MEDICAL PROPERTIES TRUST INC
Form 10-K
March 14, 2008

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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, 2007

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**	**35242**
(Address of Principal Executive Offices)	*(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. þ

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

Large accelerated filer o	Accelerated filer þ	Non-accelerated filer o (Do not check if a smaller reporting company)	Smaller reporting company o

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 June 30, 2007 was approximately $655,917,760. For purposes of the foregoing calculation only, all directors and executive officers of the Registrant have been deemed affiliates.

As of March 13, 2008, 53,710,574 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 22, 2008 are incorporated by reference into Part III, Items 10 through 14 of this Annual Report on Form 10-K.

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EX-99.2 CONSOLIDATED FINANCIAL STATEMENTS

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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 and loans;
- our ability to raise additional funds through offerings of our debt and equity securities;
- our ability to obtain future financing arrangements;
- estimates relating to, and our ability to pay, future distributions;
- our ability to compete in the marketplace;
- lease rates and interest rates;
- 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 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 and other securities, 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.

Except as required by law, we disclaim any obligation to update such statements or to publicly announce the result of any revisions to any of the forward-looking statements contained in this Annual Report on Form 10-K to reflect future events or developments.

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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 subsidiaries, MPT Operating Partnership, L.P., and MPT Development Services, Inc. References in this Annual Report on Form 10-K to Medical Properties Trust, Medical Properties, we, us, our, and the Company include Medical Properties Trust, Inc. and our subsidiaries.

Since April 2004, we have issued at various times approximately 50.7 million shares of common stock for net proceeds of approximately $539.8 million. At March 1, 2008, we have approximately $934.7 million invested in healthcare real estate and related 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 have no present plans to invest in non-U.S. markets in the foreseeable future.

During 2007, we:

- invested approximately $316 million in new healthcare real estate assets;
- reduced exposure to Vibra Healthcare to 31% of total revenue from 55% of total revenue in 2006;
- sold 12.2 million shares of common stock for net proceeds of $179.1 million or $14.66 per share, net of underwriters discount and offering expenses; and
- completed agreements for two new credit facilities which provide for new borrowings of up to $262.0 million.

Portfolio of Properties

As of December 31, 2007, our portfolio consisted of 28 properties: 25 facilities which we own are leased to eight tenants and the remaining in the form of mortgage loans to two operators. Our owned facilities consisted of 12 general acute care hospitals, 9 long-term acute care hospitals, and 4 inpatient rehabilitation hospitals. The non-owned facilities on which we have made mortgage loans consist of general acute care facilities. We intend to continue to focus on investments in licensed hospitals as our primary line of business.

Outlook and Strategy

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 but are not limited to: physical rehabilitation hospitals, long-term acute care hospitals, and regional and community hospitals.

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Our Leases and Loans

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. Similarly, borrowers under our mortgage loan arrangements retain the responsibilities of ownership, including physical maintenance and improvements and all costs and expenses. Our leases and loans also provide that our tenants will indemnify us for environmental liabilities. Our current leases and loans have initial terms of 10 to 15 years and provide for annual rent or interest escalation and, in some cases, percentage rent.

Significant Tenants

At March 1, 2008, we have leases with eight hospital operating companies covering 25 facilities and we have mortgage loans to two hospital operating companies. Vibra Healthcare, LLC (Vibra) leases eight of our facilities. Total revenue from Vibra in 2007 was approximately $30.1 million, or 31.3% of total revenue. We expect that the percentage of revenue we earn from Vibra in 2008 will be substantially less than that in 2007 because our 2007 acquisitions and our anticipated near-term future acquisitions are expected to diversify our portfolio by adding new tenants. Although we expect to make additional investments in Vibra-operated properties in the foreseeable future, we believe that our Vibra revenue will continue to decline relative to our total revenue.

At March 1, 2008, affiliates of Prime Healthcare Services, Inc. (Prime) lease seven of our facilities and we have mortgage loans on two facilities owned by affiliates of Prime. Total revenue from Prime affiliates in 2007 was approximately $24.9 million, or 25.9% of total revenue. As of December 31, 2007, expected annual revenue from Prime represented 34% of total expected annual revenues. It is likely that we will make additional investments in Prime affiliated properties in the foreseeable future.

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 remediate hazardous or toxic substances or petroleum product releases or threats of releases. Such laws also impose certain obligations and liabilities on property owners with respect to asbestos containing materials. These laws may impose remediation 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. Investigation, remediation 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.

Generally, prior to completing any acquisition or closing any mortgage loan, 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.

Competition

We compete in acquiring and developing facilities with financial institutions, other lenders, 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 invest in or develop facilities;

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many of our competitors have greater financial and operational resources than we have;

our competitors or other entities may pursue a strategy similar to ours; and

some of our competitors may have existing relationships with our potential customers.

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 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 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.

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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 monetary 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, the Centers for Medicare & Medicaid Services (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 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 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. On August 8, 2006, CMS published the final report and the moratorium expired. However, CMS continues to scrutinize physician investments in specialty hospitals. CMS has stated its intention to require certain specialty and other hospitals to provide detailed information regarding their financial arrangements with physicians. CMS will use this information to review those arrangements for compliance with the Stark Law.

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.

