MEDICAL PROPERTIES TRUST INC
Form 10-K
February 29, 2016
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2015

or

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

For the transition period from _____ to _____

Commission file number 001-32559

Medical Properties Trust, Inc.

MPT Operating Partnership, L.P.

(Exact Name of Registrant as Specified in Its Charter)

Maryland	**20-0191742**
Delaware	**20-0242069**
(State or Other Jurisdiction of	**(IRS Employer**
Incorporation or Organization)	**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 of	New York Stock Exchange

Medical Properties Trust, Inc.

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.

Medical Properties Trust, Inc. Yes x No ¨ MPT Operating Partnership, L.P. Yes ¨ No x

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.

Medical Properties Trust, Inc. Yes ¨ No x MPT Operating Partnership, L.P. Yes ¨ No x

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.

Medical Properties Trust, Inc. Yes x No ¨ MPT Operating Partnership, L.P. Yes x No ¨

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

Medical Properties Trust, Inc. Yes x No ¨ MPT Operating Partnership, L.P. Yes x No ¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) 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 to this Form 10-K. ¨.

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):

edical Properties Trust, Inc.	Large accelerated Filer x	Accelerated Filer ¨	Non-accelerated Filer ¨	Smaller Reporting Company (Do not check if a smaller reporting company)
PT Operating Partnership, L.P.	Large accelerated Filer ¨	Accelerated Filer ¨	Non-accelerated Filer x	Smaller Reporting Company (Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in 12b-2 of the Act).

Medical Properties Trust, Inc. Yes ¨ No x MPT Operating Partnership, L.P. Yes ¨ No x

As of June 30, 2015, the aggregate market value of the 209,088,398 shares of common stock, par value $0.001 per share (Common Stock), held by non-affiliates of the registrant was $2,741,148,898 based upon the last reported sale price of $13.11 on the New York Stock Exchange on that date. For purposes of the foregoing calculation only, all directors and executive officers of the registrant have been deemed affiliates.

As of February 26, 2016, 237,846,536 shares of Medical Properties Trust, Inc. Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant s definitive Proxy Statement for the Annual Meeting of Stockholders to be held on May 19, 2016 are incorporated by reference into Items 10 through 14 of Part III, of this Annual Report on Form 10-K.

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EXPLANATORY NOTE

This report combines the Annual Reports on Form 10-K for the year ended December 31, 2015, of Medical Properties Trust, Inc., a Maryland corporation, and MPT Operating Partnership, L.P., a Delaware limited partnership, through which Medical Properties Trust, Inc. conducts substantially all of its operations. Unless otherwise indicated or unless the context requires otherwise, all references in this report to we, us, our, our company, Medical Properties, M the Company refer to Medical Properties Trust, Inc. together with its consolidated subsidiaries, including MPT Operating Partnership, L.P. Unless otherwise indicated or unless the context requires otherwise, all references to our operating partnership or the operating partnership refer to MPT Operating Partnership, L.P. together with its consolidated subsidiaries.

CAUTIONARY LANGUAGE REGARDING 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 additional facilities in the United States or Europe;
- 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 debt and equity securities and/or property disposals;
- our ability to obtain future financing arrangements;
- estimates relating to, and our ability to pay, future distributions;
- our ability to service our debt and comply with all of our debt covenants;

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 Business;

U.S. (both national and local) and European (in particular Germany, the United Kingdom, Spain and Italy) economic, business, real estate, and other market conditions;

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the competitive environment in which we operate;

the execution of our business plan;

financing risks;

acquisition and development risks;

potential environmental contingencies and other liabilities;

other factors affecting the real estate industry generally or the healthcare real estate industry in particular;

our ability to maintain our status as a real estate investment trust, or REIT for U.S. federal and state income tax purposes;

our ability to attract and retain qualified personnel;

changes in foreign currency exchange rates;

U.S. (both federal and state) and European (in particular Germany, the United Kingdom, Spain and Italy) healthcare and other regulatory requirements; and

U.S. national and local economic conditions, as well as conditions in Europe and any other foreign jurisdictions where we own or will own healthcare facilities, which may have a negative effect on the following, among other things:

- the financial condition of our tenants, our lenders, counterparties to our interest rate swaps and other hedged transactions and institutions that hold our cash balances, which may expose us to increased risks of default by these parties;

- our ability to obtain equity or debt financing on attractive terms or at all, which may adversely impact our ability to pursue acquisition and development opportunities, refinance existing debt, comply with debt covenants, and our future interest expense; and

the value of our real estate assets, which may limit our ability to dispose of assets at attractive prices or obtain or maintain debt financing secured by our properties or on an unsecured basis.

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. 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.

PART I

ITEM 1. *Business*

Overview

We are a self-advised real estate investment trust (REIT) focused on investing in and owning net-leased healthcare facilities across the United States and selectively in foreign jurisdictions. We have operated as a REIT since April 6, 2004, and accordingly, elected REIT status upon the filing of our calendar year 2004 federal income tax return. Medical Properties Trust, Inc. was incorporated under Maryland law on August 27, 2003, and MPT Operating Partnership, L.P. was formed under Delaware law on September 10, 2003. We conduct substantially all of our business through MPT Operating Partnership, L.P. We acquire and develop healthcare facilities and lease the facilities to healthcare operating companies under long-term net leases, which require the tenant to bear most of the costs associated with the property. We also make mortgage loans to healthcare

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operators collateralized by their real estate assets. In addition, we selectively make loans to certain of our operators through our taxable REIT subsidiaries, the proceeds of which are typically used for acquisition and working capital purposes. Finally, from time to time, we acquire a profits or other equity interest in our tenants that gives us a right to share in such tenants profits and losses.

Our investments in healthcare real estate, including mortgage and other loans, as well as any equity investments in our tenants are considered a single reportable segment as further discussed in Note 1 of Item 8 in Part II of this Annual Report on Form 10-K. All of our investments are currently located in the United States and Europe. At December 31, 2015 and 2014, we had $5.6 billion and $3.7 billion, respectively, in total assets made up of the following:

(dollars in thousands)	2015		2014	
Real estate owned (gross)(1)	$ 3,875,536	69.1%	$ 2,589,128	69.6%
Mortgage loans	757,581	13.5%	397,594	10.7%
Other loans	664,822	11.9%	573,167	15.4%
Construction in progress	49,165	0.9%	23,163	0.6%
Other assets(1)	262,247	4.6%	137,278	3.7%
Total	$ 5,609,351	100.0%	$ 3,720,330	100.0%

(1) Includes $1.3 billion and $784.2 million of healthcare real estate assets in Europe in 2015 and 2014, respectively.

Revenue by property type:

The following is our revenue by property type for the year ended December 31 (dollars in thousands):

	2015		2014		2013	
General Acute Care Hospitals(1)(2)	$ 254,727	57.6%	$ 186,399	59.6%	$ 144,291	59.5%
Rehabilitation Hospitals(2)	134,198	30.4%	71,564	22.9%	43,441	17.9%
Long-Term Acute Care Hospitals	52,651	11.9%	53,908	17.2%	53,130	21.9%
Wellness Centers(3)	302	0.1%	661	0.3%	1,661	0.7%
Total revenue	$ 441,878	100.0%	$ 312,532	100.0%	$ 242,523	100.0%

(1) Includes three medical office buildings.
(2) Includes $83.0 million and $26.0 million in revenue from the healthcare real estate assets in Europe in 2015 and 2014, respectively.
(3) We sold our six wellness centers in August 2015.

See Overview in Item 7 of this Annual Report on Form 10-K for details of transaction activity for 2015, 2014 and 2013. More information is available on the Internet at www.medicalpropertiestrust.com.

Portfolio of Properties

As of February 26, 2016, our portfolio consisted of 205 properties: 180 facilities (of the 191 facilities that we own) are leased to 28 tenants, 11 are under development (including 10 development projects with Adeptus Health, Inc.), and the remaining assets are in the form of mortgage loans to four operators. Our facilities consist of 110 general acute care hospitals, 23 long-term acute care hospitals, 69 inpatient rehabilitation hospitals, and three medical office buildings.

At December 31, 2015, no single property accounted for more than 2% of our total assets.

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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. Our mortgage loans are structured such that we obtain similar economic returns as our net leases. In addition, we have obtained and will continue to obtain profits or other interests in certain of our tenants operations in order to enhance our overall return. 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 and that focus on the most critical components of healthcare. We typically invest in facilities that have the highest intensity of care including:

Acute care provide inpatient care for the treatment of acute conditions and manifestations of chronic conditions. They also provide ambulatory care through hospital outpatient departments and emergency rooms. Typically, hospital stays average anywhere from three to five days.

Long-term acute specialty-care hospital designed for patients with serious medical problems that require intense, special treatment for an extended period of time, typically requiring a hospital stay averaging in excess of three weeks.

Inpatient rehabilitation provide rehabilitation to patients with various neurological, muscular, skeletal orthopedic and other medical conditions following stabilization of their acute medical issues.

Diversification

A fundamental component of our business plan is the continued diversification of our tenant relationships, the types of hospitals we own and the geographic areas in which we invest. From a tenant relationship perspective, see section titled Significant Tenants below for detail. See sections titled Revenue by Property Type and Portfolio of Properties above for information on the diversification of our hospital types. From a geography perspective, we have investments across the United States. See below for investment concentration in the United States and our global concentration at December 31, 2015[(1)]:

(1) Represents investment concentration as a percentage of gross real estate assets assuming all real estate commitments are fully funded.

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We continue to believe that Europe represents an attractive market in which to invest. With two joint ventures that we formed in 2015 with affiliates of Axa Real Estate (as described more fully in Item 7 of Part II of this Form 10-K), we now have investments in Germany, the United Kingdom, Italy and Spain.

