HEALTH CARE PROPERTY INVESTORS INC
Form 10-K
February 13, 2007

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, 2006

or

o 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 1-8895

HEALTH CARE PROPERTY INVESTORS, INC.

(Exact name of registrant as specified in its charter)

Maryland	**33-0091377**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
3760 Kilroy Airport Way, Suite 300 Long Beach, California	**90806**
(Address of principal executive offices)	(Zip Code)

Registrant s telephone number, including area code **(562) 733-5100**

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

Title of each class	**Name of each exchange on which registered**
Common Stock	New York Stock Exchange
7.25% Series E Cumulative Redeemable Preferred Stock	New York Stock Exchange
7.10% Series F Cumulative Redeemable Preferred Stock	New York Stock Exchange

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

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

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. o

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

Large Accelerated Filer x Accelerated Filer o Non-accelerated Filer o

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

State the aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the registrant s most recently completed second fiscal quarter: $3,632,799,040.

As of January 31, 2007 there were 205,453,864 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the definitive Proxy Statement for the registrant s 2006 Annual Meeting of Stockholders have been incorporated into Part III of this Report.

PART I

ITEM 1. Business

Business Overview

Health Care Property Investors, Inc., together with its consolidated subsidiaries and joint ventures (collectively, HCP or the Company), invests primarily in real estate serving the healthcare industry in the United States. Health Care Property Investors, Inc. is a Maryland real estate investment trust (REIT) organized in 1985. The Company is headquartered in Long Beach, California, with operations in Nashville, Tennessee and Orlando, Florida, and its portfolio includes interests in 731 properties. The Company acquires healthcare facilities and leases them to healthcare providers and provides mortgage financing secured by healthcare facilities. The Company s portfolio includes: (i) senior housing, including independent living facilities (ILFs), assisted living facilities (ALFs), and continuing care retirement communities (CCRCs); (ii) medical office buildings (MOBs); (iii) hospitals; (iv) skilled nursing facilities (SNFs); and (v) other healthcare facilities, including laboratory and office buildings. For business segment financial data, see our consolidated financial statements included elsewhere in this report.

References herein to HCP, the Company, we, us and our include Health Care Property Investors, Inc. and its consolidated subsidiaries and jo ventures, unless the context otherwise requires.

On our internet website, www.hcpi.com, you can access, free of charge, our annual report on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after such material is electronically filed with, or furnished to, the Securities and Exchange Commission (SEC). In addition, the SEC maintains an internet website that contains reports, proxy and information statements, and other information regarding issuers, including HCP, that file electronically with the SEC at www.sec.gov.

Healthcare Industry

Healthcare is the single largest industry in the United States, representing 16% of U.S. Gross Domestic Product (GDP) in 2004 and growing at a rate faster than the overall economy.

Healthcare Expenditures Rising as a Percentage of GDP

Source: Centers for Medicare and Medicaid, December 2006.

(1) Compound Annual Growth Rate (CAGR)

The delivery of healthcare services requires real estate and as a consequence, healthcare providers depend on real estate to maintain and grow their businesses. HCP believes that the current healthcare real estate market provides an investment opportunity due to the:

- Likelihood of consolidation of the fragmented healthcare real estate sector;
- Specialized nature of healthcare real estate investing; and
- Compelling demographics driving the demand for healthcare services.

Senior citizens are the largest consumers of healthcare services. According to the Centers for Medicare and Medicaid, on a per capita basis, the 75 years and older segment of the population spends 75% more on healthcare than the 65 to 74-year-old segment and nearly 300% more than the population average.

U.S. Population Over 65 Years Old

Source: U.S. Census Bureau, Statistical Abstract of the United States: 2004-2005.

Business Strategy

We are organized to invest in healthcare-related facilities. Our primary goal is to increase shareholder value through profitable growth. Our investment strategy to achieve this goal is based on three principles opportunistic investing, portfolio diversification, and conservative financing.

Opportunistic Investing

We make real estate investments that are expected to drive profitable growth and create long-term shareholder value. We attempt to position ourselves to create and take advantage of situations to meet our goals and investment criteria. We invest in properties directly and through joint ventures, and provide secured financing, depending on the nature of the investment opportunity.

Portfolio Diversification

We believe in maintaining a portfolio of healthcare-related real estate diversified by sector, geography, operator and investment product. Diversification within the healthcare industry reduces the likelihood that a single event would materially harm our business. This allows us to take advantage of opportunities in different markets based on individual market dynamics. While pursuing our strategy of

maintaining diversification in our portfolio, there are no specific limitations under our certificate of incorporation and bylaws on the percentage of our total assets that may be invested in any one property, property type, geographic location or in the number of properties which we may invest in, lease or lend to a single operator. With investments in multiple sectors of healthcare real estate, HCP can focus on opportunities with the best risk/reward profile for the portfolio as a whole, rather than having to choose from transactions within a specific property type.

Conservative Financing

We believe a conservative balance sheet provides us with the ability to execute our opportunistic investing approach and portfolio diversification principles. We maintain our conservative balance sheet by actively managing our debt to equity levels and maintaining available sources of liquidity, such as our revolving line of credit. Our debt is primarily fixed rate, which reduces the impact of rising interest rates on our operations. Generally, we attempt to match the long-term duration of our leases with long-term fixed-rate financing.

In underwriting our investments, we structure and adjust the price of the investment in accordance with our assessment of risk. We may structure transactions as master leases, require indemnifications, obtain enhancements in the form of letters of credit or security deposits, and take other measures to mitigate risk. We finance our investments based on our evaluation of available sources of funding. For short-term purposes, we may utilize our revolving line of credit or arrange for other short-term borrowings from banks or other sources. We arrange for longer-term financing through public offerings or from institutional investors. We may incur additional indebtedness or issue preferred or common stock. We may incur additional mortgage indebtedness on real estate we acquire. We may also obtain non-recourse or other mortgage financing on unleveraged properties in which we have invested or may refinance existing debt on properties acquired.

Competition

Our properties compete with the facilities of other landlords and healthcare providers. The landlords and operators of these competing properties may have capital resources substantially in excess of ours or of the operators of our facilities. The occupancy and rental income at our properties depend upon several factors, including the number of physicians using the healthcare facilities or referring patients to the facilities, competing properties and healthcare providers, and the size and composition of the population in the surrounding area. Private, federal and state payment programs and the effect of laws and regulations may also have a significant influence on the profitability of the properties and their tenants. Virtually all of our properties operate in a competitive environment in which tenants, patients and referral sources, including physicians, may change their preferences for a healthcare facility from time to time.