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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 22, 2007, CMS published a Final Rule with comment period for IPPS for fiscal year 2008. The Final Rule includes a 3.5% 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 2008. CMS expects aggregate payments to IPPS hospitals to increase by $3.8 billion over the previous year. The changes are expected to increase payment to those hospitals treating more severely ill and costlier patients.

CMS continues to make changes to its prospective payment system for inpatient rehabilitation facilities, or IRFs. The Final Rule updates payment rates and modifies certain payment policies. Under the Final Rule, approximately 1,220 IRFs will receive increased Medicare payments of approximately $150 million. The Final Rule also includes a 3.2% market basket increase and increases the outlier threshold for cases with unusually high costs from $5,534 in fiscal year 2007 to $7,362 for fiscal year 2008. In addition, the Final Rule updates the IRF prospective payment system wage index.

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 29, 2007, President Bush signed legislation permanently freezing at 60% the threshold amount. Also, currently, IRFs, in addition to considering a patient s primary diagnosis, are able to consider comorbidities for purposes of determining compliance with the 75 percent rule. However, for cost reporting periods beginning on or after July 1, 2008, IRFs will no longer be able to consider comorbidities when making such determinations.

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,

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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. §1395ww(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 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%. CMS has reported that a significant majority of hospitals will receive the full market basket update for fiscal year 2008 because they have met the quality reporting requirements.

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

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specialty hospitals until the earlier of the date the report is submitted or six months after enactment of the DRA. The final report was published on August 8, 2006, at which time the moratorium expired. Despite the expiration of the moratorium, specialty hospitals are expected to remain under heightened scrutiny.

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. 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 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. In addition, California also recently adopted cuts to the state s Medicaid program referred to as Medi-Cal totaling $1.6 billion. Reimbursement rates for providers are expected to be cut by 10 percent and are expected to produce $47.6 million in savings for the state.

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. 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.

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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 (SNFs) 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. On August 3, 2007, CMS published a final rule regarding prospective payment system for SNFs. Pursuant to the final rule, SNFs will receive an increase of 3.3%, which amounts to approximately $690 million in fiscal year 2008. The final rule also revises the SNF market-basket, moving the base year from 1997 to 2004. On December 29, 2007, President Bush signed legislation that contained an extension to June 30, 2008 of the nursing home therapy cap exception.

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 January 2008, CMS proposed paying long term care hospitals approximately $4.44 billion under the PPS for RY 2009. This includes a proposed increase of 2.6% compared with RY 2008. Under the final rule for RY 2008, CMS had lowered payments by 3.8%. CMS is proposing to change the annual update schedule to coincide with other classification systems, thus, as proposed, the RY 2009 would be effective for 15 months, from July 1, 2008 through September 30, 2009.

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 Health and Human Services 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. 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 believe that the policy specifications and insured limits are appropriate given the relative risk of loss, the cost of the coverage and industry practice.

Employees

We have 26 employees as of March 1, 2008. We believe that any adjustments to the number of our employees will have only immaterial effects on our operations and general and administrative expenses. We believe that our relations with our employees are good. None of our employees are members of any union.

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Available Information

Our website address is www.medicalpropertiestrust.com and provides access in the Investor Relations section, free of charge, to our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, including exhibits, and all amendments to these reports as soon as reasonably practicable after such material is electronically filed with or furnished to the Securities and Exchange Commission. Also available on our website, free of charge, are our Corporate Governance Guidelines, the charters of our Ethics, Nominating and Corporate Governance, Audit and Compensation Committees and our Code of Ethics and Business Conduct. If you are not able to access our website, the information is available in print free of charge to any shareholder who should request the information directly from us at (205) 969-3755.

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

RISKS RELATED 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 were organized in 2003 and thus have a limited operating history. We first elected REIT status for our taxable year ended December 31, 2004. We are subject to the risks generally associated with the formation of any new business, including unproven business models, 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 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 development of facilities. As a REIT, we are required to make cash distributions, which reduce 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, such as the dislocations in the credit markets beginning in 2007, there may 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 payments of rent and interest 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.

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Accordingly, we rely almost exclusively on rent payments from our tenants under leases or interest payments from operators under mortgage loans we have made to them 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, operator or guarantor, could have a material adverse effect on our ability to collect rent and interest 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 and interest to us.

It may be costly to replace defaulting tenants and we may not be able to replace defaulting tenants with suitable replacements on suitable terms.

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 and loans with that tenant and enforce the payment obligations under the lease. The process of terminating a lease with a defaulting tenant and repossessing the applicable facility may be costly and require a disproportionate amount of management s attention. In addition, defaulting tenants or their affiliates may initiate litigation in connection with a lease termination or repossession against us or our subsidiaries. For example, in connection with our termination of leases relating to the Houston Town and Country Hospital and Medical Office Building in late 2006, we were subsequently named as one of a number of defendants in lawsuits filed by various affiliates of the defaulting tenant. Resolution of these types of lawsuits in a manner materially adverse to us may adversely affect our financial condition and results of operations. If a tenant-operator defaults and we choose to terminate our lease, 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.

Our revenues are dependent upon our relationship with, and success of, Vibra and Prime.

