could have a material adverse effect on our results of operations and our ability to make distributions to our stockholders.

Dependence on our tenants for rent may adversely impact our ability to make distributions to our stockholders.

We expect to continue to qualify as a REIT and, accordingly, as a REIT operating in the healthcare industry, we are not permitted by current tax law to operate or manage the businesses conducted in our facilities. Accordingly, we rely almost exclusively on rent payments from our tenants for cash with which to make distributions to our stockholders. We have no control over the success or failure of these tenants businesses. Significant adverse changes in the operations of any facility, or the financial condition of any tenant or a guarantor, could have a material adverse effect on our ability to collect rent payments and, accordingly, on our ability to make distributions to our stockholders. Facility management by our tenants and their compliance with state and federal healthcare laws could have a material impact on our tenants operating and financial condition and, in turn, their ability to pay rent to us. Failure on the part of a tenant to comply materially with the terms of a lease could give us the right to terminate our lease with that tenant, repossess the applicable facility, cross default certain other leases with that tenant and enforce the payment obligations under the lease. However, we then would be required to find another tenant-operator.

The transfer of most types of healthcare facilities is highly regulated, which may result in delays and increased costs in locating a suitable replacement tenant. The sale or lease of these properties to entities other than healthcare operators may be difficult due to the added cost and time of refitting the properties. If we are unable to re-let the properties to healthcare operators, we may be forced to sell the properties at a loss due to the repositioning expenses likely to be incurred by non-healthcare purchasers. Alternatively, we may be required to spend substantial amounts to adapt the facility to other uses. There can be no assurance that we would be able to find another tenant in a timely fashion, or at all, or that, if another tenant were found, we would be able to enter into a new lease on favorable terms.

Defaults by our tenants under our leases may adversely affect the timing of and our ability to make distributions to our stockholders.

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Failure by our tenants or other parties to whom we make loans to repay loans currently outstanding or loans we are obligated to make, or to pay us commitment or other fees that they are obligated to pay, in an aggregate amount of approximately $152.7 million, would have a material adverse effect on our revenues and our ability to make distributions to our stockholders.

In connection with the acquisition of the Vibra Facilities, our taxable REIT subsidiary made a secured loan to Vibra of approximately $41.4 million to acquire the operations at the Vibra Facilities. Payment of this loan is secured by pledges of equity interests in Vibra and its subsidiaries that are tenants of ours. All leases and other agreements between us, or our affiliates, on the one hand, and the tenant and Mr. Hollinger, or their affiliates, on the other hand, including leases for the Vibra Facilities, the lease for the facility located in Redding, California, or the Redding Facility, and the Vibra loan, are cross-defaulted. If Vibra defaulted on this loan, our primary recourse would be to foreclose on the equity interests in Vibra and its affiliates. This recourse may be impractical because of limitations imposed by the REIT tax rules on our ability to own these interests. Failure to adhere to these limitations could cause us to lose our REIT status. We have obtained guaranty agreements for the Vibra loan from Mr. Hollinger, Vibra Management, LLC and The Hollinger Group that obligate them to make loan payments in the event that Vibra fails to do so. However, we do not believe that these parties have sufficient financial resources to satisfy a material portion of the loan obligations. Mr. Hollinger s guaranty is limited to $5.0 million and Vibra Management, LLC and The Hollinger Group do not have substantial assets. Vibra has entered into a $20.0 million credit facility with Merrill Lynch, and that loan is secured by an interest in Vibra s receivables. There was approximately $10.2 million outstanding under the facility on December 31, 2005. Our loan is subordinate to Merrill Lynch with respect to Vibra s receivables.

We have also agreed to make a working capital loan to Stealth, L.P., or Stealth, of up to $1.62 million. Stealth has borrowed $1.62 million under this loan as of March 24, 2006. Stealth also owes us commitment and other fees of approximately $1.1 million. Payment of these fees and loan amounts is unsecured. We have also agreed to make a construction loan to North Cypress Medical Center Operating Company, Ltd., or North Cypress, for approximately $64.0 million to fund the construction of a community hospital in Houston, Texas, secured by the hospital improvements, $18.7 million of which has been loaned to North Cypress as of March 24, 2006. Bucks County Oncoplastic Institute, LLC, or BCO, owes us commitment and other fees of $420,000. BCO also owes us approximately $4.0 million in connection with a loan we made to BCO, the loan proceeds of which we have retained in a separate bank account as security for BCO s loan repayment obligations and its obligations under the lease for the facility we are developing in Bensalem, Pennsylvania, or the Bucks County Facility. Monroe Hospital LLC, or Monroe Hospital, owes us commitment and other fees of approximately $232,500.

On December 23, 2005, we made a $40.0 million mortgage loan to Alliance Hospital, Ltd., or Alliance. As security for Alliance s obligations under the mortgage loan, all principal, base interest and additional interest on the first $30.0 million of the loan amount is guaranteed on a pro rata basis by the shareholders of SRI-SAI Enterprises, Inc., the general partner of Alliance, until such time as Alliance meets certain financial conditions. Additionally, we have received a first mortgage on the facility and a first or second priority security interest in all of Alliance s personal property other than accounts receivable, along with other security. We are dependent upon the ability of Vibra, Stealth, North Cypress, BCO, Monroe Hospital and Alliance to repay these loans and fees, and their failure to meet these obligations would have a material adverse effect on our revenues and our ability to make distributions to our stockholders.

Accounting rules may require consolidation of entities in which we invest and other adjustments to our financial statements.

The Financial Accounting Standards Board, or FASB, issued FASB Interpretation No. 46, Consolidation of Variable Interest Entities, an interpretation of Accounting Research Bulletin No. 51 (ARB No. 51), in January 2003, and a

further interpretation of FIN 46 in December 2003 (FIN 46-R, and collectively FIN 46). FIN 46 clarifies the application of ARB No. 51, Consolidated Financial Statements, to certain entities in which equity investors do not have the characteristics of a controlling financial interest or do not have sufficient equity at risk for the entity to finance its activities without additional subordinated financial support from other parties, referred to as variable interest entities. FIN 46 generally requires consolidation by the party that has a majority of the risk and/or rewards, referred to as the primary beneficiary. FIN 46 applies immediately to variable interest entities created after

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January 31, 2003. Under certain circumstances, generally accepted accounting principles may require us to account for loans to thinly capitalized companies such as Vibra as equity investments. The resulting accounting treatment of certain income and expense items may adversely affect our results of operations, and consolidation of balance sheet amounts may adversely affect any loan covenants.

The bankruptcy or insolvency of our tenants under our leases could seriously harm our operating results and financial condition.

Five of our tenants, North Cypress, Stealth, BCO, Monroe Hospital and Vibra are, and some of our prospective tenants may be, newly organized, have limited or no operating history and may be dependent on loans from us to acquire the facility s operations and for initial working capital. Any bankruptcy filings by or relating to one of our tenants could bar us from collecting pre-bankruptcy debts from that tenant or their property, unless we receive an order permitting us to do so from the bankruptcy court. A tenant bankruptcy could delay our efforts to collect past due balances under our leases and loans, and could ultimately preclude collection of these sums. If a lease is assumed by a tenant in bankruptcy, we expect that all pre-bankruptcy balances due under the lease would be paid to us in full. However, if a lease is rejected by a tenant in bankruptcy, we would have only a general unsecured claim for damages. Any secured claims we have against our tenants may only be paid to the extent of the value of the collateral, which may not cover any or all of our losses. Any unsecured claim we hold against a bankrupt entity may be paid only to the extent that funds are available and only in the same percentage as is paid to all other holders of unsecured claims. We may recover none or substantially less than the full value of any unsecured claims, which would harm our financial condition.

Our facilities and properties under development are currently leased to only eight tenants, five of which were recently organized and have limited or no operating histories, and failure of any of these tenants and the guarantors of their leases to meet their obligations to us would have a material adverse effect on our revenues and our ability to make distributions to our stockholders.

Our existing facilities and the properties we have under development are currently leased to Vibra, Prime Healthcare Services, Inc., or Prime, Gulf States, North Cypress, BCO, Monroe Hospital and Stealth or their subsidiaries or affiliates. If any of our tenants were to experience financial difficulties, the tenant may not be able to pay its rent. Vibra, North Cypress, BCO, Monroe Hospital and Stealth were recently organized and have limited or no operating histories.

Our business is highly competitive and we may be unable to compete successfully.

We compete for development opportunities and opportunities to purchase healthcare facilities with, among others:

private investors;

healthcare providers, including physicians;

other REITs;

real estate partnerships;

financial institutions; and

local developers.

Many of these competitors have substantially greater financial and other resources than we have and may have better relationships with lenders and sellers. Competition for healthcare facilities from competitors may adversely affect our ability to acquire or develop healthcare facilities and the prices we pay for those facilities. If we are unable to acquire or develop facilities or if we pay too much for facilities, our revenue and earnings growth and financial return could be materially adversely affected. Certain of our facilities and additional facilities we may acquire or develop will face competition from other nearby facilities that provide services comparable to those offered at our facilities and additional facilities we may acquire or develop. Some of those facilities are owned by governmental agencies and supported by tax revenues, and others are owned by tax-exempt corporations and may be supported to

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a large extent by endowments and charitable contributions. Those types of support are not available to our facilities and additional facilities we may acquire or develop. In addition, competing healthcare facilities located in the areas served by our facilities and additional facilities we may acquire or develop may provide healthcare services that are not available at our facilities and additional facilities we may acquire or develop. From time to time, referral sources, including physicians and managed care organizations, may change the healthcare facilities to which they refer patients, which could adversely affect our rental revenues.