Investing in real estate is highly competitive. We face competition from other REITs, investment companies, healthcare operators and other institutional investors when we attempt to acquire properties. Increased competition reduces the number of opportunities that meet our investment criteria. If we do not identify investments that meet our investment criteria, our ability to increase shareholder value through profitable growth may be limited.

Transaction Overview

Mergers with CNL Retirement Properties, Inc. and CNL Retirement Corp.

On October 5, 2006, we closed our merger with CNL Retirement Properties, Inc. (CRP) for aggregate consideration of approximately $5.3 billion. In the CRP merger, we paid an aggregate of $2.9 billion of cash, issued 22.8 million shares of our common stock, and we either assumed or refinanced approximately $1.7 billion of CRP s outstanding debt. We initially financed the cash consideration paid to CRP stockholders and the expenses related to the transaction through an offering of senior notes, a draw down under new term and bridge loan facilities and a new three-year revolving credit facility. Our results of operations for 2006 include the results of the combined company beginning on October 5, 2006. For more information about the CRP merger, see Note 5 to our Consolidated Financial Statements.

Simultaneous with the closing of the merger with CRP, we also merged with CNL Retirement Corp. (CRC) for aggregate consideration of approximately $120 million, which included the issuance of 4.4 million shares of our common stock.

Investment Transactions

During 2006, including the CRP merger discussed above, we acquired interests in properties aggregating $5.9 billion with an average yield of 6.9%. Our 2006 investments were made in the following healthcare sectors: (i) 77% senior housing facilities; (ii) 19% MOBs; (iii) 3% hospitals; and (iv) 1% other healthcare facilities. Our 2006 real estate investments included the following:

- During the three months ended March 31, 2006, we acquired 13 medical office buildings for $138 million, including non-managing member LLC units (DownREIT units) valued at $6 million, in related transactions. The 13 buildings, with 730,000 rentable square feet, have an initial yield of 7.3%.

- On May 31, 2006, we acquired nine assisted living and independent living facilities for $99 million, including assumed debt valued at $61 million, through a sale-leaseback transaction. These facilities have an initial lease term of ten years, with two ten-year renewal options. The initial annual lease rate is approximately 8.0% with annual CPI-based escalators.

- On November 30, 2006, we acquired four assisted living and independent living facilities for $51 million, through a sale-leaseback transaction. These facilities have an initial lease term of ten years, with two ten-year renewal options. The initial annual lease rate is approximately 8.0% with annual escalators based on the Consumer Price Index (CPI).

During 2006, we sold 83 properties for $512 million and recognized gains of approximately $275 million. These sales included 69 SNFs sold on December 1, 2006, for $392 million with gains of approximately $226 million. On or before December 1, 2006, tenants for nine SNFs exercised rights of first refusal to acquire such facilities. The sales of the nine SNFs for $52 million are expected to be completed by June 30, 2007.

On November 17, 2006, we purchased $300 million senior secured notes issued by a HCA Inc. These notes accrue interest at 9.625%, mature on November 15, 2016, and are secured by second-priority liens on the HCA s and its subsidiary guarantors assets.

On January 31, 2007, we acquired three long-term acute care hospitals and received proceeds of $36 million in exchange for 11 skilled nursing facilities valued at approximately $77 million. The three acquired properties have an initial lease term of ten years, with two ten-year renewal options, and an initial

contractual yield of 12% with escalators based on the lessee s revenue growth. The acquired properties are included in a new master lease that contains 14 properties leased to the same operator.

On February 9, 2007, we acquired the Medical City Dallas campus, which includes two hospital towers, six medical office buildings, and three parking garages, for approximately $347 million, including non-managing member LLC units (DownREIT units) valued at $174 million. The initial yield on this campus is approximately 7.3%.

Joint Venture Transactions

On October 27, 2006, we formed an MOB joint venture with an institutional capital partner. The joint venture includes 13 properties valued at $140 million and encumbered by $92 million of mortgage debt. Upon formation, we received approximately $36 million in proceeds, including a one-time acquisition fee of $0.7 million. We retained an effective 26% interest in the venture, will act as the managing member, and will receive ongoing asset management fees.

On November 30, 2006, we acquired the interest held by an affiliate of General Electric Company in HCP Medical Office Portfolio, LLC (HCP MOP), for $141 million. We are now the sole owner of the venture and its 59 MOBs, which have approximately four million rentable square feet. At closing, $251 million of mortgage debt encumbered these MOBs.

On January 5, 2007, we formed a senior housing joint venture with an institutional capital partner. The joint venture includes 25 properties valued at $1.1 billion and encumbered by a $686 million secured debt facility. Upon formation, we received approximately $280 million in proceeds, including a one-time acquisition fee of $5.4 million. Including the $446 million recently received from the secured debt facility with Fannie Mae discussed below, we received $726 million in total proceeds. We retained a 35% interest in the venture, will act as the managing member, and will receive ongoing asset management fees.

Capital Market Transactions

During 2006, in addition to the mortgage debt issued under the Fannie Mae facility discussed below, we obtained $165 million of ten-year mortgage financing with a weighted average effective yield of 6.36% in five separate transactions. We received net proceeds of $162 million, which were used to repay outstanding indebtedness and for other general corporate purposes.

On February 27, 2006, we issued $150 million of 5.625% senior unsecured notes due in 2013. The notes were priced at 99.071% of the principal amount for an effective yield of 5.788%. We received net proceeds of $149 million, which were used to repay outstanding indebtedness and for other general corporate purposes.

On September 19, 2006, we issued $1 billion of senior unsecured notes, which consisted of $300 million of floating rate notes due in 2008, $300 million of 5.95% notes due in 2011, and $400 million of 6.30% notes due in 2016. We received net proceeds of $994 million, which together with cash on hand and borrowings under the new credit facilities were used to repay our then existing credit facility and to finance the CRP merger.

On October 5, 2006, in connection with the CRP merger, we entered into credit agreements with a syndicate of banks providing for aggregate borrowings of $3.4 billion. The credit facilities included a $0.7 billion bridge loan, a $1.7 billion two-year term loan, and a $1.0 billion three-year revolving credit facility. As of December 31, 2006, we had repaid the bridge loan and borrowings under the term loan were reduced to $0.5 billion. In addition, through our capital market transactions in January 2007, we fully repaid the balance outstanding under the term loan.

On November 10, 2006, we issued 33.5 million shares of common stock. We received net proceeds of approximately $960 million, which were used to repay our bridge loan facility and borrowings under our term loan and revolving credit facilities.

On December 4, 2006, we issued $400 million of 5.65% senior unsecured notes due in 2013. The notes were priced at 99.768% of the principal amount for an effective yield of 5.69%. We received net proceeds of $396 million, which were used to repay borrowings under our term loan facility.