In regards to Germany (the largest market in Europe that we are invested), we believe it is an attractive investment opportunity for us given Germany s strong macroeconomic position and healthcare environment. Germany s GDP, which is approximately $3,868 billion according to World Bank 2014 data, has been relatively more stable than other countries in the European Union due to Germany s culture, which embodies stable business practices and monetary policy. In addition to cultural influences, government policies emphasizing sound public finance and a significant presence of small and medium-sized enterprises (which employ 60% of the employment base) have also contributed to Germany s strong and sustainable economic position. The above factors have contributed to an unemployment rate in Germany of 4.5% as of December 2015, which is significantly less than the 9.0% unemployment rate in the European Union generally as of December 2015, according to Eurostat.

Underwriting/Asset Management

Our revenue is derived from rents we earn pursuant to the lease agreements with our tenants, from interest income from loans to our tenants and other facility owners and from profits or equity interests in certain of our tenants operations. Our tenants operate in the healthcare industry, generally providing medical, surgical and rehabilitative care to patients. The capacity of our tenants to pay our rents and interest is dependent upon their ability to conduct their operations at profitable levels. We believe that the business environment of the industry segments in which our tenants operate is generally positive for efficient operators. However, our tenants operations are subject to economic, regulatory and market conditions that may affect their profitability, which could impact our results. 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 portfolio.

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

- admission levels by service type;
- the current, historical and prospective operating margins (measured by a tenant s earnings before interest, taxes, depreciation, amortization and facility rent) of each tenant and at each facility;
- the ratio of our tenants operating earnings both to facility rent and to other fixed costs, including debt costs;
- trends in the source of our tenants revenue, including the relative mix of public payors (including Medicare, Medicaid/MediCal, and managed care in the U.S. as well as equivalent payors in Germany, Italy, Spain, and the United Kingdom) and private payors (including commercial insurance and private pay patients);

trends in tenant cash collections, including comparison to recorded net patient service revenues;

the effect of any legal, regulatory or compliance proceedings with our tenants;

the effect of evolving healthcare legislation and other regulations (including changes in reimbursement) on our tenants profitability and liquidity;

the competition and demographics of the local and surrounding areas in which our tenants operate;

evaluation of medical staff doctors associated with the facility/facilities, including specialty, tenure and number of procedures performed;

evaluation of the operator s and facility s administrative team, as applicable, including background and tenure within the healthcare industry;

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market position relative to competition;

compliance, accreditation, quality performance and health outcomes as measured by The Centers for Medicare and Medicaid Services (CMS) and Joint Commission; and

the level of investment in health IT systems.

Healthcare Industry

Healthcare is the single largest industry in the United States (U.S.) based on Gross Domestic Product (GDP). According to the National Health Expenditures report dated January 2015 by the CMS: (i) national health expenditures are projected to grow 5.3% in 2016; (ii) the average compound annual growth rate for national health expenditures, over the projection period of 2016 through 2024, is anticipated to be 5.8%; and (iii) the healthcare industry is projected to represent 19.6% of U.S. GDP by 2024.

In regards to Germany, the healthcare industry is also the single largest industry. Behind only the U.S., Netherlands and France, Germany s healthcare expenditures represent approximately 11.3% of its total GDP according to the Organization for Economic Co-operation and Development s 2011 data.

The German rehabilitation market (which includes our facilities in Germany) serves a broader scope of treatment with over 1,233 rehabilitation facilities (compared to 1,165 in the U.S.) and 208.5 beds per 100,000 population (compared to 114.7 in the U.S.). Approximately 90% of the payments in the German system come from governmental sources. The largest payor category is the public pension fund system representing 39% of payments. Public health insurance and payments for government employees represent 46% of payments. The balance of the payments into the German rehabilitation market come from a variety of sources including private pay and private insurance. One particular focus area of investors in the German market is the healthcare industry because the German Social Code mandates universal access, coverage and a high standard of care, thereby creating a robust healthcare dynamic in the country.

The delivery of healthcare services, whether in the U.S. or elsewhere, requires real estate and, as a consequence, healthcare providers depend on real estate to maintain and grow their businesses. We believe that the healthcare real estate market provides investment opportunities due to the:

compelling demographics driving the demand for healthcare services;

specialized nature of healthcare real estate investing; and

consolidation of the fragmented healthcare real estate sector.

Our Leases and Loans

The leases for our facilities are net leases with terms generally 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 and certain other taxes, ground lease rent (if any) and the costs of capital expenditures, repairs and maintenance (including any repairs mandated by regulatory requirements). 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 typically require our tenants to indemnify us for any past or future environmental liabilities. Our current leases and loans have a weighted-average remaining initial lease term of 14.8 years (see Item 2 for more information on remaining lease terms). Based on current monthly revenue, approximately 96% of our leases and loans provide for annual rent or interest escalations based on either increases in the U.S. Consumer Price Index (CPI) or minimum annual rent or interest escalations ranging from 0.5% to 5%. In some cases, our domestic leases and loans provide for escalations based on CPI subject to floors

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and/or ceilings. In certain limited cases, we may have arrangements that provide for additional rents based on the level of a tenant s revenue.

RIDEA Investments

We have and will make equity investments, loans (with equity like returns) and obtain profit interests in certain of our tenants. Some of these investments fall under a structure permitted by the Housing and Economic Recovery Act of 2008 (RIDEA). Under the provisions of RIDEA, a REIT may lease qualified health care properties on an arm s length basis to a taxable REIT subsidiary (TRS) if the property is operated on behalf of such subsidiary by a person who qualifies as an eligible independent contractor. We view RIDEA as a structure primarily to be used on properties that present attractive valuation entry points. At December 31, 2015, our RIDEA investments totaled approximately $600 million.

Significant Tenants

On December 31, 2015, we had total assets of approximately $5.6 billion comprised of 202 healthcare properties in 29 states, in Germany, Italy, Spain and in the United Kingdom. The properties are leased to or mortgaged by 28 different hospital operating companies.

Affiliates of Prime Healthcare Services, Inc. (Prime) lease 17 facilities pursuant to master lease agreements. The master leases are for 10 years and contain two renewal options of five years each. The annual escalators reflect 100% of CPI increases, along with a 2% minimum floor. At the end of the initial or any renewal term, Prime must exercise any available extension or purchase option with respect to all or none of the leased and mortgaged properties relative to each master lease. The master leases include repurchase options, including provisions establishing minimum repurchase prices equal to our total investment. At December 31, 2015, these facilities had an average remaining lease term of 7.2 years. In addition to leases, we hold mortgage loans on seven facilities owned by affiliates of Prime. The terms and provisions of these loans are generally equivalent to the terms and provisions of our Prime lease arrangements. Prime represented 18.4% of our total assets at December 31, 2015 and 20.0% at December 31, 2014.

Affiliates of Ernest Health, Inc. (Ernest) lease 22 facilities pursuant to a master lease agreement and other lease agreements, which includes one under development. The original master lease agreement entered into in 2012 has a 20-year term with three five-year extension options and provides for consumer price-indexed increases, limited to a 2% floor and 5% ceiling annually. At December 31, 2015, these facilities had an average remaining lease term of 16.5 years. In addition to the master lease, we hold a mortgage loan on four facilities owned by affiliates of Ernest that will mature in 2032. The terms and provisions of these loans are generally equivalent to the terms and provisions of the master lease agreement. Ernest represented 10.2% of our total assets at December 31, 2015 and 13.0% at December 31, 2014.

In December 2015, MEDIAN Kliniken S.à r.l., (lessee of 31 of our German facilities) merged with RHM Klinik-und Altenheimbetriebe GmbH & Co. KG. (RHM)(lessee of 15 of our German facilities) to form MEDIAN. MEDIAN leases 46 facilities pursuant to two master lease agreements. Each master lease agreement has a 27-year fixed term. The annual escalator for one master lease that represents approximately 15 facilities of the MEDIAN portfolio provides for fixed increases of 2% for 2016 and 2017 and additional fixed increases of 0.5% each year thereafter. In addition, at December 31, 2020 and every three years thereafter, rent will be increased to reflect 70% of cumulative increases in German CPI. The annual escalator for the other master lease that represents the remaining facilities of the MEDIAN portfolio provides for increases of the greater of 1% or 70% of the change in German CPI. MEDIAN

represented 17.4% of our total assets at December 31, 2015 and 19.0% at December 31, 2014.

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Affiliates of Capella Healthcare, Inc. (Capella) lease five facilities (four of which are leased pursuant to a master lease agreement). The real estate leases have 15-year terms with four 5-year extension options, plus consumer price-indexed increases, limited to a 2% floor and a 4% ceiling annually. At December 31, 2015, these facilities had an average remaining lease term of 14.7 years. In addition to the master lease, we hold a mortgage loan on two facilities that will mature in 2030. The terms and provisions of these loans are generally equivalent to the terms and provisions of the master lease agreement. We have closed on seven Capella properties and expect to close on an eighth during 2016. Capella represented 18.1% of our total assets at December 31, 2015.

No other tenant accounted for more than 6.2% of our total assets at December 31, 2015.

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 remediate hazardous or toxic substance releases or threats of releases. There may also be certain obligations and liabilities on property owners with respect to asbestos containing materials. Investigation, remediation and monitoring costs may be substantial. The confirmed presence of contamination or the failure to properly remediate contamination on a property may adversely affect our ability 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 (or their equivalent studies outside the United States) 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 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. Upon closing and for the remainder of the lease or loan term, our transaction documents require our tenants to repair and remediate any environmental concern at the applicable facility, and to comply in full with all environmental laws and regulations.