As of December 31, 2007, we owned 25 facilities which were being operated by eight operators, and we had mortgage loans to two operators. Vibra Healthcare, LLC, or Vibra, leased eight of our facilities, representing 21.6% of the original total cost of our operating facilities and mortgage loans as of December 31, 2007, and affiliates of Prime Healthcare Services, Inc. leased or mortgaged nine facilities, representing 39.6% of the original total cost of our operating facilities and mortgage loans as of December 31, 2007. Total revenue from Vibra and Prime, including rent, percentage rent and interest, was approximately $30.1 million and $24.9 million, respectively, or 31.3% and 25.9%, respectively, of total revenue from continuing operations in the year ended December 31, 2007.

In 2007, we completed transactions with Prime for approximately $243.0 million. We may pursue additional transactions with Vibra or Prime in the future. Our relationship with Vibra and Prime, and their respective financial performance and resulting ability to satisfy their 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 are dependent upon the ability of Vibra and Prime to make rent and loan payments to us, and their failure or delay to meet these obligations would have a material adverse effect on our financial condition and results of operations.

Accounting rules may require consolidation of entities to which we have made loans 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

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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 January 31, 2003. Under certain circumstances, generally accepted accounting principles may require us to account for loans to thinly capitalized companies 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.

Some of our tenants, including North Cypress Medical Center Operating Company, Bucks County Oncoplastic Institute, 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 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 are currently leased to Vibra, Post Acute, Prime, Healthcare Partners of America (HPA), Gulf States, North Cypress, Bucks County Oncoplastic Institute (BCO) and Monroe Hospital 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 and Monroe Hospital 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

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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 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.

As of December 31, 2007, we had $480.5 million of debt outstanding. As of March 1, 2008, we have approximately $402.7 million of debt outstanding. We may borrow from other lenders in the future, or we may issue debt securities in public or private offerings and our organizational documents do not limit the amount of debt we may incur.

Most of our current debt is, and we anticipate that much of our future 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 December 31, 2007, we had approximately $220.8 million in variable interest rate debt ($142.8 million at March 1, 2008). 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 our 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. 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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RISKS RELATING TO REAL ESTATE INVESTMENTS

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

We have acquired and have developed and have made mortgage investments in and expect to continue acquiring and developing and making mortgage investments in 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 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 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 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 have completed development and construction of four facilities which are now in operation. 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.

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We expect to fund our development projects over time. The time frame required for development and construction of these facilities means that we may have to wait years for a significant cash return. In addition, our tenants may not be able to obtain managed care provider contracts in a timely manner or at all. 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 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 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 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, which 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

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loan payments by our tenants, could 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.

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.

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 manage, 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 or developed or on which we have made mortgage loans 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 contamination and liabilities may exist of which we are unaware.

Although the leases for our facilities and our mortgage loans generally require our operators 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 material violation of environmental laws could have a material adverse affect on us. In addition, environmental and occupational health and safety laws are constantly evolving, and changes in laws, regulations or policies, or changes in interpretations of the foregoing, could create liabilities where none exists today.

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 three of our facilities, at least in part, by acquiring leasehold interests in the land on which the facility is 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 facility in San Antonio limits use of the property to operation of a comprehensive rehabilitation hospital, medical research and education and other medical uses and uses reasonably incidental thereto. 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.

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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 relying 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.

A significant number of our tenants operate long-term acute care hospitals, or LTACHs. The United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, or CMS, recently proposed a 0.71 percent increase to the LTACH prospective payment system rates for 2008. However, in light of concerns raised by an analysis of recent LTACH case mix data, CMS also proposed a budget neutrality requirement for annual payment updates.

In addition to the proposed payment changes, CMS is proposing changes to its policy known as the 25 percent rule. That rule takes into account the percentage of patients that were admitted to the LTACH from its co-located host hospital (usually a general acute care hospital). Under the current policy, if an LTACH that is a hospital-within-a-hospital or satellite facility that has more than a certain percentage (generally 25 percent) of its discharges admitted from the co-located host hospital for the cost reporting period, then the payment to the LTACH would be adjusted downward. CMS adopted a final rule that extends the 25 percent rule and implements a payment adjustment for LTACH and satellites (including grandfathered facilities) that applies to Medicare discharges that were admitted from a referring hospital that is not co-located with it. Implementation of the 25 percent rule will extend over a three year period,. For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008 (the first transition year), the threshold is no less than the lesser of 75 percent or the percentage of Medicare discharges that had been admitted to the LTACH or satellite facility during its RY 2005 cost reporting period from that referring hospital. CMS will continue to explore implementing a recommendation from MedPAC to develop facility and patient level criteria for LTACHs. If adopted as proposed, these changes could have a material adverse effect on the financial condition of some 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.

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

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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 a new tenant s 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 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 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

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Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, expired on June 8, 2005. However, that moratorium was retroactively extended by the passage of the Deficit Reduction Act of 2005, or 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 final report was published on August 8, 2006, at which time the moratorium expired. However, we expect that specialty hospitals will continue to be closely scrutinized by Congress and various federal and state agencies. Further, despite the expiration of the specialty hospital moratorium, in its final report, CMS expressed its intention to (i) revise the Medicare payment system to address incentives to physician investors; (ii) require disclosure of physician investment and compensation arrangements; (iii) continue to enforce the fraud and abuse laws; and (iv) continue to enforce prior violations of the MMA moratorium. 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. On September 7, 2007, CMS published Phase III regulations which modify certain aspects of the Stark Law regulations. Subsequently, the effective dates of a portion of those regulations was extended. In addition, CMS proposed additional changes to existing Stark Law regulations as part of the IPPS regulations.