On December 21, 2006, in anticipation of our senior housing joint venture that closed on January 5, 2007, we expanded an existing secured debt facility with Fannie Mae to $686 million, receiving $446 million in proceeds. The Fannie Mae facility bears interest at a weighted average rate of 5.66%. The funds from the expanded debt facility were used to repay borrowings under our term loan facility.

On January 19, 2007, we issued 6.8 million shares of common stock. We received net proceeds of approximately $261 million, which were used to repay borrowings under our term loan facility.

On January 22, 2007, we issued $500 million of 6.00% senior unsecured notes due in 2017. The notes were priced at 99.323% of the principal amount for an effective yield of 6.09%. We received net proceeds of $493 million, which were used to repay borrowings under our term loan and revolving credit facilities.

Other Events

During the year ended December 31, 2006, we issued approximately 797,000 shares of our common stock under our Dividend Reinvestment and Stock Purchase Plan at an average price per share of $28.68 for proceeds of $22.9 million.

Quarterly dividends paid during 2006 aggregated $1.70 per share. On January 29, 2007, we announced that our Board of Directors declared a quarterly common stock cash dividend of $0.445 per share. The common stock dividend will be paid on February 21, 2007, to stockholders of record as of the close of business on February 5, 2007. The annualized rate of distribution for 2007 is $1.78, compared with $1.70 for 2006, which represents a 4.7% increase. Our Board of Directors has determined to continue its policy of considering dividend increases on an annual rather than quarterly basis.

Properties

Portfolio Summary

Our portfolio of investments at December 31, 2006 includes direct investments in healthcare-related properties, mortgage loans, and investments through joint ventures. Our properties include hospitals, skilled nursing facilities, senior housing facilities, medical office buildings, and other healthcare facilities. As of and for the year ended December 31, 2006, our portfolio of investments, excluding assets held for sale and classified as discontinued operations, consists of the following (square feet and dollars in thousands):

Property Type	Number of Properties	Capacity(1)	Square Feet	Investment(2)	2006 Rental Revenues	Operating Expenses	NOI(4)
Owned properties:							
Hospital	33	3,356 Beds	3,650	$ 871,394	$ 94,481	$	$ 94,481
Skilled nursing	65	7,404 Beds	2,447	313,180	42,253	94	42,159
Senior housing	271	28,333 Units	24,251	3,968,837	181,500	12,491	169,009
Medical office building	246	N/A	14,952	2,366,692	176,840	66,528	110,312
Other	30	N/A	1,626	262,898	29,024	6,009	23,015
	645		46,926	$ 7,783,001	$ 524,098	$ 85,122	$ 438,976
Owned properties held for contribution(3):							
Senior housing	25	5,633 Units	5,566	1,100,600	20,043		20,043
Medical office building					12,880	4,064	8,816
Total owned properties	670		52,492	$ 8,883,601	$ 557,021	$ 89,186	$ 467,835
Direct financing leases:							
Senior housing	32	3,143 Units	1,969	$ 675,500			
Mortgage loans:							
Hospital	2	170 Beds	311	$ 75,083			
Skilled nursing	4	596 Beds	197	19,987			
Senior housing	5	180 Units	189	26,411			
Total mortgage loans	11		697	$ 121,481			
Unconsolidated joint ventures:							
Senior housing	4	412 Units	235	$ 139			
Medical office building	14	N/A	789	20,077			
Total unconsolidated joint ventures	18		1,024	$ 20,216			

See Note 21 to the Consolidated Financial Statements for additional information on our business segments.

(1) Senior housing facilities are stated in units (e.g., studio, one or two bedroom units). Medical office buildings and other healthcare facilities are measured in square feet. Hospitals and skilled nursing facilities are measured by licensed bed count.

(2) Investment for owned properties represents the carrying amount of real estate assets, including intangibles, after adding back accumulated depreciation and amortization, and excludes assets held for sale and classified as discontinued operations. Investment for direct financing leases represents the carrying amount of direct financing leases, after deducting interest accretion. Investment for mortgage loans receivable and unconsolidated joint ventures represents the carrying amount of our investment.

(3) On January 5, 2007, we formed a joint venture for 25 senior housing assets and retained a 35% interest in the venture. The carrying value of the 25 senior housing facilities is classified as real estate held for contribution on our consolidated balance sheet at December 31, 2006. On October 13, 2006, we formed a joint venture with 13 MOBs and retained an effective 26% interest in the venture. The disposition of a portion of our interest in the 25 senior housing assets and 13 MOBs met the definition under Statement of Financial Accounting Standards No. 144 (SFAS No. 144) for the assets to qualify as held for sale, however, the operations are not classified as discontinued operations resulting from our continuing interest in the ventures. The operating results of these properties prior to the formation of the ventures are included in the Company s continuing operations. The number of properties, capacity, square footage, and investment for the 13 MOBs are included under the caption of unconsolidated joint ventures.

(4) Net Operating Income from Continuing Operations (NOI) is a non-GAAP supplemental financial measure used to evaluate the operating performance of real estate properties. We define NOI as rental revenues, including tenant reimbursements, less property level operating expenses, which excludes depreciation and amortization, general and administrative expenses, impairments, interest expense and discontinued operations. We believe NOI provides investors relevant and useful information because it measures the operating performance of our real estate at the property level on an unleveraged basis. We use NOI to make decisions about resource allocations and assess property level performance. We believe that net income is the most directly comparable GAAP (U.S. generally accepted accounting principals) measure to NOI. NOI should not be viewed as an alternative measure of operating performance to net income as defined by GAAP since it does not reflect the aforementioned excluded items. Further, NOI may not be comparable to that of other real estate investment trusts, as they may use different methodologies for calculating NOI. The following reconciles NOI to Net Income for 2006 (in thousands):

	Amount
Net operating income from continuing operations	$ 467,835
Equity loss from unconsolidated joint ventures	8,331
Income from direct financing leases	15,008
Investment management fee income	3,895
Interest and other income	34,832
Interest expense	(213,304)
Depreciation and amortization	(144,215)
General and administrative expense	(47,370)
Impairments	(3,577)
Minority interests	(14,805)
Total discontinued operations	310,917
Net income	$ 417,547

Unconsolidated Joint Ventures

The following is summarized unaudited information for our unconsolidated joint ventures as of and for the year ended December 31, 2006 (square feet and dollars in thousands):

					2006	
Property Type	**Number of Properties**	**Capacity(1)**	**Square Feet**	**Joint Venture Investment(2)**	**Total Revenues**	**Total Operating Expenses**
Senior housing	4	412 Units	235	$ 20,178	$ 2,303	$ 1,428
Medical office building	14	N/A	789	150,875	5,205	1,674
Total	18		1,024	$ 171,053	$ 7,508	$ 3,102

(1) Senior housing facilities are stated in units (e.g., studio, one or two bedroom units) and medical office buildings are measured in square feet.