California Seismic Standards

California s Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1973 (the Alquist Act) established a seismic safety building standards program under the Office of Statewide Health Planning and Development (OSHPD) jurisdiction for hospitals built on or after March 7, 1973. It required the California Building Standards Commission to adopt earthquake performance categories, seismic evaluation procedures, standards and timeframes for upgrading certain facilities, and seismic retrofit building standards. These regulations required hospitals to meet certain seismic performance standards to ensure that they are capable of providing medical services to the public after an earthquake or other disaster. The Building Standards Commission completed its adoption of evaluation criteria and retrofit standards in 1998. The Alquist Act required the Building Standards Commission adopt certain evaluation criteria and retrofit standards such as:

1) hospitals in California must conduct seismic evaluations and submit these evaluations to the OSHPD, Facilities Development Division for its review and approval;

2) hospitals in California must identify the most critical nonstructural systems that represent the greatest risk of failure during an earthquake and submit timetables for upgrading these systems to the OSHPD, Facilities Development Division for its review and approval; and

3) hospitals in California must prepare a plan and compliance schedule for each regulated building demonstrating the steps a hospital will take to bring the hospital buildings into substantial compliance with the regulations and standards.

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Since the Alquist Act, subsequent legislation has modified requirements of seismic safety standards and deadlines for compliance. Originally, hospital buildings considered hazardous and at risk of collapse in the event of an earthquake must have been retrofitted, replaced or removed from providing acute care services by January 1, 2008; however, provisions were made to allow this deadline to be extended to January 1, 2013.

Senate Bill 499 was signed into law that provided for a number of seismic relief measures, including criteria for reclassifying buildings into a lower seismic risk category. These buildings would have until January 1, 2030 to comply with structural seismic safety standards. Buildings denied reclassification must have met seismic compliance standards by January 1, 2013, unless further extensions were granted.

California s AB 306 legislation permitted OSHPD to grant extensions to acute care hospitals that lacked the financial capacity to meet the January 1, 2013 retrofit deadline, and instead, requires them to replace those buildings by January 1, 2020. More recently, California SB 90 allows a hospital to seek an extension for seismic compliance up to seven years based on three elements:

1) the structural integrity of the building;

2) the loss of essential hospital services to the community if the hospital is closed; and

3) financial hardship.

As of December 31, 2015, we have 13 facilities in California totaling investments of $547.1 million. Exclusive of approved SB 90 extensions at four facilities, all of our California buildings are seismically compliant through 2030 as determined by OSHPD. For the four hospitals with SB 90 extensions, voluntary retrofit plans are underway and full compliance is expected. Under our current agreements, our tenants are responsible for capital expenditures in connection with seismic laws. Further, we do not expect California seismic standards to have a negative impact on our financial condition or cash flows. We also do not expect compliance with California seismic standards to materially impact the financial condition of our tenants.

Competition

We compete in acquiring and developing facilities with financial institutions, other lenders, real estate developers, healthcare operators, other REITs, other public and private real estate companies, and private real estate investors. Among the factors that may adversely affect 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;

- some of our competitors may have greater financial and operational resources than we have;

some of our competitors may have lower costs of capital than we do;

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 highly competitive environments, and patients and referral sources, including physicians, may change their preferences for healthcare facilities from time to time. The operators of our properties compete on a local and regional basis with operators of properties that provide comparable services. Operators compete for patients and residents based on a number of factors including quality of care, reputation, physical appearance of a facility, location, services offered, physicians, staff, and price. We also face competition from other health care facilities for tenants, such as physicians and other health care providers that provide comparable facilities and services.

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For additional information, see Risk Factors in Item 1A.

Insurance

Our leases and mortgage loans require the tenants to carry property, general liability, professional liability, loss of earnings and other insurance coverages and to name us as an additional insured under these policies. We monitor the adequacy of such coverages at least annually based upon insurance renewal. In addition, we have separately purchased contingent general liability insurance 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, and contingent business interruption insurance. At December 31, 2015, 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.

Healthcare Regulatory Matters

The following discussion describes certain material federal healthcare laws and regulations that may affect our operations and those of our tenants. The discussion, however, does not address all applicable federal healthcare laws, and 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 the operations of our tenants and, accordingly, our operations. In addition, in some instances we own a minority interest in our tenants operations and, in addition to the effect on these tenants ability to meet their financial obligations to us, our ownership and investment returns may also be negatively impacted by such laws and regulations. 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, along with the potential impact to us, 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, rules, and regulations. Our tenants failure to comply with these laws and regulations could adversely affect their ability to meet their obligations to us. Physician investment in us or in our facilities also will be subject to such laws and regulations. Although we are not a healthcare provider or in a position to influence the referral of patients or ordering of items and services reimbursable by the federal government, to the extent that a healthcare provider engages in transactions with our tenants, such as sublease or other financial arrangements, the Anti-Kickback Statute and the Stark Law (both discussed in this section) could be implicated. Our leases and mortgage loans require the tenants to comply with all applicable laws, including healthcare laws. We intend for all of our business activities and operations to conform in all material respects with all applicable laws, rules, and regulations, including healthcare laws, rules, and regulations.

Applicable Laws

Anti-Kickback Statute. The federal Anti-Kickback Statute (codified at 42 U.S.C. § 1320a-7b(b)) 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 items or 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, punishable by fines of up to $25,000 per violation, five years imprisonment, or both. Violations may also result in civil sanctions, including civil monetary 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 Office of Inspector General of the Department of Health and Human Services (OIG) has issued Safe Harbor Regulations that describe practices that will not be considered violations of the Anti-Kickback

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Statute. Nonetheless, the fact that a particular arrangement does not meet safe harbor requirements does not also mean that the arrangement violates the Anti-Kickback Statute. Rather, the safe harbor regulations simply provide a guaranty that qualifying arrangements will not be prosecuted under the Anti-Kickback Statute. We intend to use commercially reasonable efforts to structure our arrangements involving facilities, so as to satisfy, or meet as closely as possible, safe harbor conditions. We cannot assure you, however, that we will meet all the conditions for the safe harbor.

Physician Self-Referral Statute (Stark Law). Any physicians investing in us or our 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, including certain inpatient and outpatient hospital services, clinical laboratory services, and radiology 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. Sanctions for violating the Stark Law include denial of payment, refunding amounts received for services provided pursuant to prohibited referrals, civil monetary penalties of up to $15,000 per prohibited service provided, and exclusion from the participation in federal healthcare programs. The statute also provides for a penalty of up to $100,000 for a circumvention scheme.

There are exceptions to the self-referral prohibition for many of the customary financial arrangements between physicians and providers, including employment contracts, leases, and recruitment agreements. Unlike safe harbors under the Anti-Kickback Statute, the Stark Law imposes strict liability on the parties to an arrangement and an arrangement must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law.

The CMS has issued multiple phases of final regulations implementing the Stark Law and continues to make changes to these regulations. While these regulations help clarify the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. Although our lease agreements require lessees to comply with the Stark Law, and we intend for facilities to comply with the Stark Law where we own an interest in our tenants operations, we cannot offer assurance that the arrangements entered into by us and our facilities will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

False Claims Act. The federal False Claims Act prohibits the making or presenting of any false claim for payment to the federal government; it is the civil equivalent to federal criminal provisions prohibiting the submission of false claims to federally funded programs. Additionally, *qui tam*, or whistleblower, provisions of the federal False Claims Act allow private individuals to bring actions on behalf of the federal government alleging that the defendant has defrauded the federal government. Whistleblowers may collect a portion of the federal government s recovery an incentive which increases the frequency of such actions. A successful federal False Claims Act case may result in a penalty of three times the actual damages, plus additional civil penalties payable to the government, plus reimbursement of the fees of counsel for the whistleblower. Many states have enacted similar statutes preventing the presentation of a false claim to a state government, and we expect more to do so because the Social Security Act provides a financial incentive for states to enact statutes establishing state level liability.

The Civil Monetary Penalties Law. Among other things, the Civil Monetary Penalties law prohibits the knowing presentation of a claim for certain healthcare services that is false or fraudulent, the presentation of false or misleading information in connection with claims for payment, and other acts involving fraudulent conduct. Penalties include a monetary civil penalty of up to $10,000 for each item or service, $15,000 for each individual with respect to whom false or misleading information was given, as well as treble damages for the total amount of remuneration claimed.

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Licensure. Our tenants are subject to extensive federal, state, and local licensure, certification, and inspection laws and regulations including, in some cases, certificate of need laws. Further, various licenses and permits are required to dispense narcotics, operate pharmacies, handle radioactive materials, and operate equipment. Failure to comply with any of these laws could result in loss of licensure, certification or accreditation, denial of reimbursement, imposition of fines, and suspension or decertification from federal and state healthcare programs.

EMTALA. Our tenants that provide emergency care are subject to the Emergency Medical Treatment and Active Labor Act (EMTALA). This federal law requires such healthcare facilities to conduct an appropriate medical screening examination of every individual who presents to the hospital s emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize the condition or make an appropriate transfer of the individual to a facility able to handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual s ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer an individual or if the hospital delays appropriate treatment in order to first inquire about the individual s ability to pay. Liability for violations of EMTALA includes, among other things, civil monetary penalties and exclusion from participation in the federal healthcare programs. Our lease and mortgage loan agreements require our tenants to comply with EMTALA, and we believe our tenants conduct business in substantial compliance with EMTALA.

Reimbursement Pressures. Healthcare facility operating margins continue to face significant pressure due to the deterioration in pricing flexibility and payor mix, increases in operating expenses that exceed increases in payments under the Medicare program, and reductions in levels of Medicaid funding due to state budget shortfalls.