Our use of debt financing will subject us to significant risks, including refinancing risk and the risk of insufficient cash available for distribution to our stockholders.

Our charter and other organizational documents do not limit the amount of debt we may incur. We have targeted our debt level at up to approximately 50-60% of our aggregate facility acquisition and development costs. However, we may modify our target debt level at any time without stockholder or board of director approval. In October 2005 we entered into a $100.0 million credit agreement with Merrill Lynch Capital, the principal amount of which may be increased to $175.0 million at our request. We have also entered into construction loan agreements with Colonial Bank pursuant to which we can borrow up to $43.4 million. As of March 24, 2006, we have $71.9 million of long-term debt outstanding. We may borrow from other lenders in the future, or we may issue corporate debt securities in public or private offerings.

We anticipate that much of our debt will be non-amortizing and payable in balloon payments. Therefore, we will likely need to refinance at least a portion of that debt as it matures. There is a risk that we may not be able to refinance then-existing debt or that the terms of any refinancing will not be as favorable as the terms of the then-existing debt. If principal payments due at maturity cannot be refinanced, extended or repaid with proceeds from other sources, such as new equity capital or sales of facilities, our cash flow may not be sufficient to repay all maturing debt in years when significant balloon payments come due. Additionally, we may incur significant penalties if we choose to prepay the debt.

Failure to hedge effectively against interest rate changes may adversely affect our results of operations and our ability to make distributions to our stockholders.

As of March 24, 2006, we had approximately $71.9 million in variable interest rate debt. We may seek to manage our exposure to interest rate volatility by using interest rate hedging arrangements that involve risk, including the risk that counterparties may fail to honor their obligations under these arrangements, that these arrangements may not be effective in reducing our exposure to interest rate changes and that these arrangements may result in higher interest rates than we would otherwise have. Moreover, no hedging activity can completely insulate us from the risks associated with changes in interest rates. Failure to hedge effectively against interest rate changes may materially adversely affect results of operations and our ability to make distributions to our stockholders.

Most of our current tenants have, and prospective tenants may have, an option to purchase the facilities we lease to them which could disrupt our operations.

Most of our current tenants have, and some prospective tenants will have, the option to purchase the facilities we lease to them. All of our arrangements which provide or will provide tenants the option to purchase the facilities we lease to them are subject to regulatory requirements that such purchases be at fair market value. We cannot assure you that the formulas we have developed for setting the purchase price will yield a fair market value purchase price. Any purchase not at fair market value may present risks of challenge from healthcare regulatory authorities.

In the event our tenants and prospective tenants determine to purchase the facilities they lease either during the lease term or after their expiration, the timing of those purchases will be outside of our control and we may not be able to

re-invest the capital on as favorable terms, or at all. Our inability to effectively manage the turn-over of our facilities could materially adversely affect our ability to execute our business plan and our results of operations.

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Property owned in limited liability companies and partnerships in which we are not the sole equity holder may limit our ability to act exclusively in our interests.

We own, and in the future expect to own, interests in our facilities through wholly or majority owned subsidiaries of our operating partnership. We may offer limited liability company and limited partnership interests to tenants, subtenants and physicians in the future. Investments in partnerships, limited liability companies or other entities with co-owners may, under certain circumstances, involve risks not present were a co-owner not involved, including the possibility that partners or other co-owners might become bankrupt or fail to fund their share of required capital contributions. Partners or other co-owners may have economic or other business interests or goals that are inconsistent with our business interests or goals, and may be in a position to take actions contrary to our policies or objectives. Such investments may also have potential risks pertaining to healthcare regulatory compliance, particularly when partners or other co-owners are physicians, and of impasses on major decisions, such as sales or mergers, because neither we nor our partners or other co-owners would have full control over the partnership, limited liability company or other entity. Disputes between us and our partners or other co-owners may result in litigation or arbitration that would increase our expenses and prevent our officers and directors from focusing their time and effort on our business. Consequently, actions by or disputes with our partners or other co-owners might result in subjecting facilities owned by the partnership, limited liability company or other entity to additional risk. In addition, we may in certain circumstances be liable for the actions of our partners or other co-owners. The occurrence of any of the foregoing events could have a material adverse effect on our results of operations and our ability to make distributions to our stockholders.

Terrorist attacks, such as the attacks that occurred in New York and Washington, D.C. on September 11, 2001, U.S. military action and the public s reaction to the threat of terrorism or military action could adversely affect our results of operations and the market on which our common stock will trade.

There may be future terrorist threats or attacks against the United States or U.S. businesses. These attacks may directly impact the value of our facilities through damage, destruction, loss or increased security costs. Losses due to wars or terrorist attacks may be uninsurable, or insurance may not be available at a reasonable price. More generally, any of these events could cause consumer confidence and spending to decrease or result in increased volatility in the United States and worldwide financial markets and economies.

Risks Relating to Real Estate Investments

Our real estate investments are and will continue to be concentrated in net-leased healthcare facilities, making us more vulnerable economically than if our investments were more diversified.

We have acquired and are developing and expect to continue acquiring and developing net-leased healthcare facilities. We are subject to risks inherent in concentrating investments in real estate. The risks resulting from a lack of diversification become even greater as a result of our business strategy to invest in net-leased healthcare facilities. A downturn in the real estate industry could materially adversely affect the value of our facilities. A downturn in the healthcare industry could negatively affect our tenants ability to make lease or loan payments to us and, consequently, our ability to meet debt service obligations or make distributions to our stockholders. These adverse effects could be more pronounced than if we diversified our investments outside of real estate or outside of healthcare facilities.

Our net-leased facilities and targeted net-leased facilities may not have efficient alternative uses, which could impede our ability to find replacement tenants in the event of termination or default under our leases.

All of the facilities in our current portfolio are and all of the facilities we expect to acquire or develop in the future will be net-leased healthcare facilities. If we or our tenants terminate the leases for these facilities or if these tenants

lose their regulatory authority to operate these facilities, we may not be able to locate suitable replacement tenants to lease the facilities for their specialized uses. Alternatively, we may be required to spend substantial amounts to adapt the facilities to other uses. Any loss of revenues or additional capital expenditures occurring as a

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result could have a material adverse effect on our financial condition and results of operations and could hinder our ability to meet debt service obligations or make distributions to our stockholders.

Illiquidity of real estate investments could significantly impede our ability to respond to adverse changes in the performance of our facilities and harm our financial condition.

Real estate investments are relatively illiquid. Our ability to quickly sell or exchange any of our facilities in response to changes in economic and other conditions will be limited. No assurances can be given that we will recognize full value for any facility that we are required to sell for liquidity reasons. Our inability to respond rapidly to changes in the performance of our investments could adversely affect our financial condition and results of operations.

Development and construction risks could adversely affect our ability to make distributions to our stockholders.

We are developing a women s hospital and integrated medical office building in Bensalem, Pennsylvania, developing a community hospital in Bloomington, Indiana and financing the development of a community hospital in Houston, Texas. We expect to develop additional facilities in the future. Our development and related construction activities may subject us to the following risks:

- we may have to compete for suitable development sites;
- our ability to complete construction is dependent on there being no title, environmental or other legal proceedings arising during construction;
- we may be subject to delays due to weather conditions, strikes and other contingencies beyond our control;
- we may be unable to obtain, or suffer delays in obtaining, necessary zoning, land-use, building, occupancy healthcare regulatory and other required governmental permits and authorizations, which could result in increased costs, delays in construction, or our abandonment of these projects;
- we may incur construction costs for a facility which exceed our original estimates due to increased costs for materials or labor or other costs that we did not anticipate; and
- we may not be able to obtain financing on favorable terms, which may render us unable to proceed with our development activities.

We expect to fund our development projects over time. Additionally, the time frame required for development and construction of these facilities means that we may have to wait years for a significant cash return. Because we are required to make cash distributions to our stockholders, if the cash flow from operations or refinancings is not sufficient, we may be forced to borrow additional money to fund distributions. We cannot assure you that we will complete our current construction projects on time or within budget or that future development projects will not be subject to delays and cost overruns. Risks associated with our development projects may reduce anticipated rental revenue which could affect the timing of, and our ability to make, distributions to our stockholders.

Our facilities may not achieve expected results or we may be limited in our ability to finance future acquisitions, which may harm our financial condition and operating results and our ability to make the distributions to our stockholders required to maintain our REIT status.

Acquisitions and developments entail risks that investments will fail to perform in accordance with expectations and that estimates of the costs of improvements necessary to acquire and develop facilities will prove inaccurate, as well

as general investment risks associated with any new real estate investment. We anticipate that future acquisitions and developments will largely be financed through externally generated funds such as borrowings under credit facilities and other secured and unsecured debt financing and from issuances of equity securities. Because we must distribute at least 90% of our REIT taxable income, excluding net capital gain, each year to maintain our qualification as a REIT, our ability to rely upon income from operations or cash flow from operations to finance our growth and acquisition activities will be limited. Accordingly, if we are unable to obtain funds from borrowings or the capital markets to finance our acquisition and development activities, our ability to

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grow would likely be curtailed, amounts available for distribution to stockholders could be adversely affected and we could be required to reduce distributions, thereby jeopardizing our ability to maintain our status as a REIT.