(2) Represents the carrying amount of real estate assets within the joint ventures, including intangibles, after adding back accumulated depreciation and amortization.

Healthcare Sectors and Property Types

We have investments in senior housing facilities, medical office buildings, hospitals, skilled nursing facilities, and other healthcare facilities. Certain tenants of our properties are reliant on government reimbursements, such as those from Medicare and Medicaid. See Governmental Regulation for the potential impact on the value of our investments and our results of operations. The following describes the nature of the operations of our tenants and borrowers.

Senior Housing Facilities. We have interests in 337 senior housing facilities, including four properties in unconsolidated joint ventures. Senior housing properties include ILFs, ALFs and CCRCs, which cater to different segments of the elderly population based upon their needs. Services provided by our tenants in these facilities are primarily paid for by the residents directly or through private insurance and are less reliant on government reimbursement programs such as Medicaid and Medicare.

- *Independent Living Facilities.* ILFsare designed to meet the needs of seniors who choose to live in an environment surrounded by their peers with services such as housekeeping, meals and activities. These residents generally do not need assistance with activities of daily living (ADLs), including bathing, eating and dressing. However, residents have the option to contract for these services.

- *Assisted Living Facilities.* ALFs are licensed care facilities that provide personal care services, support and housing for those who need help with ADLs yet require limited medical care. The programs and services may include transportation, social activities, exercise and fitness programs, beauty or barber shop access, hobby and craft activities, community excursions, meals in a dining room setting and other activities sought by residents. These facilities are often in apartment-like buildings with private residences ranging from single rooms to large apartments. Certain ALFs may offer higher levels of personal assistance for residents with Alzheimer s disease or other forms of dementia. Levels of personal assistance are based in part on local regulations.

- *Continuing Care Retirement Communities.* CCRCs provide housing and health-related services under long-term contracts. This alternative is appealing to residents as it eliminates the need for relocating when health and medical needs change, thus allowing residents to age in place. Some CCRCs require a substantial entry fee or buy-in fee, and most also charge monthly maintenance fees in exchange for a living unit, meals and some health services. CCRCs typically require the individual to be in relatively good health and independent upon entry.

Medical Office Buildings. We have interests in 260 MOBs, including 14 properties owned by unconsolidated joint ventures. These facilities typically contain physicians offices and examination rooms, and may also include pharmacies, hospital ancillary service space and outpatient services such as diagnostic centers, rehabilitation clinics and day-surgery operating rooms. While these facilities are similar to commercial office buildings, they require more plumbing, electrical and mechanical systems to accommodate multiple exam rooms that may require sinks in every room, brighter lights and special equipment such as medical gases.

Hospitals. We have interests in 35 hospitals, which include 13 acute care, 11 rehabilitation, four long-term acute care and seven specialty hospitals. Services provided by our tenants in these facilities are paid for by private sources, third-party payors (e.g., insurance and HMOs), or through the Medicare and Medicaid programs.

- *Acute Care Hospitals.* Acute care hospitals offer a wide range of services such as fully-equipped operating and recovery rooms, obstetrics, radiology, intensive care, open heart surgery and coronary care, neurosurgery, neonatal intensive care, magnetic resonance imaging, nursing units, oncology, clinical laboratories, respiratory therapy, physical therapy, nuclear medicine, rehabilitation services and outpatient services.

- *Long-Term Acute Care Hospitals.* Long-term acute care hospitals provide care for patients with complex medical conditions that require longer stays and more intensive care, monitoring, or emergency back-up than that available in most skilled nursing-based programs.

- *Specialty Hospitals*. Specialty hospitals are licensed as acute care hospitals but focus on providing care in specific areas such as cardiac, orthopedic and women s conditions or specific procedures such as surgery and are less likely to provide emergency services.

- *Rehabilitation Hospitals.* Rehabilitation hospitals provide inpatient and outpatient care for patients who have sustained traumatic injuries or illnesses, such as spinal cord injuries, strokes, head injuries, orthopedic problems, work-related disabilities and neurological diseases.

Skilled Nursing Facilities. We have interests in 69 SNFs. SNFsoffer restorative, rehabilitative and custodial nursing care for people not requiring the more extensive and sophisticated treatment available at hospitals. Ancillary revenues and revenue from sub-acute care services are derived from providing services to residents beyond room and board and include occupational, physical, speech, respiratory and intravenous therapy, wound care, oncology treatment, brain injury care and orthopedic therapy as well as sales of pharmaceutical products and other services. Certain skilled nursing facilities provide some of the foregoing services on an out-patient basis. Skilled nursing services provided by our tenants in these facilities are primarily paid for either by private sources, or through the Medicare and Medicaid programs.

Other Healthcare Facilities. We have investments in 30 healthcare laboratory and biotech research facilities. These facilities are designed to accommodate research and development in the bio-pharmaceutical industry, drug discovery and development, and predictive and personalized medicine. Our investments include physician group practice clinic facilities, health and wellness centers, and facilities used for other healthcare purposes. The physician group practice clinics generally provide a broad range of medical services through organized physician groups representing various medical specialties. Health and wellness centers provide testing and preventative health maintenance services.

Investment Products

Owned and Joint Venture Property Investments

The Company holds its investments as wholly owned or in the form of unconsolidated joint ventures with third-party investors. As of December 31, 2006, we had investments in 731 properties, including 18 properties through joint ventures. Whether owned wholly or through joint ventures, the owned properties may be characterized as one of three types: triple-net leased property, operating property or development property.

Triple-net Leased Properties:

Triple-net leased properties are primarily single-tenant buildings leased to a healthcare provider under a triple-net lease. Pursuant to triple-net leases, tenants pay base rent and all operating expenses incurred at the property, including utilities, property taxes, insurance, and repairs and maintenance. Certain leases contain annual base rent escalations based on a predetermined fixed rate, an inflation index or some other factor. Other leases may require tenants to pay additional rent based upon the operator s achievement of specific performance thresholds. The amount of additional rent may be based on a percentage of the facility s revenues in excess of revenues for a specific base period or on the funds available for lease payment after base rent and operating expenses. As of December 31, 2006, the weighted average remaining term, excluding unexercised renewal options, on our triple-net leased properties is approximately 11 years.