Further, long-term acute care hospitals (LTACHs), which account for a significant percentage of our tenants, are continuing to face reimbursement pressures including resulting from the passage of the SGR Reform Act of 2013 (the SGR Act) in December 2013. The SGR Act impacted the provision of, and payment for, services provided by LTACHs to Medicare beneficiaries and imposed new criteria for LTACHs to be paid under the LTACH prospective payment system rather than the acute inpatient prospective payment system, or IPPS, rate. This site-neutral payment rate provides that LTACHs are reimbursed at the rate otherwise paid under the IPPS unless the patient has met certain qualifications. Payment at the IPPS rate results in reduced reimbursement. The SGR Act also delayed full implementation of the so-called 25% rule through fiscal year 2017 and reinstated the moratorium on establishing or increasing LTACH beds through September 30, 2017.

We cannot predict how and to what extent these or other initiatives will impact the business of our tenants, or whether our business will be adversely impacted.

Healthcare Reform. Though we have not provided a detailed discussion of the Patient Protection and Affordable Care Act (the Reform Law), generally, the Reform Law provides expanded health insurance coverage through tax subsidies and federal health insurance programs, individual and employer mandates for health insurance coverage, and health insurance exchanges. The Reform Law also includes various cost containment initiatives, including quality control and payment system refinements for federal programs, such as pay-for-performance criteria and value-based purchasing programs, bundled provider payments, accountable care organizations, geographic payment variations, comparative effectiveness research, and lower payments for hospital readmissions. The Reform Law also increases health information technology standards for healthcare providers in an effort to improve quality and reduce costs. The Reform Law has led, and will continue to lead, to significant changes in the healthcare system. We cannot predict the continued impact of the Reform Law on our business, as some aspects benefit the operations of our tenants, while other aspects present challenges.

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Employees

We have 50 employees as of February 26, 2016. As we continue to grow, we would expect our head count to increase as well. However, we do not believe that any adjustments to the number of employees will have a material effect on our operations or to general and administrative expenses as a percent of revenues. We believe that our relations with our employees are good. None of our employees are members of any union.

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 stockholder who should request the information directly from us at (205) 969-3755. Information on or connected to our website is neither part of nor incorporated by reference into this Annual Report or any other SEC filings.

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

The risks and uncertainties described herein are not the only ones facing us and there may be additional risks that we do not presently know of or that we currently consider not likely to have a significant impact on us. All of these risks could adversely affect our business, results of operations and financial condition. Some statements in this report including statements in the following risk factors constitute forward-looking statements. Please refer to the section entitled Cautionary Language Regarding Forward Looking Statements at the beginning of this Annual Report.

RISKS RELATED TO OUR BUSINESS AND GROWTH STRATEGY ***(Including Financing Risks)***

Limited access to capital may restrict 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 financing and access to the capital markets for cash to make investments in new facilities. Due to market or other conditions, we may have limited access to capital from the equity and debt markets. 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 or to meet our obligations, which could have a material adverse effect on our results of operations and our ability to make distributions to our stockholders.

Our indebtedness could adversely affect our financial condition and may otherwise adversely impact our business operations and our ability to make distributions to stockholders.

As of February 26, 2016, we had $3.4 billion of debt outstanding.

Our indebtedness could have significant effects on our business. For example, it could:

require us to use a substantial portion of our cash flow from operations to service our indebtedness, which would reduce the available cash flow to fund working capital, development projects and other general corporate purposes and reduce cash for distributions;

require payments of principal and interest that may be greater than our cash flow from operations;

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force us to dispose of one or more of our properties, possibly on disadvantageous terms, to make payments on our debt;

increase our vulnerability to general adverse economic and industry conditions; limit our flexibility in planning for, or reacting to, changes in our business and the industry in which we operate;

restrict us from making strategic acquisitions or exploiting other business opportunities;

make it more difficult for us to satisfy our obligations; and

place us at a competitive disadvantage compared to our competitors that have less debt.

Our future borrowings under our loan facilities may bear interest at variable rates in addition to the $1.4 billion in variable interest rate debt (excluding any debt we have fixed with interest rate swaps) that we had outstanding as of December 31, 2015. If interest rates increase significantly, our operating results would decline along with the cash available for distributions to our stockholders.

In addition, 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. Although we only have $125 million in debt maturities in 2016, there is a risk that we may not be able to refinance debt maturing in future years 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. See Item 7 of Part II of this Form 10-K for further information on debt maturities.

Covenants in our debt instruments limit our operational flexibility, and a breach of these covenants could materially affect our financial condition and results of operations.

The terms of our unsecured credit facility (Credit Facility) and the indentures governing our outstanding unsecured senior notes, and other debt instruments that we may enter into in the future are subject to customary financial and operational covenants. For example, our Credit Facility imposes certain restrictions on us, including restrictions on our ability to: incur debts; create or incur liens; provide guarantees in respect of obligations of any other entity; make redemptions and repurchases of our capital stock; prepay, redeem or repurchase debt; engage in mergers or consolidations; enter into affiliated transactions; dispose of real estate; and change our business. In addition, the agreements governing our unsecured credit facility limit the amount of dividends we can pay as a percentage of normalized adjusted funds from operations, as defined, on a rolling four quarter basis. Through the quarter ending December 31, 2015, the dividend restriction was 95% of normalized adjusted FFO. The indentures governing our senior unsecured notes also limit the amount of dividends we can pay based on the sum of 95% of funds from operations, proceeds of equity issuances and certain other net cash proceeds. Finally, our senior unsecured notes require us to maintain total unencumbered assets (as defined in the related indenture) of not less than 150% of our unsecured indebtedness.

From time-to-time, the lenders of our Credit Facility may adjust certain covenants to give us more flexibility to complete a transaction; however, such modified covenants are temporary, and we must be in a position to meet the lowered reset covenants in the future. See Short-term Liquidity Requirements section for a discussion of the resetting of our total leverage and unsecured leverage ratio in 2016.

Our continued ability to incur debt and operate our business is subject to compliance with the covenants in our debt instruments, which limit operational flexibility. Breaches of these covenants could result in defaults under applicable debt instruments and other debt instruments due to cross-default provisions, even if payment obligations are satisfied. Financial and other covenants that limit our operational flexibility, as well as defaults resulting from a breach of any of these covenants in our debt instruments, could have a material adverse effect on our financial condition and results of operations.

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

Excluding our 2006 senior unsecured notes, as of February 26, 2016, we had approximately $900 million in variable interest rate debt, which constitutes 27% of our overall indebtedness and subjects us to interest rate volatility. We may seek to manage our exposure to interest rate volatility by using interest rate hedging arrangements, such as the $125 million of interest rate swaps entered into in 2010 to fix the interest rate on our 2006 senior unsecured notes. However, even these hedging arrangements 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.

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 severely limited by current tax law with respect to our ability to operate or manage the businesses conducted in our facilities.

Accordingly, we rely heavily on rent payments from our tenants under leases or interest payments from operators under mortgage or other loans 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 our facilities, or the financial condition of our tenants, operators or guarantors, 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 healthcare and other 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. If a tenant-operator defaults and we choose to terminate our lease, we are then required to find another tenant-operator, such as the case was with our Monroe facility in 2014. 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 our results of operations, financial condition, and our ability to make distributions to our stockholders. Defaults by our significant tenants under master leases (like Prime, Ernest, MEDIAN, and Capella) will have an even greater effect.

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It may be costly to find new tenants when lease terms end and we may not be able to replace such tenants with suitable replacements on suitable terms.

Failure on the part of a tenant to renew or extend the lease at the end of its fixed term on one of our facilities could result in us having to search for, negotiate with and execute new lease agreements, such was the case with our two South Carolina facilities Bennettsville and Cheraw in 2015. The process of finding and negotiating with a new tenant along with costs (such as maintenance, property taxes, utilities, etc.) that we will incur while the facility is untenanted may be costly and require a disproportionate amount of management s attention. 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. 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. Thus, the non-renewal or extension of leases may adversely affect our results of operations, financial condition, and our ability to make distributions to our stockholders. This risk is even greater for those properties under master leases (like Prime, MEDIAN, Ernest, and Capella) because several properties have the same lease ending dates.

We have made investments in the operators of certain of our healthcare facilities and the cash flows (and related returns) from these investments are subject to more volatility than our properties with the traditional net leasing structure.

At December 31, 2015, we have 14 investments in the operations of certain of our healthcare facilities by utilizing RIDEA (or similar investments). These investments include profits interest, equity investments, and equity like loans that generate returns dependent upon the operator s performance. As a result, the cash flow and returns from these investments may be more volatile than that of our traditional triple-net leasing structure. Our business, results of operations, and financial condition may be adversely affected if the related operators fail to successfully operate the facilities efficiently and in a manner that is in our best interest.

We have limited experience with healthcare facilities in Germany, Italy, Spain, United Kingdom or anywhere else outside the United States.

We have limited experience investing in healthcare properties or other real estate-related assets located outside the United States. Investing in real estate located in foreign countries, including Germany, Italy, Spain and the United Kingdom, creates risks associated with the uncertainty of foreign laws and markets including, without limitation, laws respecting foreign ownership, the enforceability of loan and lease documents and foreclosure laws. German real estate and tax laws are complex and subject to change, and we cannot assure you we will always be in compliance with those laws or that compliance will not expose us to additional expense. The properties we acquired in connection with the MEDIAN acquisition (as more fully described in Note 3 to Item 8 of this Form 10-K) will also face risks in connection with unexpected changes in German or European regulatory requirements, political and economic instability, potential imposition of adverse or confiscatory taxes, possible challenges to the anticipated tax treatment of the structures that allow us to acquire and hold investments, possible currency transfer restrictions, the difficulty in enforcing obligations in other countries and the burden of complying with a wide variety of foreign laws. In addition, to qualify as a REIT, we generally will be required to operate any non-U.S. investments in accordance with the rules applicable to U.S. REITs, which may be inconsistent with local practices. We may also be subject to fluctuations in local real estate values or markets or the European economy as a whole, which may adversely affect our European investments.