Newly-developed or newly-renovated facilities do not have the operating history that would allow our management to make objective pricing decisions in acquiring these facilities (including facilities that may be acquired from certain of our executive officers, directors and their affiliates). The purchase prices of these facilities will be based in part upon projections by management as to the expected operating results of the facilities, subjecting us to risks that these facilities may not achieve anticipated operating results or may not achieve these results within anticipated time frames.

If we suffer losses that are not covered by insurance or that are in excess of our insurance coverage limits, we could lose investment capital and anticipated profits.

We have purchased general liability insurance (lessor s risk) that provides coverage for bodily injury and property damage to third parties resulting from our ownership of the healthcare facilities that are leased to and occupied by our tenants. Our leases generally require our tenants to carry general liability, professional liability, loss of earnings, all risk, and extended coverage insurance in amounts sufficient to permit the replacement of the facility in the event of a total loss, subject to applicable deductibles. However, there are certain types of losses, generally of a catastrophic nature, such as earthquakes, floods, hurricanes and acts of terrorism, that may be uninsurable or not insurable at a price we or our tenants can afford. Inflation, changes in building codes and ordinances, environmental considerations and other factors also might make it impracticable to use insurance proceeds to replace a facility after it has been damaged or destroyed. Under such circumstances, the insurance proceeds we receive might not be adequate to restore our economic position with respect to the affected facility. If any of these or similar events occur, it may reduce our return from the facility and the value of our investment.

Capital expenditures for facility renovation may be greater than anticipated and may adversely impact rent payments by our tenants and our ability to make distributions to stockholders.

Facilities, particularly those that consist of older structures, have an ongoing need for renovations and other capital improvements, including periodic replacement of furniture, fixtures and equipment. Although our leases require our tenants to be primarily responsible for the cost of such expenditures, renovation of facilities involves certain risks, including the possibility of environmental problems, construction cost overruns and delays, uncertainties as to market demand or deterioration in market demand after commencement of renovation and the emergence of unanticipated competition from other facilities. All of these factors could adversely impact rent and loan payments by our tenants, could have a material adverse effect on our financial condition and results of operations and could adversely effect our ability to make distributions to our stockholders.

All of our healthcare facilities are subject to property taxes that may increase in the future and adversely affect our business.

Our facilities are subject to real and personal property taxes that may increase as property tax rates change and as the facilities are assessed or reassessed by taxing authorities. Our leases generally provide that the property taxes are charged to our tenants as an expense related to the facilities that they occupy. As the owner of the facilities, however, we are ultimately responsible for payment of the taxes to the government. If property taxes increase, our tenants may be unable to make the required tax payments, ultimately requiring us to pay the taxes. If we incur these tax liabilities, our ability to make expected distributions to our stockholders could be adversely affected.

Our performance and the price of our common stock will be affected by risks associated with the real estate industry.

Factors that may adversely affect the economic performance and price of our common stock include:

- changes in the national, regional and local economic climate, including but not limited to changes in interest rates;

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local conditions such as an oversupply of, or a reduction in demand for, rehabilitation hospitals, long-term acute care hospitals, ambulatory surgery centers, medical office buildings, specialty hospitals, skilled nursing facilities, regional and community hospitals, women s and children s hospitals and other single-discipline facilities.

attractiveness of our facilities to healthcare providers and other types of tenants; and

competition from other rehabilitation hospitals, long-term acute care facilities, medical office buildings, outpatient treatment facilities, ambulatory surgery centers and specialty hospitals, skilled nursing facilities, regional and community hospitals, women s and children s hospitals and other single-discipline facilities.

As the owner and lessor of real estate, we are subject to risks under environmental laws, the cost of compliance with which and any violation of which could materially adversely affect us.

Our operating expenses could be higher than anticipated due to the cost of complying with existing and future environmental and occupational health and safety laws and regulations. Various environmental laws may impose liability on a current or prior owner or operator of real property for removal or remediation of hazardous or toxic substances. Current or prior owners or operators may also be liable for government fines and damages for injuries to persons, natural resources and adjacent property. These environmental laws often impose liability whether or not the owner or operator knew of, or was responsible for, the presence or disposal of the hazardous or toxic substances. The cost of complying with environmental laws could materially adversely affect amounts available for distribution to our stockholders and could exceed the value of all of our facilities. In addition, the presence of hazardous or toxic substances, or the failure of our tenants to properly dispose of or remediate such substances, including medical waste generated by physicians and our other healthcare tenants, may adversely affect our tenants or our ability to use, sell or rent such property or to borrow using such property as collateral which, in turn, could reduce our revenue and our financing ability. We have obtained on all facilities we have acquired and are developing and intend to obtain on all future facilities we acquire Phase I environmental assessments. However, even if the Phase I environmental assessment reports do not reveal any material environmental contamination, it is possible that material environmental liabilities may exist of which we are unaware.

Although the leases for our facilities generally require our tenants to comply with laws and regulations governing their operations, including the disposal of medical waste, and to indemnify us for certain environmental liabilities, the scope of their obligations may be limited. We cannot assure you that our tenants would be able to fulfill their indemnification obligations and, therefore, any violation of environmental laws could have a material adverse affect on us. In addition, environmental and occupational health and safety laws constantly are evolving, and changes in laws, regulations or policies, or changes in interpretations of the foregoing, could create liabilities where none exists today.

Costs associated with complying with the Americans with Disabilities Act of 1993 may adversely affect our financial condition and operating results.

Under the Americans with Disabilities Act of 1993, all public accommodations are required to meet certain federal requirements related to access and use by disabled persons. While our facilities are generally in compliance with these requirements, a determination that we are not in compliance with the Americans with Disabilities Act of 1993 could result in imposition of fines or an award of damages to private litigants. In addition, changes in governmental rules and regulations or enforcement policies affecting the use and operation of the facilities, including changes to building codes and fire and life-safety codes, may occur. If we are required to make substantial modifications at our facilities to comply with the Americans with Disabilities Act of 1993 or other changes in governmental rules and regulations, this

may have a material adverse effect on our financial condition and results of operations and could adversely affect our ability to make distributions to our stockholders.

Our facilities may contain or develop harmful mold or suffer from other air quality issues, which could lead to liability for adverse health effects and costs of remediating the problem.

When excessive moisture accumulates in buildings or on building materials, mold growth may occur, particularly if the moisture problem remains undiscovered or is not addressed over a period of time. Some molds

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may produce airborne toxins or irritants. Indoor air quality issues can also stem from inadequate ventilation, chemical contamination from indoor or outdoor sources and other biological contaminants such as pollen, viruses and bacteria. Indoor exposure to airborne toxins or irritants above certain levels can be alleged to cause a variety of adverse health effects and symptoms, including allergic or other reactions. As a result, the presence of significant mold or other airborne contaminants at any of our facilities could require us to undertake a costly remediation program to contain or remove the mold or other airborne contaminants from the affected facilities or increase indoor ventilation. In addition, the presence of significant mold or other airborne contaminants could expose us to liability from our tenants, employees of our tenants and others if property damage or health concerns arise.

Our interests in facilities through ground leases expose us to the loss of the facility upon breach or termination of the ground lease and may limit our use of the facility.

We have acquired interests in two of our facilities, at least in part, and one facility under development, by acquiring leasehold interests in the land on which the facility is or the facility under development will be located rather than an ownership interest in the property, and we may acquire additional facilities in the future through ground leases. As lessee under ground leases, we are exposed to the possibility of losing the property upon termination, or an earlier breach by us, of the ground lease. Ground leases may also restrict our use of facilities. Our current ground lease in Marlton, New Jersey limits use of the property to operation of a 76 bed rehabilitation hospital. Our current ground lease for the Redding Facility limits use of the property to operation of a hospital offering the following services: skilled nursing; physical rehabilitation; occupational therapy; speech pathology; social services; assisted living; day health programs; long-term acute care services; psychiatric services; geriatric clinic services; outpatient services related to the foregoing service categories; and other post-acute services. These restrictions and any similar future restrictions in ground leases will limit our flexibility in renting the facility and may impede our ability to sell the property.

Risks Relating to the Healthcare Industry

Reductions in reimbursement from third-party payors, including Medicare and Medicaid, could adversely affect the profitability of our tenants and hinder their ability to make rent payments to us.

Sources of revenue for our tenants and operators may include the federal Medicare program, state Medicaid programs, private insurance carriers and health maintenance organizations, among others. Efforts by such payors to reduce healthcare costs will likely continue, which may result in reductions or slower growth in reimbursement for certain services provided by some of our tenants. In addition, the failure of any of our tenants to comply with various laws and regulations could jeopardize their ability to continue participating in Medicare, Medicaid and other government-sponsored payment programs.

The healthcare industry continues to face various challenges, including increased government and private payor pressure on healthcare providers to control or reduce costs. We believe that our tenants will continue to experience a shift in payor mix away from fee-for-service payors, resulting in an increase in the percentage of revenues attributable to managed care payors, government payors and general industry trends that include pressures to control healthcare costs. Pressures to control healthcare costs and a shift away from traditional health insurance reimbursement have resulted in an increase in the number of patients whose healthcare coverage is provided under managed care plans, such as health maintenance organizations and preferred provider organizations. In addition, due to the aging of the population and the expansion of governmental payor programs, we anticipate that there will be a marked increase in the number of patients reliant on healthcare coverage provided by governmental payors. These changes could have a material adverse effect on the financial condition of some or all of our tenants, which could have a material adverse effect on our financial condition and results of operations and could negatively affect our ability to make distributions to our stockholders.