We typically require credit enhancements to cover short falls in the event the tenant does not generate enough cash flow to pay rent. The ability of certain senior housing lessees to satisfy their obligations under leases acquired from CRP depends primarily on the properties operating results. Some of these leases have credit enhancements that have either expired or will expire either by the passage of time or upon the full utilization of the credit enhancement. In addition, the terms of certain leases acquired in the CRP acquisition also provide for the tenant to maintain reserves to fund expenditures to refurbish buildings, premises and equipment to maintain the facilities in a manner that allows for the operation of the facilities for their intended purpose. To the extent the credit enhancements or reserves are inadequate, the tenant may not be able to make rent payments to us when due or we may be required to fund such amounts.

The first year annual base rental rates on properties we acquired during 2006 ranged from 6.8% to 9.0% of the purchase price of the property. Rental rates vary by lease, taking into consideration many factors, including:

- creditworthiness of the tenant;
- operating performance of the facility;
- credit support arrangements;
- cost of capital at the inception of the lease;
- location, type and physical condition of the facility;
- barriers to entry, such as certificates of need, competitive development and constraining high land costs; and
- lease term.

Operating Properties:

Our operating properties are typically multi-tenant medical office buildings that are leased to multiple healthcare providers (hospitals and physician practices) under a gross, modified gross or net lease structure. Under a gross or modified gross lease, all or a portion of operating expenses are not reimbursed by tenants. Most of our owned MOBs are managed by third-party property management companies and 21 are leased on a net basis while 239 are leased to multiple tenants under gross or modified gross leases pursuant to which we are responsible for certain operating expenses. Regardless of lease structure, most of our leases at operating properties include annual base rent escalation clauses that are either predetermined fixed increases or are a function of an inflation index, and typically have an initial term ranging from one to 15 years, with a weighted average remaining term of approximately five years as of December 31, 2006.

The following table reflects the annual reduction in revenue (based on 2007 contractual lease payments) for owned triple-net leased and operating properties resulting from lease expirations, absent the impact of renewals, if any (in thousands):

Year	Triple-net Leased	Operating Properties	Total(1)
2007	$ 5,587	$ 35,811	$ 41,398
2008	8,752	40,158	48,910
2009	45,670	33,601	79,271
2010	9,931	37,850	47,781
2011	17,573	25,781	43,354
Thereafter	410,559	104,204	514,763
Total	$ 498,072	$ 277,405	$ 775,477

(1) Excludes direct financing leases, assets classified as held for contribution, and assets held for sale and classified as discontinued operations.

Development Properties:

We generally commit to development projects only if they are at least 50% pre-leased. We use internal and external construction management expertise to evaluate local market conditions, construction costs and other factors to seek appropriate risk-adjusted returns. During 2006, we completed and placed into service approximately $36 million of development properties.

Investment Management Platform:

We co-invest in real estate with institutional investors through partnerships, limited liability companies, and joint ventures. We target investors with long-term investment horizons who seek to benefit from our expertise in healthcare real estate. Typically, we retain interests in the ventures ranging from 20% to 35% and serve as the managing member. Our co-investment ventures generally allow us to earn acquisition fees, asset management fees or priority distributions, and have the potential for promoted interests or incentive distributions based on performance of the venture. On October 27, 2006 and January 5, 2007, a total of $1.3 billion in medical office and senior housing assets were placed into joint ventures.

Investments in Secured Loans, Direct Financing Leases and Debt Securities

We have investments in 10 mortgage loans secured by 11 properties that are owned and operated by 9 healthcare providers. Our secured loan investments typically consist of senior mortgages or mezzanine financing on individual properties or a pool of properties. At December 31, 2006, the carrying amount of these mortgage loans totaled $121.5 million. The interest rates on mortgage loans outstanding at

December 31, 2006 ranged from 7.5% to 13.5% per annum. Our mortgage loans generally include prepayment penalties or yield maintenance provisions.

At December 31, 2006 we had investments in 32 properties that are accounted for under direct financing leases with original terms that range from five to 35 years. Certain leases contain provisions that allow the tenants to elect to purchase the properties during or at the end of the lease terms for the aggregate initial investment amount plus adjustments, if any, as defined in the lease agreements.

We also have investments in senior secured second lien notes of HCA Inc., which are classified as debt securities and are recorded at fair value. At December 31, 2006, the fair value of these senior secured notes was $322.5 million and they are classified as available for sale. These notes accrue interest at a rate of 9.625%, mature in 2016, and are secured by second-priority liens on HCA s and its subsidiary guarantors assets. The issuer of these notes may elect to pay interest in cash, by increasing the principal amount of the notes for the entire amount of the interest payments, or by paying half of the interest in cash and half in additional notes. The first payment due on May 15, 2007 is payable only in cash. After November 15, 2011, all interest on these notes will be payable in cash. If the issuer elects to pay with additional principal amounts or additional notes, the accrual rate is at 10.375%.

Operator Concentration

The following table provides information about the concentration of business with our top five operators for the year ended December 31, 2006 (dollars in thousands):

Operators	Facilities	Investment(1)	Percentage of Revenue(2)
Sunrise Senior Living (NYSE:SRZ) (Sunrise)	106	$ 2,245,673	5 %
Brookdale Senior Living Inc. (NYSE:BKD) (Brookdale)	23	668,637	8
Tenet Healthcare Corporation (NYSE:THC) (Tenet)	8	423,497	9
Summerville Healthcare Group (Summerville)	31	274,842	4
Emeritus Corporation (AMEX:ESC) (Emeritus)	36	245,676	5

(1) Represents the carrying amount of real estate assets, including intangibles, after adding back accumulated depreciation and amortization.

(2) 106 properties managed by Sunrise and six properties managed by Brookdale were acquired from CRP on October 5, 2006.

All of our properties associated with the aforementioned operators are primarily under triple-net leases. These operators, excluding Summerville, are subject to the informational filing requirements of the Securities Exchange Act of 1934, as amended, and are required to file periodic reports with the Securities and Exchange Commission. Financial and other information relating to these operators may be obtained from their public reports.

According to public disclosures by Tenet and Sunrise, these companies are experiencing various legal, financial, and regulatory difficulties. We cannot predict with certainty the impact, if any, of the outcome of these uncertainties on their financial condition. The failure or inability of these operators to pay their obligations could materially reduce our revenues, net income and cash flows, which could in turn reduce the amount of cash available for the payment of dividends, cause our stock price to decline and cause us to incur impairment charges or a loss on the sale of the properties.

One of our hospitals located in Tarzana, California is operated by Tenet and is affected by State of California Senate Bill 1953, which requires certain seismic safety building standards for acute care hospital facilities. See Government Regulation California Senate Bill 1953 for more information.