In addition, the rents payable under our leases of foreign assets are payable in either euros or British pounds, which could expose us to losses resulting from fluctuations in exchange rates to the extent we have not hedged our position, which in turn could adversely affect our revenues, operating margins and dividends, and may also affect the book value of our assets and the amount of stockholders equity. Further, any international currency gain recognized with respect to changes in exchange rates may not qualify under the 75% gross income test that we must satisfy annually in order to qualify and maintain our status as a REIT. Although we expect to hedge

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some of our foreign currency risk, we may not be able to do so successfully and may incur losses on our investments as a result of exchange rate fluctuations. Furthermore, we are subject to laws and regulations, such as the Foreign Corrupt Practices Act and similar local anti-bribery laws, that generally prohibit companies and their employees, agents and contractors from making improper payments to governmental officials for the purpose of obtaining or retaining business. Failure to comply with these laws could subject us to civil and criminal penalties that could materially adversely affect our results of operations, the value of our international investments, and our ability to make distributions to our stockholders.

Our revenues are dependent upon our relationship with, and success of, our significant tenants.

As of December 31, 2015, our real estate portfolio included 202 healthcare properties in 29 states and in Germany, Italy, Spain and the United Kingdom of which 179 facilities were leased to 28 hospital operating companies and 14 of the investments were in the form of mortgage loans. Affiliates of Prime leased or mortgaged 24 facilities, representing 18% of our total assets as of December 31, 2015. Total revenues from Prime were $104 million, or 24% of our total revenue for the year ended December 31, 2015. Affiliates of Ernest leased or mortgaged 26 facilities (including one under development), representing 10% of our total assets as of December 31, 2015. Total revenues from Ernest were $62 million, or 14% of our total revenue for the year ended December 31, 2015. Affiliates of Capella leased or mortgaged 7 facilities, representing 18% of our total assets as of December 31, 2015. Total revenues from Capella were $29 million, or 6% of our total revenue for the year ended December 31, 2015. Finally, MEDIAN leased 46 facilities and represented 17% of total assets as of December 31, 2015. Total revenues from the combined MEDIAN-RHM were $79 million, or 18% of our total revenue for the year ended December 31, 2015.

Our relationships with our significant tenants, and their 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 our significant tenants to make rent and loan payments to us, and their failure or delay to meet these obligations could have a material adverse effect on our financial condition and results of operations. For additional discussion of risks relating to our tenants operations and obligations to comply with applicable industry laws, rules and regulations, see Risks Relating to the Healthcare Industry below.

We have now, and may have in the future, exposure to contingent rent escalators, which could hinder our growth and profitability.

We receive a significant portion of our revenues by leasing assets under long-term net leases that generally provide for fixed rental rates subject to annual escalations. These annual escalations may be contingent on changes in CPI, typically with specified caps and floors. Certain of our other leases may provide for additional rents contingent upon a percentage of the tenant s revenues in excess of specified threshold. If, as a result of weak economic conditions or other factors, the CPI does not increase or the properties subject to these leases do not generate sufficient revenue to achieve the specified threshold, our growth and profitability may be hindered by these leases. In addition, if strong economic conditions result in significant increases in CPI, but the escalations under our leases are capped, our growth and profitability may be limited.

The bankruptcy or insolvency of our tenants or investees could harm our operating results and financial condition.

Some of our tenants/investees are, and some of our prospective tenants/investees 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/investees 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 can be expected to delay our efforts to collect past due

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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 (such as our equity interests in our tenants) 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 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, including large private equity funds;

healthcare providers, including physicians;

other REITs;

real estate developers;

government-sponsored and/or not-for-profit agencies;

financial institutions; and

other lenders.

Some of these competitors may 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, earnings growth and financial return could be materially adversely affected. Certain of our facilities, or facilities we may acquire or develop in the future will face competition from other nearby facilities that provide services comparable to those offered at our facilities. 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 generally available to our facilities. In addition, competing healthcare facilities located in the areas served by our facilities 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

tenants and thus our rental revenues, interest income, and/or our earnings from equity investments.

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. There is no assurance that the formulas we have developed for setting the purchase price will yield a fair market value purchase price.

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 may 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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We have 113 leased properties that are subject to purchase options as of December 31, 2015. For 91 of these properties, the purchase option generally allows the lessee to purchase the real estate at the end of the lease term, as long as no default has occurred, at a price equivalent to the greater of (i) fair market value or (ii) our original purchase price (increased, in some cases, by a certain annual rate of return from lease commencement date). The lease agreements provide for an appraisal process to determine fair market value. For 13 of these properties, the purchase option generally allows the lessee to purchase the real estate at the end of the lease term, as long as no default has occurred, at our purchase price (increased, in some cases, by a certain annual rate of return from lease commencement date). For the remaining nine leases, the purchase options approximate fair value. At December 31, 2015, none of our leases contained any bargain purchase options.

In certain circumstances, a prospective purchaser of our hospital real estate may be deemed to be subject to Anti-Kickback and Stark statutes, which are described on page 11 of this 2015 Form 10-K. In such event, it may not be practicable for us to sell property to such prospective purchasers at prices other than fair market value.

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

There is no assurance that we will be able to adapt our management, administrative, accounting and operational systems, or hire and retain sufficient operational staff, to manage the facilities we have acquired and those that we may acquire or develop, including those properties located in Europe or any future investments outside the United States. Our failure to successfully 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.

Merger and acquisition activity or consolidation in the healthcare industry may result in a change of control of, or a competitor s investment in, one or more of our tenants or operators, which could have a material adverse effect on us.

The healthcare industry has recently experienced increased consolidation, including among owners of real estate and healthcare providers. We compete with other healthcare REITs, healthcare providers, healthcare lenders, real estate partnerships, banks, insurance companies, private equity firms and other investors that pursue a variety of investments, which may include investments in our tenants or operators. We have historically developed strong, long-term relationships with many of our tenants and operators. A competitor s investment in one of our tenants or operators, any change of control of a tenant or operator, or a change in the tenant s or operator s management team could enable our competitor to influence or control that tenant s or operator s business and strategy. This influence could have a material adverse effect on us by impairing our relationship with the tenant or operator, negatively affecting our interest, or impacting the tenant s or operator s financial and operational performance, including their ability to pay us rent or interest. Depending on our contractual agreements and the specific facts and circumstances, we may have consent rights, termination rights, remedies upon default or other rights and remedies related to a competitor s investment in, a change of control of, or other transactions impacting a tenant or operator. In deciding whether to exercise our rights and remedies, including termination rights or remedies upon default, we assess numerous factors, including legal, contractual, regulatory, business and other relevant considerations.

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, and Emmett E. McLean 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

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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.

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 prices 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 future capital through a sale of additional equity securities.

Downgrades in our credit ratings could have a material adverse effect on our cost and availability of capital.

As of February 26, 2016, our corporate credit rating from Standard and Poor s Ratings Service was BB+, and our corporate family rating from Moody s Investors Service was Ba1. There can be no assurance that we will be able to maintain our current credit ratings. Any downgrades in terms of ratings or outlook by any or all of the rating agencies could have a material adverse effect on our cost and availability of capital, which could in turn have a material adverse effect on our financial condition and results of operations.

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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 on our securities or seek securities paying higher distributions. The market price of our common stock likely will be based primarily on the earnings that we derive from rental and interest 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.

Ownership of property outside the United States may subject us to a different or greater risk than those associated with our domestic operations.

We currently have operations in Europe. International development, ownership, and operating activities involve risks that are different from those we face with respect to our domestic properties and operations. These risks include, but are not limited to, currency fluctuations; changes in foreign political, regulatory, and economic conditions; challenges in managing international operations (including the use of third-parties in providing accounting, legal, and other administrative functions); challenges of complying with a wide variety of foreign laws and regulations; foreign ownership restrictions with respect to operations in countries; and changes in applicable laws and regulations in the United States that affect foreign operations. If we are unable to successfully manage the risks associated with international expansion and operations, our results of operations and financial condition may be adversely affected.

Changes in currency exchange rates may subject us to risk.

As our operations have expanded internationally where the U.S. dollar is not the denominated currency, currency exchange rate fluctuations could affect our results of operations and financial position. A significant change in the value of the foreign currency of one or more countries where we have a significant investment may have a material adverse effect on our financial position, debt covenant ratios, results of operations and cash flow.

Although we may enter into foreign exchange agreements with financial institutions and/or obtain local currency mortgage debt in order to reduce our exposure to fluctuations in the value of foreign currencies, we cannot assure you that foreign currency fluctuations will not have a material adverse effect on us.

RISKS RELATING TO REAL ESTATE INVESTMENTS

Our real estate, mortgage, and equity investments are and are expected to continue to be concentrated in a single industry segment, making us more vulnerable economically than if our investments were more diversified.

We acquire, develop, and make mortgage investments in healthcare real estate. In addition, we selectively make RIDEA investments in healthcare operators. 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 solely 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 as well as our return on our equity investments. Consequently, our ability to meet debt service

obligations or make distributions to our stockholders are dependent on the real estate and healthcare industries. These adverse effects could be more pronounced than if we diversified our investments outside of real estate or outside of healthcare facilities.

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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. Additionally, the real estate market is affected by many factors beyond our control, including adverse changes in global, national, and local economic and market conditions and the availability, costs and terms of financing. 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 developed and constructed facilities in the past and are currently developing nine facilities. We will develop additional facilities in the future as opportunities present themselves. Our development and related construction activities may subject us to the following risks:

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

we may not be able to obtain financing on favorable terms, which may render us unable to proceed with our development activities.