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The healthcare industry is heavily regulated and existing and new laws or regulations, changes to existing laws or regulations, loss of licensure or certification or failure to obtain licensure or certification could result in the inability of our tenants to make lease payments to us.

The healthcare industry is highly regulated by federal, state and local laws, and is directly affected by federal conditions of participation, state licensing requirements, facility inspections, state and federal reimbursement policies, regulations concerning capital and other expenditures, certification requirements and other such laws, regulations and rules. In addition, establishment of healthcare facilities and transfers of operations of healthcare facilities are subject to regulatory approvals not required for establishment of or transfers of other types of commercial operations and real estate. Sanctions for failure to comply with these regulations and laws include, but are not limited to, loss of or inability to obtain licensure, fines and loss of or inability to obtain certification to participate in the Medicare and Medicaid programs, as well as potential criminal penalties. The failure of any tenant to comply with such laws, requirements and regulations could affect its ability to establish or continue its operation of the facility or facilities and could adversely affect the tenant s ability to make lease payments to us which could have a material adverse effect on our financial condition and results of operations and could negatively affect our ability to make distributions to our stockholders. In addition, restrictions and delays in transferring the operations of healthcare facilities, in obtaining new third-party payor contracts including Medicare and Medicaid provider agreements, and in receiving licensure and certification approval from appropriate state and federal agencies by new tenants may affect our ability to terminate lease agreements, remove tenants that violate lease terms, and replace existing tenants with new tenants. Furthermore, these matters may affect new tenants ability to obtain reimbursement for services rendered, which could adversely affect their ability to pay rent to us and to pay principal and interest on their loans from us.

Our tenants are subject to fraud and abuse laws, the violation of which by a tenant may jeopardize the tenant s ability to make lease and loan payments to us.

The federal government and numerous state governments have passed laws and regulations that attempt to eliminate healthcare fraud and abuse by prohibiting business arrangements that induce patient referrals or the ordering of specific ancillary services. In addition, the Balanced Budget Act of 1997 strengthened the federal anti-fraud and abuse laws to provide for stiffer penalties for violations. Violations of these laws may result in the imposition of criminal and civil penalties, including possible exclusion from federal and state healthcare programs. Imposition of any of these penalties upon any of our tenants could jeopardize any tenant s ability to operate a facility or to make lease and loan payments, thereby potentially adversely affecting us.

In the past several years, federal and state governments have significantly increased investigation and enforcement activity to detect and eliminate fraud and abuse in the Medicare and Medicaid programs. In addition, legislation has been adopted at both state and federal levels which severely restricts the ability of physicians to refer patients to entities in which they have a financial interest. It is anticipated that the trend toward increased investigation and enforcement activity in the area of fraud and abuse, as well as self-referrals, will continue in future years and could adversely affect our prospective tenants and their operations, and in turn their ability to make lease and loan payments to us.

Vibra has accepted, and prospective tenants may accept, an assignment of the previous operator s Medicare provider agreement. Vibra and other new-operator tenants that take assignment of Medicare provider agreements might be subject to federal or state regulatory, civil and criminal investigations of the previous owner s operations and claims submissions. While we conduct due diligence in connection with the acquisition of such facilities, these types of issues may not be discovered prior to purchase. Adverse decisions, fines or recoupments might negatively impact our tenants financial condition.

Certain of our lease arrangements may be subject to fraud and abuse or physician self-referral laws.

Local physician investment in our operating partnership or our subsidiaries that own our facilities could subject our lease arrangements to scrutiny under fraud and abuse and physician self-referral laws. Under the federal Ethics in Patient Referrals Act of 1989, or Stark Law, and regulations adopted thereunder, if our lease arrangements do not satisfy the requirements of an applicable exception, that noncompliance could adversely affect the ability of our

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tenants to bill for services provided to Medicare beneficiaries pursuant to referrals from physician investors and subject us and our tenants to fines, which could impact their ability to make lease and loan payments to us. On March 26, 2004, CMS issued Phase II final rules under the Stark Law, which, together with the 2001 Phase I final rules, set forth CMS current interpretation and application of the Stark Law prohibition on referrals of designated health services, or DHS. These rules provide us additional guidance on application of the Stark Law through the implementation of bright-line tests, including additional regulations regarding the indirect compensation exception, but do not eliminate the risk that our lease arrangements and business strategy of physician investment may violate the Stark Law. Finally, the Phase II rules implemented an 18-month moratorium on physician ownership or investment in specialty hospitals imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The moratorium imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 expired on June 8, 2005. However, that moratorium was retroactively extended by the passage of the Deficit Reduction Act of 2005 (the DRA) which requires the Secretary of Health and Human Services to develop a strategic and implementing plan for physician investment in specialty hospitals that addresses the issues of proportionality of investment return, bona fide investment, annual disclosure of investments, and the provision of medical assistance (Medicaid) and charity care. The report is due six months after the date of enactment, but this deadline may be extended by two months. The DRA also directs CMS to continue the moratorium on enrollment of specialty hospitals until the earlier of the date the report is submitted or 6 months after enactment of the DRA. We intend to use our good faith efforts to structure our lease arrangements to comply with these laws; however, if we are unable to do so, this failure may restrict our ability to permit physician investment or, where such physicians do participate, may restrict the types of lease arrangements into which we may enter, including our ability to enter into percentage rent arrangements.

State certificate of need laws may adversely affect our development of facilities and the operations of our tenants.

Certain healthcare facilities in which we invest may also be subject to state laws which require regulatory approval in the form of a certificate of need prior to initiation of certain projects, including, but not limited to, the establishment of new or replacement facilities, the addition of beds, the addition or expansion of services and certain capital expenditures. State certificate of need laws are not uniform throughout the United States and are subject to change. We cannot predict the impact of state certificate of need laws on our development of facilities or the operations of our tenants.

In addition, certificate of need laws often materially impact the ability of competitors to enter into the marketplace of our facilities. Finally, in limited circumstances, loss of state licensure or certification or closure of a facility could ultimately result in loss of authority to operate the facility and require re-licensure or new certificate of need authorization to re-institute operations. As a result, a portion of the value of the facility may be related to the limitation on new competitors. In the event of a change in the certificate of need laws, this value may markedly decrease.

Risks Relating to Our Organization and Structure

Maryland law, our charter and our bylaws contain provisions which may prevent or deter changes in management and third-party acquisition proposals that you may believe to be in your best interest, depress our stock price or cause dilution.

Our charter contains ownership limitations that may restrict business combination opportunities, inhibit change of control transactions and reduce the value of our stock. To qualify as a REIT under the Revenue Code of 1986, as amended (the Code), no more than 50% in value of our outstanding stock, after taking into account options to acquire stock, may be owned, directly or indirectly, by five or fewer persons during the last half of each taxable year, other than our first REIT taxable year. Our charter generally prohibits direct or indirect ownership by any person of more than 9.8% in value or in number, whichever is more restrictive, of outstanding shares of any class or series of our

securities, including our common stock. Generally, common stock owned by affiliated owners will be aggregated for purposes of the ownership limitation. The ownership limitation could have the effect of delaying, deterring or preventing a change in control or other transaction in which holders of common stock might receive a premium for their common stock over the then-current market price or which such holders otherwise might believe

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to be in their best interests. The ownership limitation provisions also may make our common stock an unsuitable investment vehicle for any person seeking to obtain, either alone or with others as a group, ownership of more than 9.8% of either the value or number of the outstanding shares of our common stock.

Our charter and bylaws contain provisions that may impede third-party acquisition proposals that may be in your best interests. Our charter and bylaws also provide that our directors may only be removed by the affirmative vote of the holders of two-thirds of our stock, that stockholders are required to give us advance notice of director nominations and new business to be conducted at our annual meetings of stockholders and that special meetings of stockholders can only be called by our president, our board of directors or the holders of at least 25% of stock entitled to vote at the meetings. These and other charter and bylaw provisions may delay or prevent a change of control or other transaction in which holders of our common stock might receive a premium for their common stock over the then-current market price or which such holders otherwise might believe to be in their best interests.

We depend on key personnel, the loss of any one of whom may threaten our ability to operate our business successfully.

We depend on the services of Edward K. Aldag, Jr., William G. McKenzie, Emmett E. McLean, R. Steven Hamner and Michael G. Stewart to carry out our business and investment strategy. If we were to lose any of these executive officers, it may be more difficult for us to locate attractive acquisition targets, complete our acquisitions and manage the facilities that we have acquired or are developing. Additionally, as we expand, we will continue to need to attract and retain additional qualified officers and employees. The loss of the services of any of our executive officers, or our inability to recruit and retain qualified personnel in the future, could have a material adverse effect on our business and financial results.

We may experience conflicts of interest with our officers and directors, which could result in our officers and directors acting other than in our best interest.

Our officers and directors may have conflicts of interest in connection with their duties to us and the limited partners of our operating partnership and with allocation of their time between our business and affairs and their other business interests. In addition, from time to time, we may acquire or develop facilities in transactions involving prospective tenants in which our directors or officers have an interest. In transactions of this nature, there will be conflicts between our interests and the interests of the director or officer involved, and that director or officer may be in a position to influence the terms of those transactions.

In the event we purchase properties from executive officers or directors in exchange for units of limited partnership in our operating partnership, the interests of those persons with the interests of the company may conflict. Where a unitholder has unrealized gains associated with his limited partnership interests in our operating partnership, these holders may incur adverse tax consequences in the event of a sale or refinancing of those properties. Therefore the interest of these executive officers or directors of our company could be different from the interests of the company in connection with the disposition or refinancing of a property. Conflicts of interest with our officers and directors could result in our officers and directors acting other than in our best interest.