Joint Ventures

Consolidated Joint Ventures

At December 31, 2006, we held ownership interests in 23 consolidated limited liability companies and partnerships that together own 85 properties and one mortgage, and an interest in one unconsolidated joint venture including the following:

- A 77% interest in Health Care Property Partners, which owns two hospitals, seven skilled nursing facilities and has one mortgage on a skilled nursing facility.
- A 93% interest in HCPI/Sorrento, LLC, which owns a life science facility.
- A 90% interest in HCPI VPI Sorrento II, LLC, which owns four laboratory, office and biotechnology manufacturing buildings.
- A 95% interest in HCPI/Indiana, LLC, which owns six medical office buildings.
- A 36% interest in HCPI/Tennessee, LLC, which owns 14 medical office buildings and one assisted living facility.
- A 70% interest in HCPI/Utah, LLC, which owns 18 medical office buildings.
- A 66% interest in HCPI/Utah II, LLC, which owns eight medical office buildings and eight other healthcare facilities.
- A 75% interest in HCP DR California, LLC, which owns four independent and assisted living facilities.
- An 85% interest in HCP Birmingham Portfolio LLC, which owns a 30% interest in HCP Ventures III, LLC. HCP Ventures III, LLC owns 13 medical office buildings.

Unconsolidated Joint Ventures

At December 31, 2006, we held ownership interests in six unconsolidated limited liability companies and partnerships that together own 18 properties as follows:

- An effective 26% interest in HCP Ventures III, LLC which owns 13 medical office buildings.
- A 45% to 50% interest in each of four limited liability companies (Seminole Shores Living Center, LLC 50%, Edgewood Assisted Living Center, LLC 45%, Arborwood Living Center, LLC 45%, and Greenleaf Living Center, LLC 45%) which each own an assisted living facility.
- A 67% interest in Suburban Properties, LLC which owns one medical office building.

Taxation of HCP

We believe that we have operated in such a manner as to qualify for taxation as a REIT under Sections 856 to 860 of the Internal Revenue Code of 1986, as amended (the Code), commencing with our taxable year ended December 31, 1985, and we intend to continue to operate in such a manner. No assurance can be given that we have operated or will be able to continue to operate in a manner so as to qualify or to remain so qualified. This summary is qualified in its entirety by the applicable Code provisions, rules and regulations promulgated thereunder, and administrative and judicial interpretations thereof.

If we qualify for taxation as a REIT, we will generally not be required to pay federal corporate income taxes on the portion of our net income that is currently distributed to stockholders. This treatment substantially eliminates the double taxation (i.e., at the corporate and stockholder levels) that generally

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results from investment in a corporation. However, we will be required to pay federal income tax under certain circumstances.

The Code defines a REIT as a corporation, trust or association (i) which is managed by one or more trustees or directors; (ii) the beneficial ownership of which is evidenced by transferable shares, or by transferable certificates of beneficial interest; (iii) which would be taxable, but for Sections 856 through 860 of the Code, as a domestic corporation; (iv) which is neither a financial institution nor an insurance company subject to certain provisions of the Code; (v) the beneficial ownership of which is held by 100 or more persons; (vi) during the last half of each taxable year not more than 50% in value of the outstanding stock of which is owned, actually or constructively, by five or fewer individuals; and (vii) which meets certain other tests, described below, regarding the amount of its distributions and the nature of its income and assets. The Code provides that conditions (i) to (iv), inclusive, must be met during the entire taxable year and that condition (v) must be met during at least 335 days of a taxable year of 12 months, or during a proportionate part of a taxable year of less than 12 months.

There are presently two gross income requirements. First, at least 75% of our gross income (excluding gross income from prohibited transactions as defined below) for each taxable year must be derived directly or indirectly from investments relating to real property or mortgages on real property or from certain types of temporary investment income. Second, at least 95% of our gross income (excluding gross income from prohibited transactions) for each taxable year must be derived from income that qualifies under the 75% test and all other dividends, interest and gain from the sale or other disposition of stock or securities. A prohibited transaction is a sale or other disposition of property (other than foreclosure property) held for sale to customers in the ordinary course of business.

At the close of each quarter of our taxable year, we must also satisfy four tests relating to the nature of our assets. First, at least 75% of the value of our total assets must be represented by real estate assets, certain stock or debt instruments purchased with the proceeds of a stock offering or long term public debt offering by us (but only for the one-year period after such offering), cash, cash items and government securities. Second, not more than 25% of our total assets may be represented by securities other than those in the 75% asset class. Third, of the investments included in the 25% asset class, the value of any one issuer s securities owned by us may not exceed 5% of the value of our total assets and we may not own more than 10% of the vote or value of the securities of a non-REIT corporation, other than certain debt securities and interests in taxable REIT subsidiaries or qualified REIT subsidiaries, each as defined below. Fourth, not more than 20% of the value of our total assets may be represented by securities of one or more taxable REIT subsidiaries.

We own interests in various partnerships and limited liability companies. In the case of a REIT that is a partner in a partnership or a member of a limited liability company that is treated as a partnership under the Code, Treasury Regulations provide that for purposes of the REIT income and asset tests, the REIT will be deemed to own its proportionate share of the assets of the partnership or limited liability company (determined in accordance with its capital interest in the entity), subject to special rules related to the 10% asset test, and will be deemed to be entitled to the income of the partnership or limited liability company attributable to such share. The ownership of an interest in a partnership or limited liability company by a REIT may involve special tax risks, including the challenge by the Internal Revenue Service (the Service) of the allocations of income and expense items of the partnership or limited liability company, which would affect the computation of taxable income of the REIT, and the status of the partnership or limited liability company as a partnership (as opposed to an association taxable as a corporation) for federal income tax purposes.

We also own interests in a number of subsidiaries which are intended to be treated as qualified REIT subsidiaries (each a QRS). The Code provides that such subsidiaries will be ignored for federal income tax purposes and all assets, liabilities and items of income, deduction and credit of such subsidiaries will be

treated as our assets, liabilities and such items. If any partnership, limited liability company, or subsidiary in which we own an interest were treated as a regular corporation (and not as a partnership, QRS or taxable REIT subsidiary, as the case may be) for federal income tax purposes, we would likely fail to satisfy the REIT asset tests described above and would therefore fail to qualify as a REIT, unless certain relief provisions apply. We believe that each of the partnerships, limited liability companies, and subsidiaries (other than taxable REIT subsidiaries) in which we own an interest will be treated for tax purposes as a partnership, or disregarded entity (in the case of a 100% owned partnership or limited liability company) or QRS, as applicable, although no assurance can be given that the Service will not successfully challenge the status of any such organization.