We expect to fund our development projects over time. The time frame required for development and construction of these facilities means that we may have to wait for some time to earn significant cash returns. In addition, our tenants may not be able to obtain managed care provider contracts in a timely manner or at all. Finally, there is no assurance that future development projects will occur without 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.

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We may be subject to risks arising from future acquisitions of real estate.

We may be subject to risks in connection with our acquisition of healthcare real estate, including without limitation the following:

- we may have no previous business experience with the tenants at the facilities acquired, and we may face difficulties in managing them;
- underperformance of the acquired facilities due to various factors, including unfavorable terms and conditions of the existing lease agreements relating to the facilities, disruptions caused by the management of our tenants or changes in economic conditions;
- diversion of our management s attention away from other business concerns;
- exposure to any undisclosed or unknown potential liabilities relating to the acquired facilities; and
- potential underinsured losses on the acquired facilities.

We cannot assure you that we will be able to manage the new properties without encountering difficulties or that any such difficulties will not have a material adverse effect on us.

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. Newly-developed or newly-renovated facilities may not have operating histories that are helpful in making objective pricing decisions. 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.

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 gains, each year to maintain our qualification as a REIT, our ability to rely upon income from operations or cash flows from operations to finance our growth and acquisition activities will be limited.

If our facilities do not achieve expected results and generate ample cash flows from operations or if we are unable to obtain funds from borrowings or the capital markets to finance our acquisition and development activities, 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.

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.

Our leases generally require our tenants to carry property, 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. We carry general liability insurance and loss of earnings coverage on all of our properties as a contingent measure in case our tenant s coverage is not sufficient. 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

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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. We continually review the insurance maintained by our tenants and operators and believe the coverage provided to be adequate and customary for similarly situated companies in our industry. However, we cannot provide any assurances that such insurance will be available at a reasonable cost in the future. Also, we cannot assure you that material uninsured losses, or losses in excess of insurance proceeds, will not occur in the future.

Our 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 fixtures and fixed 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, regulatory requirements, construction cost overruns and delays, uncertainties as to market demand or deterioration in market demand after commencement of renovation and the emergence of unanticipated competition from other facilities. All of these factors could adversely impact rent and loan payments by our tenants and returns on our equity investments, which in turn could have a material adverse effect on our financial condition and results of operations along with 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. In addition, if such taxes increase on properties in which we have an equity investment in the tenant, our return on investment maybe negatively 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 laws and regulations. Various environmental laws may impose liability on the 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

typically obtain Phase I environmental assessments (or similar studies) on facilities we acquire or develop or on which we make mortgage loans, and intend to obtain on future facilities we acquire. 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.

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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 laws are constantly evolving, and changes in laws, regulations or policies, or changes in interpretations of the foregoing, could create liabilities where none exist 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 24 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, which may limit our flexibility in renting the facility and may impede our ability to sell the property.

Our acquisitions may not prove to be successful.

We are exposed to the risk that some of our acquisitions may not prove to be successful. We could encounter unanticipated difficulties and expenditures relating to any acquired properties, including contingent liabilities, and acquired properties might require significant management attention that would otherwise be devoted to our ongoing business. In addition, we might be exposed to undisclosed and unknown liabilities related to any acquired properties. If we agree to provide construction funding to an operator/tenant and the project is not completed, we may need to take steps to ensure completion of the project. Moreover, if we issue equity securities or incur additional debt, or both, to finance future acquisitions, it may reduce our per share financial results. These costs may negatively affect our results of operations.

RISKS RELATING TO THE HEALTHCARE INDUSTRY

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

Sources of revenue for our tenants and operators may include the Medicare and Medicaid programs, private insurance carriers, and health maintenance organizations, among others. Efforts by such payors to reduce healthcare costs could 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 United States 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. In instances where we have an equity investment in our tenants operations, in addition to the effect on these tenants ability to meet their financial obligations to us, our ownership and investment interests may also be negatively impacted.

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CMS s increased attention on reimbursement for LTACHs and inpatient rehabilitation facilities (IRFs), and increased regulatory restrictions on LTACH and IRF reimbursement, has reduced reimbursement for some tenants that operate LTACHs and IRFs. CMS may continue to explore implementing other restrictions on LTACH and IRF reimbursement and possibly develop more restrictive facility and patient level criteria for these types of facilities. 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 United States healthcare industry is heavily regulated and loss of licensure or certification or failure to obtain licensure or certification could negatively impact our financial condition and results of operations.

The United States healthcare industry is highly regulated by federal, state, and local laws (as discussed on pages 10-13) 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. We are aware of various federal and state inquiries, investigations, and other proceedings currently affecting several of our tenants and would expect such governmental compliance and enforcement activities to be ongoing at any given time with respect to one or more of our tenants, either on a confidential or public basis. As discussed in further detail below, an adverse result to our tenants in one or more such governmental proceedings may have a material adverse effect on the relevant tenant s operations and financial condition and on its ability to make required lease and mortgage payments to us. In instances where we have an equity investment in our tenants operations, in addition to the effect on these tenants ability to meet their financial obligation to us, our ownership and investment interests may also be negatively impacted.

Licensed health care facilities must comply with minimum health and safety standards and are subject to survey and inspection by state and federal agencies and their agents or affiliates, including CMS, the Joint Commission, and state departments of health. CMS develops Conditions of Participation and Conditions for Coverage that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs and receive payment under such programs. These minimum health and safety standards are aimed at improving quality and protecting the health and safety of beneficiaries. There are several common criteria that exist across health entities. Examples of common conditions include: a governing body responsible for effectively governing affairs of the organization, a quality assurance program to evaluate entity-wide patient care, medical record service responsible for medical records, a utilization review of the services furnished by the organization and its staff, and a facility constructed, arranged, and maintained according to a life safety code that ensures patient safety and the deliverance of services appropriate to the needs of the community. The failure to comply with these standards could jeopardize a healthcare organization s Medicare certification and, in turn, its right to receive payment under the Medicare and Medicaid programs.

Further, many hospitals and other institutional providers are accredited by accrediting agencies such as the Joint Commission, a national healthcare accrediting organization. The Joint Commission was created to accredit healthcare organizations that meet its minimum health and safety standards. A national accrediting organization, such as the Joint Commission, enforces standards that meet or exceed such requirements. Surveyors for the Joint Commission, prior to the opening of a facility and approximately every three years thereafter, conduct on site surveys of facilities for compliance with a multitude of patient safety, treatment, and administrative requirements. Facilities may lose accreditation for failure to meet such requirements, which in turn may result in the loss of license or certification including under the Medicare and Medicaid programs. For example, a facility may lose accreditation for failing to maintain proper medication in the operating room to treat potentially fatal reactions to anesthesia or for failure to

maintain safe and sanitary medical equipment.

Finally, healthcare facility reimbursement practices and quality of care issues may result in loss of license or certification. For instance, the practice of upcoding, whereby services are billed for higher procedure codes than were actually performed, may lead to the revocation of a hospital s license. An event involving poor quality

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of care, such as that which leads to the serious injury or death of a patient, may also result in loss of license or certification. The Services Employees International Union (SEIU) has alleged that our tenant Prime may have upcoded for certain procedures and may be providing poor quality of care, in addition to allegations of delaying the transfer of out-of-network patients to their preferred medical provider once they have stabilized. Prime has addressed these allegations publicly and has provided clinical and other data to us refuting these allegations. Prime has also informed us that the SEIU is attempting to organize certain Prime employees. Prime has also disclosed an ongoing investigation by the United States Department of Justice into billing practices and patient confidentiality statutes.

The failure of any tenant to comply with such laws, requirements, and regulations resulting in a loss of its license would affect its ability to continue its operation of the facility and would adversely affect the tenant s ability to make lease and/or principal and interest payments to us. This, in turn, 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 shareholders. In instances where we have an equity investment in our tenants operations, in addition to the effects on these tenants ability to meet their financial obligations to us, our ownership and investment interests would be negatively impacted.

In addition, establishment of healthcare facilities and transfers of operations of healthcare facilities are subject to regulatory approvals not required for establishment, or transfers, of other types of commercial operations and real estate. 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/or to pay principal and interest on their loans from us. In instances where we have an equity investment in our tenants operations, in addition to the effect on these tenants ability to meet their financial obligations to us, our ownership and investment interests may also be negatively impacted.

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

As noted earlier, 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, federal and state governments continue to increase investigation and enforcement activity to detect and eliminate fraud and abuse in the Medicare and Medicaid programs. It is anticipated that the trend toward increased investigation and enforcement activity in the areas of fraud and abuse and patient self-referrals will continue in future years. 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 instances where we have an equity investment in our tenants operations, in addition to the effect on the tenants ability to meet their financial obligations to us, our ownership and investment interests may also be negatively impacted.

Some of our tenants have accepted, and prospective tenants may accept, an assignment of the previous operator s Medicare provider agreement. Such operators and other new-operator tenants that take assignment of Medicare provider agreements might be subject to liability for 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, and in turn their ability to make lease and loan payments to us. In instances where we have an equity investment in our

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tenants operations, in addition to the effect on these tenants ability to meet their financial obligations to us, our ownership and investment interests may also be negatively impacted.

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

Although no such investment exists today, 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 its implementing regulations, if our lease arrangements do not satisfy the requirements of an applicable exception, the ability of our tenants to bill for services provided to Medicare beneficiaries pursuant to referrals from physician investors could be adversely impacted and subject us and our tenants to fines, which could impact our tenants ability to make lease and loan payments to us. In instances where we have an equity investment in our tenants operations, in addition to the effect on the tenants ability to meet their financial obligations to us, our ownership and investment interests may also be negatively impacted.