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 and Medical Properties charter and 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 the price of Medical Properties common stock or cause dilution.

Medical Properties charter contains ownership limitations that may restrict business combination opportunities, inhibit change of control transactions and reduce the value of Medical Properties common stock. To qualify as a REIT under the Internal Revenue Code of 1986, as amended, or the Code, no more than 50% in value of Medical Properties 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. Medical Properties 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 Medical Properties common stock. Generally, Medical Properties 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 to be in their best interests. The ownership limitation provisions also may make Medical Properties 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 Medical Properties common stock.

Medical Properties charter and bylaws contain provisions that may impede third-party acquisition proposals that may be in your best interests. Medical Properties charter and bylaws also provide that our directors may only

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be removed by the affirmative vote of the holders of two-thirds of Medical Properties common 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 Medical Properties 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., R. Steven Hamner, Emmett E. McLean, Michael G. Stewart and William G. Mc Kenzie 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 developed. 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.

Our UPREIT structure may result in conflicts of interest between Medical Properties 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 issue operating 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 sole member of the general partner of the operating partnership, Medical Properties has fiduciary duties to the limited partners of the operating partnership that may conflict with fiduciary duties Medical Properties officers and directors owe to its 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 Medical Properties 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.

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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 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.

Loans to our tenants could be recharacterized as equity, in which case our rental income from that tenant might 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. As of March 1, 2008, that loan had been reduced to approximately $29.4 million. 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%.

Our taxable REIT subsidiary has made and will make loans to tenants to acquire operations or for other purposes. The Internal Revenue Service, or IRS, may take the position that certain loans to tenants should be treated as equity interests rather than debt, and that our rental income from such tenant should not be treated as qualifying income for purposes of the REIT gross income tests. If the IRS were to successfully treat a loan to a particular tenant as equity interests, the tenant would be a related party tenant with respect to our company and the rent that we receive from the tenant 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 a particular loan as interests held by our operating partnership rather than by our taxable REIT subsidiary, we could fail the 5% asset test, and if the IRS further successfully treated the loan as other than straight debt, we could fail the 10% asset test with respect to such interest. As a result of the failure of either test, 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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RISKS RELATED TO AN INVESTMENT IN OUR COMMON STOCK

The market price and trading volume of our common stock may be volatile.

The market price of our common stock may be highly volatile and be subject to wide fluctuations. In addition, the trading volume in our common stock may fluctuate and cause significant price variations to occur. If the market price of our common stock declines significantly, you may be unable to resell your shares at or above your purchase price.

We cannot assure you that the market price of our common stock will not fluctuate or decline significantly in the future. Some of the factors that could negatively affect our share price or result in fluctuations in the price or trading volume of our common stock include:

- actual or anticipated variations in our quarterly operating results or distributions;
- changes in our funds from operations or earnings estimates or publication of research reports about us or the real estate industry;
- increases in market interest rates that lead purchasers of our shares of common stock to demand a higher yield;
- changes in market valuations of similar companies;
- adverse market reaction to any increased indebtedness we incur in the future;
- additions or departures of key management personnel;
- actions by institutional stockholders;
- 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;
- speculation in the press or investment community; and
- general market and economic conditions.

Future sales of common stock may have adverse effects on our stock price.

We cannot predict the effect, if any, of future sales of common stock, or the availability of shares for future sales, on the market price of our common stock. Sales of substantial amounts of common stock, or the perception that these sales could occur, may adversely affect prevailing market price for our common stock. We may issue from time to time additional common stock or units of our operating partnership in connection with the acquisition of facilities and we may grant additional demand or piggyback registration rights in connection with these issuances. Sales of substantial amounts of common stock or the perception that these sales could occur may adversely affect the prevailing market price for our common stock. In addition, the sale of these shares could impair our ability to raise capital through a sale of additional equity securities.

An increase in market interest rates may have an adverse effect on the market price of our securities.

One of the factors that investors may consider in deciding whether to buy or sell our securities is our distribution rate as a percentage of our price per share of common stock, relative to market interest rates. If market interest rates increase, prospective investors may desire a higher distribution or interest rate on our securities or seek securities paying higher distributions or interest. The market price of our common stock likely will be based primarily on the earnings that we derive from rental income with respect to our facilities and our related distributions to stockholders, and not from the underlying appraised value of the facilities themselves. As a result, interest rate fluctuations and capital market conditions can affect the market price of our common stock. In addition, rising interest rates would result in increased interest expense on our variable-rate debt, thereby adversely affecting cash flow and our ability to service our indebtedness and make distributions.

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ITEM 1B. ***Unresolved Staff Comments***

None

ITEM 2. ***Properties***

At December 31, 2007, our portfolio consisted of 28 properties: 25 facilities which we own are leased to eight tenants with the remainder in the form of mortgage loans to two operators, totaling an aggregate of approximately 3.3 million square feet and 3,453 licensed beds.