As of December 31, 2006, we owned interests in two subsidiaries which are intended to be treated as taxable REIT subsidiaries (each a TRS). A REIT may own any percentage of the voting stock and value of the securities of a corporation which jointly elects with the REIT to be a TRS, provided certain requirements are met. A TRS generally may engage in any business, including the provision of customary or noncustomary services to tenants of its parent REIT and of others, except a TRS may not manage or operate a hotel or healthcare facility. A TRS is treated as a regular corporation and is subject to federal income tax and applicable state income and franchise taxes at regular corporate rates. In addition, a 100% tax may be imposed on a REIT if its rental, service or other agreements with its TRS, or the TRS s agreements with the REIT s tenants, are not on arm s-length terms.

In order to qualify as a REIT, we are required to distribute dividends (other than capital gain dividends) to our stockholders in an amount at least equal to (A) the sum of (i) 90% of our real estate investment trust taxable income (computed without regard to the dividends paid deduction and our net capital gain) and (ii) 90% of the net income, if any (after tax), from foreclosure property, minus (B) the sum of certain items of non-cash income. Such distributions must be paid in the taxable year to which they relate, or in the following taxable year if declared before we timely file our tax return for such year, if paid on or before the first regular dividend payment date after such declaration and if we so elect and specify the dollar amount in our tax return. To the extent that we do not distribute all of our net long-term capital gain or distribute at least 90%, but less than 100%, of our real estate investment trust taxable income , as adjusted, we will be required to pay tax thereon at regular corporate tax rates. Furthermore, if we should fail to distribute during each calendar year at least the sum of (i) 85% of our ordinary income for such year, (ii) 95% of our capital gain income for such year, and (iii) any undistributed taxable income from prior periods, we would be required to pay a 4% excise tax on the excess of such required distributions over the amounts actually distributed.

If we fail to qualify for taxation as a REIT in any taxable year, and certain relief provisions do not apply, we will be required to pay tax (including any applicable alternative minimum tax) on our taxable income at regular corporate rates. Distributions to stockholders in any year in which we fail to qualify will not be deductible by us nor will they be required to be made. Unless entitled to relief under specific statutory provisions, we will also be disqualified from taxation as a REIT for the four taxable years following the year during which qualification was lost. It is not possible to state whether in all circumstances we would be entitled to the statutory relief. Failure to qualify for even one year could substantially reduce distributions to stockholders and could result in our incurring substantial indebtedness (to the extent borrowings are feasible) or liquidating substantial investments in order to pay the resulting taxes.

We and our stockholders may be required to pay state or local tax in various state or local jurisdictions, including those in which we or they transact business or reside. The state and local tax treatment of us and our stockholders may not conform to the federal income tax consequences discussed above.

We may also be subject to certain taxes applicable to REITs, including taxes in lieu of disqualification as a REIT, on undistributed income, on income from prohibited transactions, on net income from foreclosure property and on built-in gains from the sale of certain assets acquired from C corporations in tax-free transactions.

Government Regulation

The healthcare industry is heavily regulated by federal, state and local laws. This government regulation of the healthcare industry affects us because:

(1) Governmental regulations such as licensure, certification for participation in government programs, and government reimbursement may impact the financial ability of some of our operators to make rent and debt payments to us, which in turn may affect the value of our investments, and

(2) The amount of reimbursement such operators receive from the government and other third parties may affect the amounts we receive in additional rents, which are often based on our operators gross revenue from operations.

These laws and regulations are subject to frequent and substantial changes resulting from legislation, adoption of rules and regulations, and administrative and judicial interpretations of existing law. These changes may have a dramatic effect on the definition of permissible or impermissible activities, the relative costs associated with doing business and the amount of reimbursement by government and other third-party payors. These changes may be applied retroactively. The ultimate timing or effect of these changes cannot be predicted. The failure of any tenant or borrower to comply with such laws, regulations and requirements could affect its ability to operate its facility or facilities and could adversely affect such operator s ability to make lease or debt payments to us, which in turn may affect the value of our investments.

Fraud and Abuse Laws. There are various federal and state laws prohibiting fraud and abusive business practices by healthcare providers who participate in, receive payments from or are in a position to make referrals in connection with a government-sponsored healthcare program, including, but not limited to, the Medicare and Medicaid programs. These include:

- The Federal Anti-Kickback Statute, which prohibits, among other things, the offer, payment, solicitation or receipt of any form of remuneration in return for, or to induce, the referral of Medicare and Medicaid patients.

- The Federal Physician Self-Referral Prohibition (Stark), which restricts physicians from making referrals for certain designated health services for which payment may be made under Medicare or Medicaid programs to an entity with which the physician (or an immediate family member) has a financial relationship.

- The False Claims Act, which prohibits any person from knowingly presenting false or fraudulent claims for payment to the federal government (including the Medicare and Medicaid programs).

- The Civil Monetary Penalties Law, which is imposed by the Department of Health and Human Services for fraudulent acts.

Each of these laws include criminal and/or civil penalties for violations that range from punitive sanctions, damage assessments, penalties, imprisonment, denial of Medicare and Medicaid payments, and/or exclusion from the Medicare and Medicaid programs. Imposition of any of these types of penalties on our tenants or borrowers could result in a material adverse effect on their operations, which could adversely affect our business. Additionally, certain laws, such as the False Claims Act, allow for individuals to bring *qui tam* (whistleblower) actions on behalf of the government for violations of fraud and abuse

laws. Some Medicare Administrative Contractors (private companies that contract with Centers for Medicare & Medicaid Services (CMS) to administer the Medicare program) have also increased scrutiny of cost reports filed by skilled nursing providers.

Environmental Matters. A wide variety of federal, state and local environmental and occupational health and safety laws and regulations affect healthcare facility operations. Under various federal, state and local environmental laws, ordinances and regulations, an owner of real property or a secured lender (such as us) may be liable for the costs of removal or remediation of hazardous or toxic substances at, under or disposed of in connection with such property, as well as other potential costs relating to hazardous or toxic substances (including government fines and damages for injuries to persons and adjacent property). The cost of any required remediation, removal, fines or personal or property damages and the owner s or secured lender s liability therefore could exceed the value of the property, and/or the assets of the owner or secured lender. In addition, the presence of such substances, or the failure to properly dispose of or remediate such substances, may adversely affect the owner s ability to sell or rent such property or to borrow using such property as collateral which, in turn, would reduce our revenue. Although the mortgage loans that we provide and the leases covering our properties require the borrower and the tenant to indemnify us for certain environmental liabilities, the scope of such obligations may be limited and we cannot assure that any such borrower or tenant would be able to fulfill its indemnification obligations.