The vice chairman of our board of directors, William G. McKenzie, has other business interests that may hinder his ability to allocate sufficient time to the management of our operations, which could jeopardize our ability to execute our business plan.

Our employment agreement with the vice chairman of our board of directors, Mr. McKenzie, permits him to continue to own, operate and control facilities that he owned as of the date of his employment agreement and requires that he only provide a limited amount of his time per month to our company. In addition, the terms of Mr. McKenzie s

employment agreement permit him to compete against us with respect to these previously owned healthcare facilities.

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Our UPREIT structure may result in conflicts of interest between our stockholders and the holders of our operating partnership units.

We are organized as an UPREIT, which means that we hold our assets and conduct substantially all of our operations through an operating limited partnership, and may in the future issue limited partnership units to third parties. Persons holding operating partnership units would have the right to vote on certain amendments to the partnership agreement of our operating partnership, as well as on certain other matters. Persons holding these voting rights may exercise them in a manner that conflicts with the interests of our stockholders. Circumstances may arise in the future, such as the sale or refinancing of one of our facilities, when the interests of limited partners in our operating partnership conflict with the interests of our stockholders. As the general partner of our operating partnership, we have fiduciary duties to the limited partners of our operating partnership that may conflict with fiduciary duties our officers and directors owe to our stockholders. These conflicts may result in decisions that are not in your best interest.

Tax Risks Associated With Our Status as a REIT

Loss of our tax status as a REIT would have significant adverse consequences to us and the value of our common stock.

We believe that we qualify as a REIT for federal income tax purposes and have elected to be taxed as a REIT under the federal income tax laws commencing with our taxable year that began on April 6, 2004 and ended on December 31, 2004. The REIT qualification requirements are extremely complex, and interpretations of the federal income tax laws governing qualification as a REIT are limited. Accordingly, there is no assurance that we will be successful in operating so as to qualify as a REIT. At any time, new laws, regulations, interpretations or court decisions may change the federal tax laws relating to, or the federal income tax consequences of, qualification as a REIT. It is possible that future economic, market, legal, tax or other considerations may cause our board of directors to revoke the REIT election, which it may do without stockholder approval.

If we lose or revoke our REIT status, we will face serious tax consequences that will substantially reduce the funds available for distribution because:

- we would not be allowed a deduction for distributions to stockholders in computing our taxable income; therefore we would be subject to federal income tax at regular corporate rates and we might need to borrow money or sell assets in order to pay any such tax;

- we also could be subject to the federal alternative minimum tax and possibly increased state and local taxes; and

- unless we are entitled to relief under statutory provisions, we also would be disqualified from taxation as a REIT for the four taxable years following the year during which we ceased to qualify.

As a result of all these factors, a failure to achieve or a loss or revocation of our REIT status could have a material adverse effect on our financial condition and results of operations and would adversely affect the value of our common stock.

Failure to make required distributions would subject us to tax.

In order to qualify as a REIT, each year we must distribute to our stockholders at least 90% of our REIT taxable income, excluding net capital gain. To the extent that we satisfy the distribution requirement, but distribute less than 100% of our taxable income, we will be subject to federal corporate income tax on our undistributed income. In addition, we will incur a 4% nondeductible excise tax on the amount, if any, by which our distributions in any year are

less than the sum of (1) 85% of our ordinary income for that year; (2) 95% of our capital gain net income for that year; and (3) 100% of our undistributed taxable income from prior years.

We may be required to make distributions to stockholders at disadvantageous times or when we do not have funds readily available for distribution. Differences in timing between the recognition of income and the related cash receipts or the effect of required debt amortization payments could require us to borrow money or sell assets to pay out enough of our taxable income to satisfy the distribution requirement and to avoid corporate income tax and

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the 4% excise tax in a particular year. In the future, we may borrow to pay distributions to our stockholders and the limited partners of our operating partnership. Any funds that we borrow would subject us to interest rate and other market risks.

Complying with REIT requirements may cause us to forego otherwise attractive opportunities.

To qualify as a REIT for federal income tax purposes, we must continually satisfy tests concerning, among other things, the sources of our income, the nature and diversification of our assets, the amounts we distribute to our stockholders and the ownership of our stock. In order to meet these tests, we may be required to forego attractive business or investment opportunities. Overall, no more than 20% of the value of our assets may consist of securities of one or more taxable REIT subsidiaries, and no more than 25% of the value of our assets may consist of securities that are not qualifying assets under the test requiring that 75% of a REIT s assets consist of real estate and other related assets. Further, a taxable REIT subsidiary may not directly or indirectly operate or manage a healthcare facility. For purposes of this definition a healthcare facility means a hospital, nursing facility, assisted living facility, congregate care facility, qualified continuing care facility, or other licensed facility which extends medical or nursing or ancillary services to patients and which is operated by a service provider that is eligible for participation in the Medicare program under Title XVIII of the Social Security Act with respect to the facility. Thus, compliance with the REIT requirements may limit our flexibility in executing our business plan.

Our loan to Vibra could be recharacterized as equity, in which case our rental income from Vibra would not be qualifying income under the REIT rules and we could lose our REIT status.

In connection with the acquisition of the Vibra Facilities, our taxable REIT subsidiary made a loan to Vibra in an aggregate amount of approximately $41.4 million to acquire the operations at the Vibra Facilities. Our taxable REIT subsidiary also made a loan of approximately $6.2 million to Vibra and its subsidiaries for working capital purposes, which has been paid in full. The acquisition loan bears interest at an annual rate of 10.25%. Our operating partnership loaned the funds to our taxable REIT subsidiary to make these loans. The loan from our operating partnership to our taxable REIT subsidiary bears interest at an annual rate of 9.25%.

The Internal Revenue Service, or IRS, may take the position that the loans to Vibra should be treated as equity interests in Vibra rather than debt, and that our rental income from Vibra should not be treated as qualifying income for purposes of the REIT gross income tests. If the IRS were to successfully treat the loans to Vibra as equity interests in Vibra, Vibra would be a related party tenant with respect to our company and the rent that we receive from Vibra would not be qualifying income for purposes of the REIT gross income tests. As a result, we could lose our REIT status. In addition, if the IRS were to successfully treat the loans to Vibra as interests held by our operating partnership rather than by our taxable REIT subsidiary and to treat the loans as other than straight debt, we would fail the 10% asset test with respect to such interests and, as a result, could lose our REIT status, which would subject us to corporate level income tax and adversely affect our ability to make distributions to our stockholders.

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ITEM 2. ***Properties***

At December 31, 2005, our portfolio consisted of 14 properties with an aggregate of approximately one million square feet and 1,030 licensed beds. We also own three land parcels containing three buildings in various stages of completion that we believe can support up to approximately 432,000 square feet and 128 licensed beds.

State	Total Revenue	Percentage of Total Revenue	Total Investment
California	$ 9,701,292	30.7%	$ 116,196,486
Colorado	2,175,235	6.9%	8,491,481
Kentucky	6,876,806	21.8%	38,211,658
Louisiana	1,169,679	3.7%	17,534,836
Massachusetts	4,386,374	13.9%	22,077,847
New Jersey	6,043,017	19.2%	32,267,622
Texas	1,196,796	3.8%	56,409,377
	$ 31,549,199	100.0%	$ 291,189,307

Type of Property	Number of Properties	Number of Square Feet	Number of Licensed Beds
Community Hospital	4	434,247	360
Long-term Acute Care Hospital	5	248,699	355
Medical Office Building	1	122,325	
Rehabilitation Hospital	4	362,880	315
	14	1,168,151	1,030

ITEM 3. ***Legal Proceedings***

None.

ITEM 4. ***Submission of Matters to a Vote of Security Holders***

Our annual meeting of stockholders was held on October 12, 2005.

Proxies for the annual meeting were solicited pursuant to Regulation 14A under the Exchange Act. There were no solicitations in opposition to management s nominees for the board of directors or other proposals listed in our proxy statement. All nominees listed in the proxy statement were elected and all proposals listed in the proxy statement were approved.

The election of seven directors for the ensuing year was voted upon at the annual meeting. The number of votes cast for and withheld for each nominee for director is set forth below:

Nominee:	**For:**	**Withheld:**
Edward K. Aldag, Jr.	32,859,227	3,839,050
Virginia A. Clarke	33,031,667	3,666,610
G. Steven Dawson	32,956,013	3,742,264
Bryan L. Goolsby	33,644,757	3,053,520
R. Steven Hamner	32,939,027	3,759,250
Robert E. Holmes, Ph.D.	34,107,972	2,590,305
William G. McKenzie	32,946,427	3,751,850
L. Glenn Orr, Jr.	33,023,467	3,674,810

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A proposal to amend our charter regarding transfer or ownership restrictions on our common stock. The number of votes that were cast for and against this proposal and the number of abstentions and broker non-votes are set forth below:

For:	Against:	Abstentions and Broker Non-Votes:
35,526,816	1,159,160	12,300

A proposal to adopt the Amended and Restated Medical Properties Trust, Inc. 2004 Equity Incentive Plan was voted upon at the Annual Meeting. The number of votes that were cast for and against this proposal and the number of abstentions and broker non-votes are set forth below:

For:	Against:	Abstentions and Broker Non-Votes:
20,476,994	4,846,100	766,410

PART II

ITEM 5. ***Market for Registrant s Common Equity and Related Stockholder Matters***

Our common stock is traded on the New York Stock Exchange under the symbol MPW. The following sets forth the high and low sales prices for the common stock for each quarter from the initial public offering to the period ending December 31, 2005, as reported by the New York Stock Exchange Composite Tape, and the distributions declared by us with respect to each such period.