State	Total Revenue	Percentage of Total Revenue	Total Investment
California	$ 41,835,572	43.4%	$ 501,016,031
Colorado	1,398,953	1.5%	9,502,455
Indiana	5,289,316	5.5%	50,211,656
Kentucky	6,886,681	7.2%	45,595,371
Louisiana	2,222,137	2.3%	17,562,684
Massachusetts	4,551,598	4.7%	29,934,621
New Jersey	6,299,852	6.5%	41,569,113
Oregon	1,866,904	1.9%	24,447,351
Pennsylvania	5,749,929	6.0%	45,515,767
Texas	20,186,421	21.0%	158,307,473
	$ 96,287,363	100.0%	$ 923,662,522

Type of Property	Number of Properties	Number of Square Feet	Number of Licensed Beds
Community Hospital	15	2,383,434	2,623
Long-term Acute Care Hospital	9	594,238	567
Rehabilitation Hospital	4	335,492	263
	28	3,313,164	3,453

ITEM 3. ***Legal Proceedings***

None.

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

None.

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PART II

ITEM 5. ***Market for Registrant s Common Equity, Related Stockholder Matter, and Issuer Purchases of Equity Securities***

Medical Properties common stock is traded on the New York Stock Exchange under the symbol MPW. The following table sets forth the high and low sales prices for the common stock for the periods indicated, as reported by the New York Stock Exchange Composite Tape, and the distributions declared by us with respect to each such period.

	High	Low	Distribution
Year ended December 31, 2006			
First Quarter	11.23	9.40	0.21
Second Quarter	12.50	10.25	0.25
Third Quarter	13.93	11.25	0.26
Fourth Quarter	15.65	13.12	0.27
Year ended December 31, 2007			
First Quarter	16.70	14.44	0.27
Second Quarter	15.25	12.16	0.27
Third Quarter	13.88	10.86	0.27
Fourth Quarter	13.99	9.80	0.27

On March 13, 2008, the closing price for our common stock, as reported on the New York Stock Exchange, was $12.08. As of March 13, 2008, there were 82 holders of record of our common stock. This figure does not reflect the beneficial ownership of shares held in nominee name.

On August 1, 2007, the Company announced that its Board authorized the Company to repurchase up to 3.0 million of its Common Stock. The stock may be repurchased by the Company from time to time on the open market or in privately negotiated transactions between August 1, 2007 and July 31, 2008. The extent to which the Company repurchases its shares and the timing of such purchases will depend upon price, corporate and regulatory requirements, market conditions and other corporate considerations.

The following table provides information as of December 31, 2007 with respect to the shares of common stock repurchased by the Company:

Period	(a) Total # of Shares Purchased	(b) Average Price Paid per Share	(c) Total # of Shares Purchased as Part of Publicly Announced Programs	(d) Maximum # of Shares that May Yet be Purchased Under the Programs
October 1- October 31, 2007				
November 1-November 31, 2007				
December 1-December 31, 2007	25,000	$ 10.46	25,000	2,975,000

Total	25,000	$	10.46	25,000	2,975,000

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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, 2007, 2006, 2005, and 2004, and for the period from inception (August 27, 2003) to December 31, 2003:

	For the Year Ended December 31, 2007	For the Year Ended December 31, 2006	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	$ 96,287,363	$ 50,471,432	$ 30,452,545	$ 10,893,459	$
Depreciation and amortization	12,612,630	6,704,924	4,182,731	1,478,470	
General and administrative expenses	15,791,840	10,190,850	8,016,992	5,150,786	992,418
Interest expense	28,236,502	4,417,955	1,521,169	32,769	
Income (loss) from continuing operations	40,009,949	29,672,741	18,822,785	4,576,349	(1,023,276)
Income from discontinued operations	1,229,690	486,957	817,562		
Net income (loss)	41,239,639	30,159,698	19,640,347	4,576,349	(1,023,276)
Income (loss) from continuing operations per diluted common share	0.84	0.75	0.58	0.24	(0.63)
Income from discontinued operations per diluted common share	0.02	0.01	0.03		
Net income (loss) per diluted common share	0.86	0.76	0.61	0.24	(0.63)
Weighted average number of common shares diluted	47,903,432	39,701,976	32,370,089	19,312,634	1,630,435
OTHER DATA					
Net income (loss)	$ 41,239,639	$ 30,159,698	$ 19,640,347	$ 4,576,349	$ (1,023,276)
Depreciation and amortization	12,612,630	6,704,924	4,182,731	1,478,470	
	(4,061,626)				

Gain on sale of real estate sold						
Funds from operations	49,790,643	36,864,622	23,823,078	6,054,819	$	(1,023,276)
Funds from operations per diluted common share	1.03	0.93	0.74	0.31		(0.63)
Dividends declared per diluted common share	0.94	0.99	0.62	0.21		