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.

We may be required to incur substantial renovation costs to make certain of our healthcare properties suitable for other operators and tenants.

Healthcare facilities are typically highly customized and may not be easily adapted to non-healthcare-related uses. The improvements generally required to conform a property to healthcare use can be costly and at times tenant-specific. A new or replacement operator or tenant may require different features in a property, depending on that operator s or tenant s particular business. If a current operator or tenant is unable to pay rent and/or vacates a property, we may incur substantial expenditures to modify a property before we are able to secure another operator or tenant. Also, if the property needs to be renovated to accommodate multiple operators or tenants, we may incur substantial expenditures before we are able to re-lease the space. These expenditures or renovations may have a material adverse effect on our business, results of operations, and financial condition.

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 the transfer of a healthcare facility or 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, are subject to change, and may delay acquisitions of facilities. We cannot predict the impact of state certificate of need laws on our acquisition or development of facilities or the operations of our tenants. Certificate of need laws often materially impact the ability of competitors to enter into the marketplace of our facilities. In addition, 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 change.

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RISKS RELATING TO OUR ORGANIZATION AND STRUCTURE

Maryland law and our 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.

Our charter contains ownership limitations that may restrict business combination opportunities, inhibit change of control transactions and reduce the value of our 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 our outstanding stock, after taking into account options to acquire stock, may be owned, directly or indirectly, by five or fewer persons during the last half of each taxable year. Our charter generally prohibits direct or indirect ownership by any person of more than 9.8% in value or in number, whichever is more restrictive, of outstanding shares of any class or series of our securities, including our common stock. Generally, our 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 our common stock an unsuitable investment vehicle for any person seeking to obtain, either alone or with others as a group, ownership of more than 9.8% of either the value or number of the outstanding shares of our common stock.

Our charter and bylaws contain provisions that may impede third-party acquisition proposals that may be in the best interests of our stockholders. Our charter and bylaws also provide that our directors may only be removed by the affirmative vote of the holders of two-thirds of our 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 our common stock might receive a premium for their common stock over the then-current market price or which such holders otherwise might believe to be in their best interests.

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

We are organized as an umbrella partnership real estate investment trust, 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 employees and/or 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, we have fiduciary duties to the limited partners of the operating partnership that may conflict with fiduciary duties that our officers and directors owe to its stockholders. These conflicts may result in decisions that are not in the best interest of our stockholders.

We rely on information technology in our operations, and any material failure, inadequacy, interruption or security failure of that technology could harm our business.

We rely on information technology networks and systems, including the Internet, to process, transmit and store electronic information, and to manage or support a variety of business processes, including financial transactions and records, and maintaining personal identifying information and tenant and lease data. We purchase or license some of our information technology from vendors, on whom our systems depend. We rely on

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commercially available systems, software, tools and monitoring to provide security for the processing, transmission and storage of confidential tenant data. Although we have taken steps to protect the security of our information systems and the data maintained in those systems, it is possible that our safety and security measures will not prevent the systems improper functioning or the improper access or disclosure of our or our tenant s information such as in the event of cyber-attacks. Security breaches, including physical or electronic break-ins, computer viruses, attacks by hackers and similar breaches, can create system disruptions, shutdowns or unauthorized disclosure of confidential information. The risk of security breaches has generally increased as the number, intensity and sophistication of attacks have increased. In some cases, it may be difficult to anticipate or immediately detect such incidents and the damage they cause. Any failure to maintain proper function, security and availability of our information systems could interrupt our operations, damage our reputation, subject us to liability claims or regulatory penalties and could have a materially adverse effect on our business, financial condition and results of operations.

Changes in accounting pronouncements could adversely affect our operating results, in addition to the reported financial performance of our tenants.

Uncertainties posed by various initiatives of accounting standard-setting by the Financial Accounting Standards Board and the Securities and Exchange Commission, which create and interpret applicable accounting standards for U.S. companies, may change the financial accounting and reporting standards or their interpretation and application of these standards that govern the preparation of our financial statements. Proposed changes include, but are not limited to, changes in lease accounting and the adoption of accounting standards likely to require the increased use of fair-value measures.

These changes could have a material impact on our reported financial condition and results of operations. In some cases, we could be required to apply a new or revised standard retroactively, resulting in potentially material restatements of prior period financial statements. Similarly, these changes could have a material impact on our tenants reported financial condition or results of operations or could affect our tenants preferences regarding leasing real estate.

TAX RISKS ASSOCIATED WITH OUR STATUS AS A REIT

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

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

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

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

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

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

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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 gains. 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 United States 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. Currently, no more than 25% 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. In addition, at least 75% of our gross income must be generated from either rents from real estate or interest on loans secured by real estate (i.e. mortgage loans). 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.

In addition to current requirements, tax laws are always evolving. Changes to the tax laws, such as the Protecting Americans From Tax Hikes Act of 2015 (PATH Act) enacted on December 18, 2015, or interpretations thereof by the IRS, could materially and adversely impact us and our stockholders. The PATH Act included several law changes impacting REITs that have various effective dates. One of the more notable changes reduces the value of our assets that may consist of securities of one or more taxable REIT subsidiaries from 25% to 20% for taxable years beginning after December 31, 2017. Compliance with current and future changes to REIT requirements may limit our flexibility in executing our business plan.

If certain sale-leaseback transactions are not characterized by the Internal Revenue Service (IRS) as true leases, we may be subject to adverse tax consequences.

We have purchased certain properties and leased them back to the sellers of such properties, and we may enter into similar transactions in the future. We intend for any such sale-leaseback transaction to be structured in

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a manner that the lease will be characterized as a true lease, thereby allowing us to be treated as the owner of the property for U.S. federal income tax purposes. However, depending on the terms of any specific transaction, the IRS might take the position that the transaction is not a true lease but is more properly treated in some other manner. In the event any sale-leaseback transaction is challenged and successfully re-characterized, we might fail to satisfy the REIT asset tests or income test and, consequently could lose our REIT status effective with the year of re-characterizations.

Transactions with taxable REIT subsidiaries may be subject to excise tax.

We have historically entered into lease and other transactions with our taxable REIT subsidiaries and their subsidiaries and expect to continue to do so in the future. Under applicable rules, transactions such as leases between our taxable REIT subsidiaries and their parent REIT that are not conducted on a market terms basis may be subject to a 100% excise tax. While we believe that all of our transactions with our taxable REIT subsidiaries are at arm s length, imposition of a 100% excise tax could have a material adverse effect on our financial condition and results of operations and could adversely affect the trading price of our common stock.

Loans to our tenants could be characterized as equity, in which case our 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 in 2004 of certain Vibra Healthcare, LLC (Vibra) facilities, one of our taxable REIT subsidiaries made a loan to Vibra to acquire the operations at those Vibra facilities. The acquisition loan bore interest at an annual rate of 10.25%. Our operating partnership loaned the funds to the taxable REIT subsidiary to make this loan. The loan from our operating partnership to the taxable REIT subsidiary bore interest at an annual rate of 9.25%.

Like the Vibra loan discussed above, our taxable REIT subsidiaries have made and will make loans to tenants in our facilities to acquire operations or for working capital purposes. The IRS may take the position that certain loans to tenants should be treated as equity interests rather than debt, and that our interest 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 be in jeopardy of failing the 75% income test discussed above, which if we did would cause us to 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 subsidiaries, 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, we 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.

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

None.

ITEM 2. ***Properties***

At December 31, 2015, our portfolio consisted of 202 properties: 179 facilities (of the 188 facilities that we owned) were in operation and leased to 28 operators, 14 assets were in the form of first mortgage loans to four operators, and nine properties that were under construction. Our owned facilities consisted of 97 general acute care hospitals, 22 long-term acute care hospitals, 66 inpatient rehabilitation hospitals, and three medical office buildings. The 14 non-owned facilities were in the form of first mortgage loans to four operators. These non-owned properties consisted of 10 general acute care facilities, one long-term acute care hospital, and three inpatient rehabilitation hospitals to four operators.

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	Total Properties	Total 2015 Revenue	Percentage of Total Revenue	Total Investment
		(Dollars in thousands)		
United States:				
Alabama	2	$ 509	0.1%	$ 8,614
Arizona	9	21,188	4.8%	220,447(C)
Arkansas	2	9,311	2.1%	278,646
California	13	66,120	15.0%	547,085
Colorado	12	10,188	2.3%	87,741(C)
Connecticut		173	0.0%	1,500(D)
Florida	1	2,250	0.5%	25,810
Idaho	4	12,461	2.8%	102,196
Indiana	2	4,829	1.1%	52,003
Kansas	3	11,050	2.5%	97,372
Louisiana	4	12,351	2.8%	131,326
Massachusetts		69	0.0%	(D)
Michigan	2	2,274	0.5%	40,743
Missouri	4	17,745	4.0%	210,921
Montana	1	2,544	0.6%	21,374
Nevada	1	9,826	2.2%	83,598
New Jersey	7	27,688	6.3%	338,847
New Mexico	2	5,911	1.3%	53,081
Ohio	1		0.0%	13,693(C)
Oklahoma	2	9,354	2.1%	277,742
Oregon	2	9,497	2.2%	203,595
Pennsylvania	1	4,638	1.1%	39,766
Rhode Island		60	0.0%	(D)
South Carolina	6	12,321	2.8%	213,509
Texas	58	87,541	19.8%	917,314(A)(C)
Utah	3	9,759	2.2%	104,805
Virginia	1	1,072	0.2%	10,915
Washington			0.0%	163,191(E)
West Virginia	1	2,563	0.6%	21,109
Wisconsin	1	2,861	0.7%	29,048
Wyoming	1	2,708	0.6%	22,753
Total United States	146	$ 358,861	81.2%	$ 4,318,744
International:				
United Kingdom	1	$ 4,365	1.0%	$ 41,629
Germany	46	78,541	17.8%	978,530
Italy	8		0.0%	97,364(F)
Spain	1	111	0.0%	13,668
Total international	56	$ 83,017	18.8%	$ 1,131,191

Total	202	$ 441,878	100.0%	$ 5,449,935(B)

(A) Includes our Twelve Oaks facility that is 55% occupied. Our total gross investment in the facility is $62.5 million.
(B) Excludes domestic equity interests and accumulated depreciation and amortization. Includes other loans of $664.8 million.
(C) Includes development projects still under construction at December 31, 2015.
(D) Includes revenue related to properties that were disposed during 2015, including an existing loan related to the disposed property. We do not own any property in this state as of December 31, 2015.
(E) Includes acquisition loan for Capella facility that has not converted to real estate at December 31, 2015.
(F) Includes $97 million equity investment in eight facilities that is included in other assets on the balance sheet at December 31, 2015.