Calendar Period	High	Low	Distribution
2005			
Third Quarter	11.20	9.62	0.17
Fourth Quarter	10.09	7.60	0.18

On March 24, 2006, the last reported sale price of the common shares on the New York Stock Exchange was $10.40. On March 24, we had approximately 31 shareholders of record.

The table below is a summary of our distributions:

Declaration Date	Record Date	Date of Distribution	Distribution per Share
February 16, 2006	March 15, 2006	April 12, 2006	$ .21
November 18, 2005	December 15, 2005	January 19, 2006	$ .18
August 18, 2005	September 15, 2005	September 29, 2005	$ .17
May 19, 2005	June 20, 2005	July 14, 2005	$ .16

March 4, 2005	March 16, 2005	April 15, 2005	$	.11
November 11, 2004	December 16, 2004	January 11, 2005	$	.11
September 2, 2004	September 16, 2004	October 11, 2004	$	.10

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ITEM 6. ***Selected Financial Data***

The following table sets forth selected financial and operating information on a historical basis for the years ended December 31, 2005 and 2004, and for the period from inception (August 27, 2003) to December 31, 2003:

	For the Year Ended December 31, 2005	For the Year Ended December 31, 2004	Period from Inception (August 27, 2003) to December 31, 2003
OPERATING DATA			
Total revenue	$ 31,549,199	$ 10,893,459	$
Depreciation and amortization	4,404,361	1,478,470	
General and administrative expenses	8,016,992	5,150,786	992,418
Interest expense	1,542,266	32,769	
Net income	19,640,347	4,576,349	(1,023,276)
Net income per diluted common share	0.61	0.24	(0.63)
Weighted average number of common shares diluted	32,370,089	19,312,634	1,630,435
OTHER DATA			
Net income	$ 19,640,347	$ 4,576,349	$ (1,023,276)
Depreciation and amortization	4,404,361	1,478,470	
Funds from operations	24,044,708	6,054,819	(1,023,276)
Funds from operations per diluted common share	0.74	0.31	(0.63)
Dividends declared per diluted common share	0.62	0.21	

	December 31, 2005	December 31, 2004	December 31, 2003
BALANCE SHEET DATA			
Real estate assets at cost	$ 337,102,392	$ 151,690,293	$ 166,301
Other loans and investments	88,205,611	50,224,069	
Cash and equivalents	59,115,832	97,543,677	100,000
Total assets	501,173,546	306,506,063	468,133
Debt	100,484,520	56,000,000	100,000
Other liabilities	42,238,018	17,777,619	1,389,779
Minority interests	2,173,866	1,000,000	
Total stockholders equity	356,277,142	231,728,444	(1,021,646)
Total liabilities and stockholders equity	501,173,546	306,506,063	468,133

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ITEM 7. ***Managements Discussion and Analysis of Financial Condition and Results of Operations***

Overview

We were incorporated in Maryland on August 27, 2003 primarily for the purpose of investing in and owning net-leased healthcare facilities across the United States. We also make real estate mortgage loans and other loans to our tenants. We have operated as a real estate investment trust (REIT) since April 6, 2004, and accordingly, elected REIT status upon the filing in September 2005 of our calendar year 2004 Federal income tax return. Our existing tenants are, and our prospective tenants will generally be, healthcare operating companies and other healthcare providers that use substantial real estate assets in their operations. We offer financing for these operators real estate through 100% lease and mortgage financing and generally seek lease and loan terms of at least 10 years with a series of shorter renewal terms at the option of our tenants and borrowers. We also have included and intend to include in our lease agreements annual contractual rate increases that in the current market range from 1.5% to 3.5%. Our existing portfolio escalators range from 2.0% to 3.5%. In addition to the base rent, our leases require our tenants to pay all operating costs and expenses associated with the facility.

We acquire and develop healthcare facilities and lease the facilities to healthcare operating companies under long-term net leases. We also make mortgage loans to healthcare operators secured by their real estate assets. We selectively make loans to certain of our operators through our taxable REIT subsidiary, the proceeds of which are used for acquisitions and working capital. We consider our lending business an important element of our overall business strategy for two primary reasons: (1) it provides opportunities to make income-earning investments that yield attractive risk-adjusted returns in an industry in which our management has expertise, and (2) by making debt capital available to certain qualified operators, we believe we create for our company a competitive advantage over other buyers of, and financing sources for, healthcare facilities. For purpose of Statement of Financial Accounting Standards (SFAS) No. 131, *Disclosures about Segments of an Enterprise and Related Information*, we conduct business operations in one segment.

At December 31, 2005, we owned 14 operating healthcare facilities and held a mortgage loan secured by another. In addition, we were in process of developing three additional healthcare facilities that were not yet in operation. We had one acquisition loan outstanding, the proceeds of which our tenant used for the acquisition of six hospital operating companies. The 17 facilities we owned and the one facility that secured our mortgage loan were in nine states, had a carrying cost of approximately $331.2 million (including the balance of our mortgage loan) and comprised approximately 66.1% of our total assets. Our acquisition and other loans of approximately $48.2 million represented approximately 9.6% of our total assets. We do not expect such loan assets at any time to exceed 20% of our total assets. We also had cash and temporary investments of approximately $59.1 million that represented approximately 11.8% of our assets. Subsequent to December 31, 2005, we used $29.0 million of cash to pay down debt and $7.2 million for distributions to shareholders.

Our revenues are derived from rents we earn pursuant to the lease agreements with our tenants and from interest income from loans to our tenants and other facility owners. Our tenants operate in the healthcare industry, generally providing medical, surgical and rehabilitative care to patients. The capacity of our tenants to pay our rents and interest is dependent upon their ability to conduct their operations at profitable levels. We believe that the business environment of the industry segments in which our tenants operate is generally positive for efficient operators. However, our tenants operations are subject to economic, regulatory and market conditions that may affect their profitability. Accordingly, we monitor certain key factors, changes to which we believe may provide early indications of conditions that may affect the level of risk in our lease and loan portfolio.

Key factors that we consider in underwriting prospective tenants and in monitoring the performance of existing tenants include the following:

- the historical and prospective operating margins (measured by a tenant s earnings before interest, taxes, depreciation, amortization and facility rent) of each tenant and at each facility;

- the ratio of our tenants operating earnings both to facility rent and to facility rent plus other fixed costs, including debt costs;

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trends in the source of our tenants revenue, including the relative mix of Medicare, Medicaid/MediCal, managed care, commercial insurance, and private pay patients; and

the effect of evolving healthcare regulations on our tenants profitability.

Certain business factors, in addition to those described above that directly affect our tenants, will likely materially influence our future results of operations. These factors include:

trends in the cost and availability of capital, including market interest rates, that our prospective tenants may use for their real estate assets instead of financing their real estate assets through lease structures;

unforeseen changes in healthcare regulations that may limit the opportunities for physicians to participate in the ownership of healthcare providers and healthcare real estate;

reductions in reimbursements from Medicare, state healthcare programs, and commercial insurance providers that may reduce our tenants profitability and our lease rates, and;

competition from other financing sources.

At March 15, 2006, we had 20 employees. Over the next 12 months, we expect to add four to six additional employees.

Critical Accounting Policies

In order to prepare financial statements in conformity with accounting principles generally accepted in the United States, we must make estimates about certain types of transactions and account balances. We believe that our estimates of the amount and timing of lease revenues, credit losses, fair values and periodic depreciation of our real estate assets, stock compensation expense, and the effects of any derivative and hedging activities will have significant effects on our financial statements. Each of these items involves estimates that require us to make subjective judgments. We intend to rely on our experience, collect historical and current market data, and develop relevant assumptions to arrive at what we believe to be reasonable estimates. Under different conditions or assumptions, materially different amounts could be reported related to the accounting policies described below. In addition, application of these accounting policies involves the exercise of judgment on the use of assumptions as to future uncertainties and, as a result, actual results could materially differ from these estimates. Our accounting estimates will include the following:

Revenue Recognition. Our revenues, which are comprised largely of rental income, include rents that each tenant pays in accordance with the terms of its respective lease reported on a straight-line basis over the initial term of the lease. Since some of our leases provide for rental increases at specified intervals, straight-line basis accounting requires us to record as an asset, and include in revenues, straight-line rent that we will only receive if the tenant makes all rent payments required through the expiration of the term of the lease.

Accordingly, our management must determine, in its judgment, to what extent the straight-line rent receivable applicable to each specific tenant is collectible. We review each tenant s straight-line rent receivable on a quarterly basis and take into consideration the tenant s payment history, the financial condition of the tenant, business conditions in the industry in which the tenant operates, and economic conditions in the area in which the facility is located. In the event that the collectibility of straight-line rent with respect to any given tenant is in doubt, we are required to record an increase in our allowance for uncollectible accounts or record a direct write-off of the specific rent receivable,

which would have an adverse effect on our net income for the year in which the reserve is increased or the direct write-off is recorded and would decrease our total assets and stockholders equity. At that time, we stop accruing additional straight-line rent income.

Our development projects normally allow for us to earn what we term construction period rent . We record the accrued construction period rent as a receivable and as deferred revenue during the construction period. We recognize earned revenue on the straight-line method as the construction period rent is paid to us by the lessee/operator, usually beginning when the lessee/operator takes physical possession of the facility.