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	December 31, 2007	December 31, 2006	December 31, 2005	December 31, 2004	December 31, 2003
BALANCE SHEET DATA					
Real estate assets at cost	$ 657,904,249	$ 558,124,367	$ 337,102,392	$ 151,690,293	$ 166,301
Other loans and investments	265,758,273	150,172,830	85,813,486	50,224,069	
Cash and equivalents	94,215,134	4,102,873	59,115,832	97,543,677	100,000
Total assets	1,051,660,686	744,756,745	495,452,717	306,506,063	468,133
Debt	480,525,166	304,961,898	65,010,178	56,000,000	100,000
Other liabilities	57,937,525	95,021,876	71,991,531	17,777,619	1,389,779
Minority interests	77,552	1,051,835	2,173,866	1,000,000	
Total stockholders equity (deficit)	513,120,443	343,721,136	356,277,142	231,728,444	(1,021,646)
Total liabilities and stockholders equity(deficit)	1,051,660,686	744,756,745	495,452,717	306,506,063	468,133,063

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ITEM 7. ***Management s 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 typically for 15 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 and loan agreements annual contractual rate increases that in the current market range from 1.5% to 3.5%. Our existing portfolio escalators range from 0% to 2.5%. Most of our leases and loans also include rate increases based on the general rate of inflation if greater than the minimum contractual increases. In addition to the base rent, our leases require our tenants to pay all operating costs and expenses associated with the facility. Some leases also require our tenants to pay percentage rents which are based on the level of those tenants net revenues from their operations.

We selectively make loans to certain of our operators through our taxable REIT subsidiary, which they use 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, 2007, our portfolio consisted of 28 properties: 25 healthcare facilities which we own are leased to eight tenants with the remainder in the form of mortgage loans secured by interests in health care real estate. We had one acquisition loan outstanding, the proceeds of which our tenant used for the acquisition of six hospital operating companies. The facilities we owned and the facilities that secured our mortgage loans were in ten states, had a carrying cost of approximately $820.2 million (including the balances of our mortgage loans) and comprised approximately 78.0% of our total assets. Our acquisition and other loans of approximately $85.1 million represented approximately 8.1% of our total assets. We do not expect such non-mortgage loans at any time to exceed 20% of our total assets. We also had cash and temporary investments of approximately $94.2 million that represented approximately 9.0% of our total assets. Subsequent to December 31, 2007, we used approximately $83.0 million of such cash to repay our revolving credit facilities.

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 and borrowers 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 borrowers and in monitoring the performance of existing tenants and borrowers 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 or borrower and at each facility;

- the ratio of our tenants and borrowers 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 or borrowers 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 and borrowers profitability.

Certain business factors, in addition to those described above that directly affect our tenants and borrowers, 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 1, 2008, we had 26 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 have significant effects on our financial statements. Each of these items involves estimates that require us to make subjective judgments. We 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 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 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-owned 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 and related assets 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. The Company s strategy to date has been the simultaneous acquisition of facilities and the origination of new long-term leases at market rates. Future acquisitions, in some cases, may be for properties with in-place leases which may require the evaluation of above-market and below-market lease values.

We measure the aggregate value of other intangible assets to be acquired based on the difference between (i) the property valued with new or 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

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expenses and estimates of lost rentals at market rates during the expected lease-up periods, which we expect to range 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 are typically 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 are charged to expense.

Accounting for Derivative Financial Investments and Hedging Activities. We 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.

In 2006, we entered into derivative contracts as part of our offering of Exchangeable Senior Notes due 2011 (the exchangeable notes). The contracts are generally termed capped call or call spread contracts. These contracts are financial instruments which are separate from the exchangeable notes themselves, but affect the overall potential number of shares which will be issued by us to satisfy the conversion feature in the exchangeable notes. The exchangeable notes can be exchanged into shares of our common stock when our stock price exceeds $16.51 per share, which is the equivalent of 60.5566 shares per $1,000 note. The number of shares actually issued upon conversion is equivalent to the amount by which our stock price exceeds $16.51 times the 60.5566 conversion rate. The capped call transaction allowed us to effectively increase that exchange price from $16.51 to $18.94. Therefore, our shareholders would not experience dilution of their shares from any settlement or conversion of the exchangeable notes until the price of our stock exceeds $18.94 per share rather than $16.51 per share. When evaluating this transaction, we have followed the guidance in Emerging Issues Task Force (EITF) No. 00-19 *Accounting for Derivative Financial Instruments Indexed to, and Potentially Settled in, a Company s Own Stock.* EITF No. 00-19 requires that contracts such as this capped call which meet certain conditions must be accounted for as permanent

adjustments to equity rather than periodically adjusted to their fair value as assets or liabilities. We have evaluated the terms of these contracts and have determined that this capped call must be recorded as a permanent adjustment to stockholders equity. We have therefore shown the premium paid in this transaction as a one-time adjustment in the statement of stockholders equity.

The exchangeable notes themselves also contain the conversion feature described above. SFAS No. 133 also states that certain embedded derivative contracts must follow the guidance of EITF No. 00-19 and be evaluated as

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though they also were a freestanding derivative contract. Embedded derivative contracts such the conversion feature in the notes should not be treated as a financial instrument separate from the note if it meets certain conditions in EITF No. 00-19. We have evaluated the conversion feature in the exchangeable notes and have determined that it should not be reported separately from the debt.