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Type of Property *(includes properties subject to leases and loans)*	Number of Properties	Number of Square Feet	Number of Licensed Beds(C)
General Acute Care Hospitals(A)	107	15,080,765	9,557
Long-Term Acute Care Hospitals	23	1,209,361	1,304
Rehabilitation Hospitals(B)	69	7,716,590	10,439
Medical Office Buildings	3	96,106	
	202	24,102,822	21,300

(A) One of our general acute care hospitals, currently under development, with 387,500 square feet and 183 beds, is located in Spain. One of our general acute care hospitals, with 69,965 square feet and 28 beds, is located in the United Kingdom. Eight of our general acute care hospitals, with 822,000 square feet and 807 beds, are located in Italy. One of our general acute care hospitals, with 135,216 square feet and 160 beds, is located in Germany.

(B) 45 of our rehabilitation facilities, with 6.5 million square feet and 9,361 beds, are located in Germany.

(C) Excludes our nine facilities that are under development.

The following table shows lease and mortgage loan expirations, for the next 10 years and thereafter (excludes properties under development), assuming that none of the tenants/borrowers exercise any of their renewal options (dollars in thousands):

Total Lease and Mortgage Loan Portfolio(2)	Total Leases/Mortgage Loans	Base Rent/ Interest(1)	% of Total Base Rent/Interest	Total Square Footage	Total Licensed Beds
2016	1	$ 2,250	0.5%	95,445	126
2017			0.0%		
2018	1	1,989	0.5%	66,459	62
2019	2	4,994	1.2%	307,706	136
2020	5	9,185	2.1%	1,200,306	590
2021	2	10,609	2.5%	327,234	212
2022	15	72,123	16.9%	3,543,907	2,591
2023	4	12,380	2.9%	912,652	851
2024	2	4,768	1.1%	235,627	264
2025	8	20,375	4.8%	1,337,203	969
Thereafter	144	287,843	67.5%	14,762,129	14,086
Total	184	$ 426,516	100.0%	22,788,668	19,887

(1) The most recent monthly base rent and mortgage loan interest annualized. This does not include tenant recoveries, additional rents and other lease/loan-related adjustments to revenue (i.e., straight-line rents and deferred revenues).

(2) Excludes our nine facilities that are under development.

ITEM 3. ***Legal Proceedings***

From time to time, there are various legal proceedings pending to which we are a party or to which some of our properties are subject to arising in the normal course of business. At this time, we do not believe that the ultimate resolution of these proceedings will have a material adverse effect on our consolidated financial position or results of operations.

ITEM 4. ***Mine Safety Disclosures***

None.

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PART II

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

(a) 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 dividends per share declared by us with respect to each such period.

	High	Low	Dividends
Year ended December 31, 2015			
First Quarter	$ 15.62	$ 13.81	$ 0.22
Second Quarter	15.42	13.04	0.22
Third Quarter	13.98	10.79	0.22
Fourth Quarter	12.21	10.59	0.22
Year ended December 31, 2014			
First Quarter	$ 13.66	$ 12.09	$ 0.21
Second Quarter	13.97	12.65	0.21
Third Quarter	14.14	12.18	0.21
Fourth Quarter	14.22	12.23	0.21

On February 26, 2016, the closing price for our common stock, as reported on the New York Stock Exchange, was $11.57 per share. As of February 26, 2016, there were 68 holders of record of our common stock. This figure does not reflect the beneficial ownership of shares held in nominee name.

To qualify as a REIT, we must distribute at least 90% of our REIT taxable income, excluding net capital gain, as dividends to our stockholders. If dividends are declared in a quarter, those dividends will be paid during the subsequent quarter. We expect to continue the policy of distributing our taxable income through regular cash dividends on a quarterly basis, although there is no assurance as to future dividends because they depend on future earnings, capital requirements, and our financial condition. In addition, our Credit Facility limits the amounts of dividends we can pay see Note 4 of Item 8 of this Annual Report on Form 10-K for more information.

(b) Not applicable.

(c) None.

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The following graph provides comparison of cumulative total stockholder return for the period from December 31, 2010 through December 31, 2015, among Medical Properties Trust, Inc., the Russell 2000 Index, NAREIT Equity REIT Index, and SNL US REIT Healthcare Index. The stock performance graph assumes an investment of $100 in each of Medical Properties Trust, Inc. and the three indices, and the reinvestment of dividends. The historical information below is not indicative of future performance.

	Period Ending					
Index	**12/31/10**	**12/31/11**	**12/31/12**	**12/31/13**	**12/31/14**	**12/31/15**
Medical Properties Trust, Inc.	100.00	98.32	128.99	139.81	167.97	150.70
Russell 2000	100.00	95.82	111.49	154.78	162.35	155.18
NAREIT All Equity REIT Index	100.00	108.28	129.62	133.32	170.68	175.51
SNL US REIT Healthcare	100.00	114.49	137.46	128.83	171.57	159.09

The graph and accompanying text shall not be deemed incorporated by reference by any general statement incorporating by reference this Annual Report on Form 10-K into any filing under the Securities Act of 1933, as amended, or under the Securities Exchange Act of 1934, as amended.

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

The following tables set forth are selected consolidated financial and operating data for Medical Properties Trust, Inc. and MPT Operating Partnership, L.P. and their respective subsidiaries. You should read the following selected financial data in conjunction with the consolidated historical financial statements and notes thereto of each of Medical Properties Trust, Inc. and MPT Operating Partnership, L.P. and their respective subsidiaries included in Item 8, in this Annual Report on Form 10-K, along with Management s Discussion and Analysis of Financial Condition and Results of Operations included in Item 7, in this Annual Report on Form 10-K.

Medical Properties Trust, Inc.

The consolidated balance sheet and operating data have been derived from our audited consolidated financial statements. As of December 31, 2015, Medical Properties Trust, Inc. had a 99.8% equity ownership interest in the Operating Partnership. Medical Properties Trust, Inc. has no significant operations other than as the sole member of its wholly owned subsidiary, Medical Properties Trust, LLC, which is the sole general partner of the Operating Partnership, and no material assets, other than its direct and indirect investment in the Operating Partnership.

	2015(1)	2014(1)	2013(1)	2012(1)	2011(1)
	(In thousands except per share data)				
OPERATING DATA					
Total revenue	$ 441,878	$ 312,532	$ 242,523	$ 198,125	$ 132,322
Real estate depreciation and amortization (expense)	(69,867)	(53,938)	(36,978)	(32,815)	(30,147)
Property-related and general and administrative (expenses)	(47,431)	(39,125)	(32,513)	(30,039)	(27,815)
Acquisition expenses(2)	(61,342)	(26,389)	(19,494)	(5,420)	(4,184)
Impairment (charge)		(50,128)			
Interest and other income	3,444	8,040	3,235	1,281	96
Debt refinancing/unutilized financing (expense)	(4,368)	(1,698)			(14,214)
Interest (expense)	(120,884)	(98,156)	(66,746)	(58,243)	(43,810)
Income tax (expense)	(1,503)	(340)	(726)	(19)	(128)
Income from continuing operations	139,927	50,798	89,301	72,870	12,120
Income (loss) from discontinued operations		(2)	7,914	17,207	14,594
Net income	139,927	50,796	97,215	90,077	26,714
Net income attributable to non-controlling interests	(329)	(274)	(224)	(177)	(178)
Net income attributable to MPT common stockholders	$ 139,598	$ 50,522	$ 96,991	$ 89,900	$ 26,536
Income from continuing operations attributable to MPT common stockholders per diluted share	$ 0.63	$ 0.29	$ 0.58	$ 0.54	$ 0.10
			0.05	0.13	0.13

Income from discontinued operations attributable to MPT common stockholders per diluted share					
Net income attributable to MPT common stockholders per diluted share	$ 0.63	$ 0.29	$ 0.63	$ 0.67	$ 0.23
Weighted average number of common shares diluted	218,304	170,540	152,598	132,333	110,629
OTHER DATA					
Dividends declared per common share	$ 0.88	$ 0.84	$ 0.81	$ 0.80	$ 0.80

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	2015(1)	2014(1)	December 31, 2013(1)	2012(1)	2011(1)
			(In thousands)		
BALANCE SHEET DATA					
Real estate assets at cost	$ 3,924,701	$ 2,612,291	$ 2,296,479	$ 1,591,189	$ 1,261,644
Real estate accumulated depreciation/amortization	(257,928)	(202,627)	(159,776)	(122,796)	(89,982)
Mortgage and other loans	1,422,403	970,761	549,746	527,893	239,839
Cash and equivalents	195,541	144,541	45,979	37,311	102,726
Other assets	324,634	195,364	147,915	128,393	94,462

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