We make loans to certain tenants and from time to time may make construction or mortgage loans to facility owners or other parties. We recognize interest income on loans as earned based upon the principal amount

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outstanding. These loans are generally secured by interests in real estate, receivables, the equity interests of a tenant, or corporate and individual guarantees. As with straight-line rent receivables, our management must also periodically evaluate loans to determine what amounts may not be collectible. Accordingly, a provision for losses on loans receivable is recorded when it becomes probable that the loan will not be collected in full. The provision is an amount which reduces the loan to its estimated net receivable value based on a determination of the eventual amounts to be collected either from the debtor or from the collateral, if any. At that time, we discontinue recording interest income on the loan to the tenant.

Investments in Real Estate. We record investments in real estate at cost, and we capitalize improvements and replacements when they extend the useful life or improve the efficiency of the asset. While our tenants are generally responsible for all operating costs at a facility, to the extent that we incur costs of repairs and maintenance, we expense those costs as incurred. We compute depreciation using the straight-line method over the estimated useful life of 40 years for buildings and improvements, five to seven years for equipment and fixtures, and the shorter of the useful life or the remaining lease term for tenant improvements and leasehold interests.

We are required to make subjective assessments as to the useful lives of our facilities for purposes of determining the amount of depreciation expense to record on an annual basis with respect to our investments in real estate improvements. These assessments have a direct impact on our net income because, if we were to shorten the expected useful lives of our investments in real estate improvements, we would depreciate these investments over fewer years, resulting in more depreciation expense and lower net income on an annual basis.

We have adopted SFAS No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets*, which establishes a single accounting model for the impairment or disposal of long-lived assets, including discontinued operations. SFAS No. 144 requires that the operations related to facilities that have been sold, or that we intend to sell, be presented as discontinued operations in the statement of operations for all periods presented, and facilities we intend to sell be designated as held for sale on our balance sheet.

When circumstances such as adverse market conditions indicate a possible impairment of the value of a facility, we review the recoverability of the facility s carrying value. The review of recoverability is based on our estimate of the future undiscounted cash flows, excluding interest charges, from the facility s use and eventual disposition. Our forecast of these cash flows considers factors such as expected future operating income, market and other applicable trends, and residual value, as well as the effects of leasing demand, competition and other factors. If impairment exists due to the inability to recover the carrying value of a facility, an impairment loss is recorded to the extent that the carrying value exceeds the estimated fair value of the facility. We are required to make subjective assessments as to whether there are impairments in the values of our investments in real estate.

Purchase Price Allocation. We record above-market and below-market in-place lease values, if any, for the facilities we own which are based on the present value (using an interest rate which reflects the risks associated with the leases acquired) of the difference between (i) the contractual amounts to be paid pursuant to the in-place leases and (ii) management s estimate of fair market lease rates for the corresponding in-place leases, measured over a period equal to the remaining non-cancelable term of the lease. We amortize any resulting capitalized above-market lease values as a reduction of rental income over the remaining non-cancelable terms of the respective leases. We amortize any resulting capitalized below-market lease values as an increase to rental income over the initial term and any fixed-rate renewal periods in the respective leases. Because our strategy to a large degree involves the origination of long term lease arrangements at market rates, we do not expect the above-market and below-market in-place lease values to be significant for many of our anticipated transactions.

We measure the aggregate value of other intangible assets to be acquired based on the difference between (i) the property valued with existing leases adjusted to market rental rates and (ii) the property valued as if vacant.

Management s estimates of value are made using methods similar to those used by independent appraisers (*e.g.*, discounted cash flow analysis). Factors considered by management in its analysis include an estimate of carrying costs during hypothetical expected lease-up periods considering current market conditions, and costs to execute similar leases. We also consider information obtained about each targeted facility as a result of our pre-acquisition due diligence, marketing, and leasing activities in estimating the fair value of the tangible and intangible assets acquired. In estimating carrying costs, management also includes real estate taxes, insurance and other operating expenses and estimates of lost rentals at market rates during the expected lease-up periods, which we expect to range

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primarily from three to 18 months, depending on specific local market conditions. Management also estimates costs to execute similar leases including leasing commissions, legal costs, and other related expenses to the extent that such costs are not already incurred in connection with a new lease origination as part of the transaction.

The total amount of other intangible assets to be acquired, if any, is further allocated to in-place lease values and customer relationship intangible values based on management s evaluation of the specific characteristics of each prospective tenant s lease and our overall relationship with that tenant. Characteristics to be considered by management in allocating these values include the nature and extent of our existing business relationships with the tenant, growth prospects for developing new business with the tenant, the tenant s credit quality, and expectations of lease renewals, including those existing under the terms of the lease agreement, among other factors.

We amortize the value of in-place leases to expense over the initial term of the respective leases, which range primarily from 10 to 15 years. The value of customer relationship intangibles is amortized to expense over the initial term and any renewal periods in the respective leases, but in no event will the amortization period for intangible assets exceed the remaining depreciable life of the building. Should a tenant terminate its lease, the unamortized portion of the in-place lease value and customer relationship intangibles would be charged to expense.

Accounting for Derivative Financial Investments and Hedging Activities. We expect to account for our derivative and hedging activities, if any, using SFAS No. 133, *Accounting for Derivative Instruments and Hedging Activities*, as amended by SFAS No. 137 and SFAS No. 149, which requires all derivative instruments to be carried at fair value on the balance sheet.

Derivative instruments designated in a hedge relationship to mitigate exposure to variability in expected future cash flows, or other types of forecasted transactions, are considered cash flow hedges. We expect to formally document all relationships between hedging instruments and hedged items, as well as our risk-management objective and strategy for undertaking each hedge transaction. We plan to review periodically the effectiveness of each hedging transaction, which involves estimating future cash flows. Cash flow hedges, if any, will be accounted for by recording the fair value of the derivative instrument on the balance sheet as either an asset or liability, with a corresponding amount recorded in other comprehensive income within stockholders equity. Amounts will be reclassified from other comprehensive income to the income statement in the period or periods the hedged forecasted transaction affects earnings. Derivative instruments designated in a hedge relationship to mitigate exposure to changes in the fair value of an asset, liability, or firm commitment attributable to a particular risk, which we expect to affect the Company primarily in the form of interest rate risk or variability of interest rates, are considered fair value hedges under SFAS No. 133. We are not currently a party to any derivatives contracts.

Variable Interest Entities. In January 2003, the FASB issued Interpretation No. 46 (FIN 46), *Consolidation of Variable Interest Entities.* In December 2003, the FASB issued a revision to FIN 46, which is termed FIN 46(R). FIN 46(R) clarifies the application of Accounting Research Bulletin No. 51, *Consolidated Financial Statements*, and provides guidance on the identification of entities for which control is achieved through means other than voting rights, guidance on how to determine which business enterprise should consolidate such an entity, and guidance on when it should do so. This model for consolidation applies to an entity in which either (1) the equity investors (if any) do not have a controlling financial interest or (2) the equity investment at risk is insufficient to finance that entity s activities without receiving additional subordinated financial support from other parties. An entity meeting either of these two criteria is a variable interest entity, or VIE. A VIE must be consolidated by any entity which is the primary beneficiary of the VIE. If an entity is not the primary beneficiary of the VIE, the VIE is not consolidated. We periodically evaluate the terms of our relationships with our tenants and borrowers to determine whether we are the primary beneficiary and would therefore be required to consolidate any tenants or borrowers that are VIEs. Our evaluations of our transactions indicate that we have loans receivable from two entities which we classify as VIEs. However, because we are not the primary beneficiary of these VIEs, we do not consolidate these entities in our

financial statements.

Stock-Based Compensation. We currently apply the intrinsic value method to account for the issuance of stock options under our equity incentive plan in accordance with APB Opinion No. 25, *Accounting for Stock Issued to Employees.* In this regard, we anticipate that a substantial portion of our options will be granted to individuals who are our officers or directors. Accordingly, because the grants are expected to be at exercise prices that represent fair value of the stock at the date of grant, we do not currently record any expense related to the issuance of these

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options under the intrinsic value method. If the actual terms vary from the expected, the impact to our compensation expense could differ.

In December 2004, the FASB issued SFAS No. 123(R), *Share-Based Payment*, which is a revision of SFAS No. 123, *Accounting for Stock Based Compensation.* SFAS No. 123(R) establishes standards for accounting for transactions in which an entity exchanges its equity instruments for goods or services. The Statement focuses primarily on accounting for transactions in which an entity obtains employee services in share-based payment transactions. SFAS No. 123(R) requires that the fair value of such equity instruments be recognized as expense in the historical financial statements as services are performed. The impact of SFAS No. 123(R) will also be affected by the types of stock-based awards that our board of directors chooses to grant. Prior to SFAS No. 123(R), only certain pro forma disclosures of fair value were required, which primarily applies to stock options granted at the then current market price per share of stock. Our existing equity incentive plan allows for stock-based awards to be in the form of options, restricted stock, restricted stock units and deferred stock units. Currently, we expect that our board of directors will make awards in the form of restricted stock, restricted stock units and deferred stock units. The SEC has ruled that both SFAS No. 123 and SFAS 123(R) are acceptable GAAP until SFAS No. 123(R) becomes effective for our annual and interim periods beginning January 1, 2006. However, we have elected to continue following the guidelines of SFAS No. 123 to account for our awards of restricted stock in 2005. During the year ended December 31, 2005, we recorded a $1.2 million non-cash expense for restricted shares issued to employees, officers and directors.