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. Prior to 2006, we used 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.* SFAS No. 123(R) became effective for our annual and interim periods beginning January 1, 2006, but had no material effect on the results of our operations. During the years ended December 31, 2007 and 2006, we recorded approximately $4.5 million and $3.1 million, respectively, of expense for share-based compensation related to grants of restricted common stock, deferred stock units and other stock-based awards. In 2006, we also granted performance-based restricted share awards. Because these awards will vest based on the Company s performance, we must evaluate and estimate the probability of achieving those performance targets. Any changes in these estimates and probabilities must be recorded in the period when they are changed. In 2007, the Compensation Committee made awards which are earned only if the Company achieves certain stock price levels, total shareholder return or other market conditions. The 2007 awards were made pursuant to the Company s 2007 Multi-Year Incentive Plan (MIP) adopted by the Compensation Committee and consisted of three components: service-based awards, core performance awards (CPRE), and superior performance awards (SPRE). The service-based awards vest annually and ratably over a seven-year period. We recognize expense over the vesting period on the straight-line method for service based awards. The CPRE and SPRE awards vest based on what SFAS No. 123(R) terms market conditions . Market conditions are vesting conditions which are based on our stock price levels or our total shareholder return (stock price and dividends) compared to an index of other REIT stocks. The SPRE awards require additional service after being earned, if they are in fact earned. For the CPRE awards, the period over which the awards are earned is not fixed because the awards provide for cumulative measures over multiple years. SFAS No. 123(R) requires that we estimate the period over which the awards will likely be earned, regardless of the period over which the award allows as the maximum period over which it can be earned. Also, because some awards have multiple periods over which they can be earned, we must segregate individual awards into tranches , based on their vesting or estimated earning periods. These complexities required us to use an independent consultant to model both the value of the award and the various periods over which the each tranche of an award will be earned. Our consultant used what is termed a Monte Carlo simulation model which determines a value and earnings periods based on multiple outcomes and their probabilities. Beginning in 2007, we have begun recording expense over the expected or derived vesting periods using the calculated value of the awards. We must record expense over these vesting periods even though the awards have not yet been earned and, in fact, may never be earned. In some cases, if the award is not earned, we will be required to

reverse expenses recognized in earlier periods. As a result, future stock-based compensation expense may fluctuate based on the potential reversal of previously recorded expense.

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Disclosure of Contractual Obligations

The following table summarizes known material contractual obligations associated with investing and financing activities as of December 31, 2007:

Contractual Obligations	Less Than 1 Year	1-3 Years	3-5 Years	More than 5 Years	Total
Senior notes	9,630,775	19,261,550	17,825,825	156,904,466	203,622,616
Exchangeable notes	8,452,500	16,905,000	145,364,096		170,721,596
Revolving credit facility(1)	88,084,252	10,094,727	77,687,920		175,866,899
Term Note	5,139,626	10,144,019	67,586,331		82,869,976
Operating lease commitments(2)	820,886	1,675,297	1,728,843	31,001,675	35,226,701
Totals	$ 112,128,039	$ 58,080,593	$ 310,193,015	$ 187,906,141	$ 668,307,788

(1) Assumes the balance and interest rates are those in effect at December 31, 2007 and no principal payments are made until the expiration of the facilities.

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

Liquidity and Capital Resources

At December 31, 2007 we had cash and short-term investments of approximately $94.2 million. In early January 2008 we used approximately $83.0 million of cash to reduce the balances under our revolving credit facilities. Subsequent to the early January repayment, we have available under our credit facilities approximately $120 million in borrowing capacity. The terms of one of our credit facilities give us the right to increase its total size from $220 million presently to $350 million. However, any such expansion is subject to pricing and other market conditions, and we believe it is unlikely that lenders in the present market would commit to additional capacity at pricing levels that we would find acceptable.

Short-term Liquidity Requirements: We believe that the $120 million available to us mentioned above is sufficient to provide the resources necessary for operations, distributions in compliance with REIT requirements and a limited amount of acquisitions. In the event that we elect to make more than a limited amount of acquisitions in the near term, we will need to access additional capital. Based on current conditions in the capital markets, we believe such capital will be available; however, the capital markets have recently been highly volatile and there is no assurance that we could obtain acquisition capital at prices that we consider acceptable.

Long-term Liquidity Requirements: We believe that cash flow from operating activities subsequent to 2007 and available borrowing capacity will be sufficient to provide adequate working capital and make required distributions to our stockholders in compliance with our requirements as a REIT. To maintain our growth plans, and because of the tax requirements that we distribute a substantial portion of our earnings, we will need combined access to capital. To the extent market conditions or conditions specific to us make such capital unavailable or unaffordable, we may be unable to execute our growth strategies or we may be able to grow only at rates and margins lower than what we have

anticipated.

Investing Activities

During 2007 we invested approximately $316 million, or approximately 42% of our December 31, 2006 total assets, in new hospital real estate assets. We received early pay-offs of approximately $65 million in mortgage loans and approximately $8 million in other loans. Our net increase in assets during 2007, after consideration of the January 2008 credit facility reductions, was approximately $228 million, or approximately 31%.

Results of Operations

We began operations during the second quarter of 2004. Since then, we have substantially increased our income earning investments each year, and we expect to continue to materially add to our investment portfolio,

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subject to the capital markets and other conditions described in this Annual Report on Form 10-K. Accordingly, we expect that future results of operations will vary materially from our historical results. The results of operations presented below for the year ended December 31, 2005, have been adjusted to reflect the operations of two facilities which are recorded as discontinued operations at December 31, 2007.