Disclosure of Contractual Obligations

The following table summarizes known material contractual obligations associated with investing and financing activities as of December 31, 2005:

Contractual Obligations	Less Than 1 Year	2-3 Years	4-5 Years	After 5 Years	Total
Construction contracts	$ 55,790,115	$	$	$	$ 55,790,115
Construction loans (1)	1,538,899	40,703,502			42,242,401
Revolving credit facility (2)	4,839,232	9,678,464	69,446,141		83,963,837
Operating lease commitments (3)	424,790	871,989	838,010	22,639,194	24,773,983
Totals	$ 62,593,036	$ 51,253,955	$ 70,284,151	$ 22,639,194	$ 206,770,336

(1) Assumes the Company exercises its option to convert the construction loans to term loans in June 2006, and the balance and interest rates are those at December 31, 2005.

(2) Assumes the balance and interest rates are those in effect at December 31, 2005 and no principal payments are made until the expiration of the facility in 2009. The Company did make a principal reduction of $29.0 million in January, 2006.

(3) Substantially all of our contractual obligations to make operating lease payments are related to ground leases for which we are reimbursed by our tenants.

The Company also has outstanding letters-of-credit which total $2.2 million at December 31, 2005 and which expire in 2007.

Liquidity and Capital Resources

As of March 24, 2006, we have approximately $4.3 million in cash and temporary liquid investments.

In 2005, we completed our initial public offering with the sale of 13,175,023 shares of common stock at an offering price of $10.50 per share. After deducting underwriter s discounts and offering expenses, our net proceeds from the offering totaled approximately $124.4 million. In 2004, we completed the sale of 25,560,954 shares of common stock in a private placement at an offering price of $10.00 per share. After deducting underwriters discounts and offering expenses, our net proceeds from the private placement totaled approximately $233.5 million.

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In October 2005, we entered into a four-year $100.0 million secured revolving credit facility (the revolver), using proceeds to replace our existing $75.0 million term loan, which had a balance of approximately $65.0 million at December 31, 2005. As of March 24, 2006, the revolver has an outstanding balance of approximately $36.0 million. The loan is secured by a collateral pool comprised of several of our properties. The six properties currently in the collateral pool provide available borrowing capacity of approximately $74.2 million. We believe we have sufficient value in our other properties to increase the availability under the credit facility to its present maximum of $100.0 million. Under the terms of the credit agreement, we may increase the maximum commitment to $175.0 million subject to adequate collateral valuation and payment of customary commitment fees.

In addition to availability under the revolving credit facility, we have two construction/term facilities totaling approximately $43.0 million from a bank to finance our Houston Town and Country Hospital and Medical Office Building. As of March 24, 2006, the loans have an aggregate balance totaling approximately $35.8 million. We have the option, until June 2006 to convert these loans to 30 month term loans.

At December 31, 2005, we had remaining commitments to complete the funding of three development projects as described below (in millions):

	Original Commitment	Cost Incurred	Remaining Commitment
North Cypress community hospital	$ 64.0	$ 22.1	$ 41.9
Bucks County women s hospital and medical office building	38.0	10.0	28.0
Monroe County community hospital	35.5	13.2	22.3
Total	$ 137.5	$ 45.3	$ 92.2

Short-term Liquidity Requirements: We believe that our existing cash and temporary investments, funds available under our existing loan agreements, additional financing arrangements and cash from operations will be sufficient for us to complete the developments described above, acquire between $200 and $300 million in additional assets, provide for working capital, and make distributions to our stockholders through 2006. We expect that such additional financing arrangements will include various types of new debt, including long-term, fixed-rate mortgage loans, variable-rate term loans, and construction financing facilities. Generally, we believe we will be able to finance up to approximately 50-60% of the cost of our healthcare facilities; however, there is no assurance that we will be able to obtain or maintain those levels of debt on our portfolio of real estate assets on favorable terms in the future.

Long-term Liquidity Requirements: We believe that cash flow from operating activities subsequent to 2006 will be sufficient to provide adequate working capital and make distributions to our stockholders in compliance with our requirements as a REIT. However, in order to continue acquisition and development of healthcare facilities after 2006, we will require access to more permanent external capital, such as equity capital. If equity capital is not available at a price that we consider appropriate, we may increase our debt, utilize other forms of capital, if available, or reduce our acquisition activity.

Financing Activities

During the year ended December 31, 2005, we raised $124.7 million, net of offering costs and expenses, from the sale of common stock, primarily from our IPO. We also borrowed an additional $19.0 million on our term loan, for a total of $75.0 million of loan proceeds on the term loan. After reducing the principal balance of the term loan through

principal repayments, we converted the remaining $40.0 million balance into borrowings on our $100.0 million secured revolving credit facility. We borrowed an additional net $25.0 million on the revolver during the last quarter of 2005. We also borrowed an $35.5 million on our two Houston construction loans. The revolver, the construction loans and our expectations concerning future financing activities are further described above under Liquidity and Capital Resources. We also sold $1.1 million in limited partnership units in our West Houston medical office building partnership (a subsidiary of our Operating Partnership). Our sale of such interests in certain of our healthcare facilities is based on a strategy of encouraging physicians and other parties to locate their practices in or near our healthcare facilities. We do not consider this strategy integral to our capital raising process.

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Investing Activities

During the year ended December 31, 2005, we made investments in six existing healthcare facilities with an aggregate investment value of $107.3 million, and net cash outlays of $97.7 million, after subtracting contingent payments and facility improvement reserves, and including a $6.0 million first mortgage loan that was converted to a sale-leaseback arrangement. We also invested $78.8 million in our development projects. In 2005, we made loans with a total principal value of $47.5 million, and net cash outlays of $46.0 million, after subtracting contingent payments and facility improvement reserves. Our primary loan in 2005 was a first mortgage loan of $40.0 million. In February 2005, Vibra reduced the principal amount of its loans by $7.7 million. Our expectations about future investing activities are described above under Liquidity and Capital Resources.

Results of Operations

Our historical operations are generated substantially by investments we have made since we completed our private offering and raised approximately $233.5 million in common equity in the second quarter of 2004 and since we completed our IPO and raised approximately $124.7 million in common equity in the third quarter of 2005. We also are in the process of developing additional healthcare facilities that have not yet begun generating revenue, and we expect to acquire additional existing healthcare facilities in the foreseeable future. Accordingly, we expect that future results of operations will vary materially from our historical results.

Year Ended December 31, 2005 Compared to the Year Ended December 31, 2004

Net income for the year ended December 31, 2005 was $19,640,347 compared to net income of $4,576,349 for the year ended December 31, 2004.

A comparison of revenues for the years ended December 31, 2005 and 2004, is as follows:

	2005		2004		Change
Base rents	$ 18,979,580	60.2%	$ 6,162,278	56.6%	$ 12,817,302
Straight-line rents	5,460,148	17.3%	2,449,065	22.5%	3,011,083
Percentage rents	2,259,230	7.2%			2,259,230
Interest from loans	4,726,579	14.9%	2,282,116	20.9%	2,444,463
Fee income	123,662	0.4%			123,662
Total revenue	$ 31,549,199	100.0%	$ 10,893,459	100.0%	$ 20,655,740

Revenue for the year ended December 31, 2005, was comprised of rents (84.7%) and interest and fee income from loans (15.3%). All of this revenue was derived from properties that we have acquired since July 1, 2004. Our base and straight-line rents increased in 2005 due to the timing of 2004 acquisitions, plus the acquisition and development of seven new facilities in 2005. In 2005, we received percentage rents of approximately $2.3 million from Vibra. Pursuant to our lease terms with Vibra, we were not eligible to receive percentage rent in 2004. Interest income from loans in the year ended December 31, 2005, increased primarily based on the timing and amount of Vibra loan advances and repayments in 2004 and 2005, and on the origination of the Denham Springs loan in 2005. Vibra accounted for 83.2% and 100.0% of our gross revenues in 2005 and 2004, respectively. In 2005, Vibra accounted for 81.7% of our total rent revenues. We expect that the portion of our total revenues attributable to Vibra will decline in relation to our acquisition of properties leased to tenants other than Vibra. At December 31, 2005, assets leased and

loaned to Vibra comprised 37.0% of our total assets.

Depreciation and amortization during the year ended December 31, 2005 was $4,404,361, compared to $1,478,470 during the year ended December 31, 2004. The increase is due to the timing and amount of acquisitions and developments in 2004 (six properties owned for less than six months) and 2005 (six properties owned for a full year and eight properties placed in service throughout the year). We expect our depreciation and amortization expense to continue to increase commensurate with our acquisition and development activity.

General and administrative expenses during the years ended December 31, 2005 and 2004, totaled $8,016,992 and $5,150,786, respectively, which represents an increase of 28.5%. The increase is due primarily to

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approximately $1.2 million of share based compensation expense (52% of the increase in general and administrative expenses) as a result of restricted shares granted to employees, officers and directors during 2005. In addition, we incurred incremental legal and professional expenses in 2005 related to our reporting and other compliance requirements as a public company. During 2005 we also incurred additional compensation expense related to the increased number of employees in 2005.

Interest income (other than from loans) for the years ended December 31, 2005 and 2004, totaled $2,091,132 and $930,260, respectively. Interest income increased due to the timing and amount of offering proceeds temporarily invested in short-term cash equivalent instruments and to higher interest rates in 2005.