Year Ended December 31, 2007 Compared to the Year Ended December 31, 2006

Net income for the year ended December 31, 2007 was $41,239,639 compared to net income of $30,159,698 for the year ended December 31, 2006.

A comparison of revenues for the years ended December 31, 2007 and 2006 is as follows:

	2007		2006		Change
Base rents	$ 54,232,567	56.3%	$ 29,806,171	59.1%	$ 24,426,396
Straight-line rents	11,079,704	11.5%	5,952,442	11.8%	5,127,262
Percentage rents	607,121	0.6%	2,384,601	4.7%	(1,777,480)
Interest from loans	26,000,486	27.0%	11,893,339	23.6%	14,107,147
Fee income	4,367,485	4.6%	434,879	0.8%	3,932,606
Total revenue	$ 96,287,363	100.0%	$ 50,471,432	100.0%	$ 45,815,931

Revenue for the year ended December 31, 2007, was comprised of rents (68.4%) and interest and fee income from loans (31.6%). Our base and straight-line rents increased in 2007 due to the acquisition of four facilities and opening of two developments in 2007. Interest income from loans in the year ended December 31, 2007, increased primarily due to origination of two additional mortgage loans totaling $120,000,000 in the first quarter of 2007 offset by the repayment of a $40 million mortgage loan in the second quarter of 2007 and a $25 million mortgage loan in the fourth quarter of 2007. Our fee income increased in 2007 due to the receipt of $3.8 million in mortgage loan pre-payment fees.

Vibra accounted for 31.3% and 55.0% of our gross revenues in 2007 and 2006, respectively. This includes percentage rents of approximately $0.5 million and $2.4 million in 2007 and 2006, respectively. We expect that the portion of our total revenues attributable to Vibra will decline in relation to our total revenue, and based solely on our portfolio at December 31, 2007, we estimate that Vibra will represent 18.5% of total revenue in 2008. At December 31, 2007, assets leased and loaned to Vibra comprised 19.7% of our total assets and 23.7% of our total investment.

Depreciation and amortization during the year ended December 31, 2007 was $12,612,630, compared to $6,704,924 during the year ended December 31, 2006. All of this increase is related to an increase in the number of rent producing properties from 21 (cost $437.4 million) at December 31, 2006 to 25 (cost $657.5 million) at December 31, 2007. 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, 2007 and 2006, totaled $15,971,840 and $10,190,850, respectively, which represents an increase of 55.0%. The increase is partially due to an increase of approximately $1.4 million of non-cash share-based compensation expense from stock-based awards made during 2007. We expect non-cash share-based compensation to increase in 2008 because awards that were made in 2007 but do not vest until certain performance hurdles are met must nonetheless be expensed beginning in the year of the award

based on our estimate of the likelihood of achieving those performance hurdles.

Interest expense for the years ended December 31, 2007 and 2006 totaled $28,236,502 and $4,417,955, respectively. Interest expense in 2007 and 2006 excludes interest of approximately $1.3 million and $6.2 million, respectively, which was capitalized as part of the cost of development projects under construction during 2007 and 2006. Capitalized interest decreased due to our final two developments under construction being placed into service in April 2007, which represented construction in process totaling $59.8 million at December 31, 2006. Interest expense increased during 2007 due to the issuance of $263.0 million in fixed rate notes in the second half of 2006 and the cessation of capitalization of interest on approximately $155.3 million in development projects that were

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placed in service in 2006 and 2007. We expect interest expense to increase during 2008 due to larger debt balances in 2008 than in 2007.

Year Ended December 31, 2006 Compared to the Year Ended December 31, 2005

Net income for the year ended December 31, 2006 was $30,159,698 compared to net income of $19,640,347 for the year ended December 31, 2005.

A comparison of revenues for the years ended December 31, 2006 and 2005 is as follows:

	2006		2005		Change
Base rents	$ 29,806,171	59.1%	$ 18,608,236	61.1%	$ 11,197,935
Straight-line rents	5,952,442	11.8%	4,764,527	15.7%	1,187,915
Percentage rents	2,384,601	4.7%	2,259,230	7.4%	125,371
Interest from loans	11,893,339	23.6%	4,704,369	15.4%	7,188,970
Fee income	434,879	0.8%	116,183	0.4%	318,696
Total revenue	$ 50,471,432	100.0%	$ 30,452,545	100.0%	$ 20,018,887

Revenue for the year ended December 31, 2006, was comprised of rents (75.6%) and interest and fee income from loans (24.4%). All of this revenue was derived from properties that we have acquired since July 1, 2004. Our base and straight-line rents increased in 2006 due to the acquisition of 10 facilities and opening of two developments in 2006. Interest income from loans in the year ended December 31, 2006, increased primarily based on the timing and amount of the Alliance mortgage loan made in 2005, and on the two mortgage loans made in 2006.

Vibra accounted for 55.0% and 86.2% of our gross revenues in 2006 and 2005, respectively, This includes percentage rents of approximately $2.4 million and $2.3 million in 2006 and 2005, respectively. In 2006, Vibra accounted for 61.5% of our total rent revenues. We expect that the portion of our total revenues attributable to Vibra will decline in relation to our total revenue. At December 31, 2006, assets leased and loaned to Vibra comprised 29.0% of our total assets and 33.4% of our to