The Medicare and Medicaid Programs. Sources of revenue for operators may include the federal Medicare program, state Medicaid programs, private insurance carriers, healthcare service plans and health maintenance organizations, among others. Efforts to reduce costs by these payors will likely continue, which may result in reduced or slower growth in reimbursement for certain services provided by some of our operators. In addition, the failure of any of our operators to comply with various laws and regulations could jeopardize their certification and ability to continue to participate in the Medicare and Medicaid programs. Medicaid programs differ from state to state but they are all subject to federally-imposed requirements. At least 50% of the funds available under these programs are provided by the federal government under a matching program. Medicaid programs generally pay for acute and rehabilitative care based on reasonable costs at fixed rates; skilled nursing facilities are generally reimbursed using fixed daily rates. Medicaid payments are generally below retail rates for tenant-operated facilities, and the Deficit Reduction Act of 2005 may further reduce Medicaid reimbursement, as the Act included cuts of approximately $4.8 billion over five years to the Medicaid program. Increasingly, states have introduced managed care contracting techniques into the administration of Medicaid programs. Such mechanisms could have the impact of reducing utilization of and reimbursement to facilities. Other third-party payors in various states base payments on costs, retail rates or, increasingly, negotiated rates. Negotiated rates can include discounts from normal charges, fixed daily rates and prepaid capitated rates.

Healthcare Facilities. The healthcare facilities in our portfolio, including hospitals, skilled nursing facilities, assisted living facilities, and physician group practice clinics, are subject to extensive federal, state and local licensure, certification and inspection laws and regulations. Failure to comply with any of these laws could result in loss of accreditation, denial of reimbursement, imposition of fines, suspension or decertification from federal and state healthcare programs, loss of license or closure of the facility. Such actions may have an effect on the revenue of the operators of properties owned by or mortgaged to us and therefore adversely impact us.

Entrance Fee Communities. Certain of the senior housing facilities mortgaged to or owned by us are operated as entrance fee communities. Generally, an entrance fee is an upfront fee or consideration paid by a resident, a portion of which may be refundable, in exchange for some form of long-term benefit. Some of the entrance fee communities are subject to significant state regulatory oversight, including, for example, oversight of each facility s financial condition, establishment and monitoring of reserve requirements and other financial restrictions, the right of residents to cancel their contracts within a

specified period of time, lien rights in favor of the residents, restrictions on change of ownership and similar matters. Such oversight and the rights of residents within these entrance fee communities may have an effect on the revenue or operations of the operators of such facilities and therefore may adversely impact us.

California Senate Bill 1953. Our hospital located in Tarzana, California is affected by State of California Senate Bill 1953 (SB 1953), which requires certain seismic safety building standards for acute care hospital facilities. This hospital is operated by Tenet under a lease expiring in February 2009. We and Tenet are currently reviewing the SB 1953 compliance of this hospital, multiple plans of action to cause such compliance, the estimated time for completing the same, and the cost of performing necessary remediation of the property. We cannot currently estimate the remediation costs that will need to be incurred prior to 2013 in order to make the facility SB 1953-compliant through 2030, or the final allocation of any remediation costs between us and Tenet. Rent on the hospital in 2006 and 2005 was $10.8 million in each year and the carrying amount of the facility is $73.9 million at December 31, 2006.

Current Developments

The healthcare industry continues to face various challenges, including increased government and private payor pressure on healthcare providers to control costs, the migration of patients from acute care facilities into extended care and home care settings, and the vertical and horizontal consolidation of healthcare providers.

Changes in the law, new interpretations of existing laws, and changes in payment methodologies may have a dramatic effect on the definition of permissible or impermissible activities, the relative costs associated with doing business and the amount of reimbursement furnished by government and other third-party payors. These changes may be applied retroactively under certain circumstances. The ultimate timing or effect of legislative efforts cannot be predicted and may impact us in different ways.

In December of 2003, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the Act) was signed into law. The Act established an 18-month moratorium on the whole hospital exception to the Stark law, whereby physicians have been permitted to refer patients for Designated Health Services to hospitals in which they have an ownership interest. On August 8, 2006, CMS released its final report and plan to address issues relating to physician investment in specialty hospitals. Specialty hospitals include hospitals primarily or exclusively engaged in the care and treatment of cardiac conditions or orthopedic conditions, or hospitals that perform certain surgical procedures. CMS strategic plan includes strict enforcement of federal fraud and abuse laws for improper investments, disclosure of information regarding physician investment and compensation arrangements, acceptance of emergency transfer cases even if the specialty hospital lacks an emergency department, and changes to the hospital inpatient prospective and ambulatory surgical center payment systems. CMS declined to extend the moratorium on approving new specialty hospitals, despite a request for an extension by two senators. In light of continued interest in specialty hospital regulation, there is a risk that legislation could be adopted that affects the operation of specialty hospitals. The specialty hospital issue is controversial and after significant discussion and legislation, the current federal government permitted operation of specialty hospitals; however, there can be no assurance that a new Congress or Administration would continue similar treatment of specialty hospitals. Our hospital tenants may face additional competition from an increased number of specialty hospitals, including specialty hospitals owned by physicians currently on staff at tenant hospitals.

In addition to the reforms enacted and considered by Congress from time to time, state legislatures periodically consider various healthcare reform proposals. Congress and state legislatures can be expected to continue to review and assess alternative healthcare delivery systems, new regulatory enforcement initiatives, and new payment methodologies.

We believe that government and private efforts to contain or reduce healthcare costs will continue. These trends are likely to lead to reduced or slower growth in reimbursement for certain services provided by some of our operators. In addition, recent trends of hospitals providing more services to uninsured patients or on an outpatient basis rather than inpatient basis may continue and could adversely affect the profitability of our operators. We believe that the vast nature of the healthcare industry, the financial strength and operating flexibility of our operators, and the diversity of our portfolio will mitigate the impact of any such trends. However, we cannot predict what legislation will be adopted, and no assurance can be given that the healthcare reforms will not have a material adverse effect on our financial condition or results of operations.

Employees

At December 31, 2006, we had 165 full-time employees and no part-time employees, none of whom are subject to a collective bargaining agreement. We consider our relations with our employees to be good.

ITEM 1A. Risk Factors

You should carefully consider the risks described below as well as the risks described in Competition, Government Regulation, and Taxation of HCP and elsewhere in this report, which risks are incorporated by reference into this section, before making an investment decision regarding our company. 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. All of these risks could adversely affect our business, financial condition, results of operations and cash flows.

Risks Related to Our Operators

If our facility operators are unable to operate our properties in a manner sufficient to generate income, they may be unable to make rent and loan payments to us.

The healthcare industry is highly competitive and we expect that it may become more competitive in the future. Our operators are subject to competition from other healthcare providers that provide similar services. Such competition, which has intensified due to overbuilding in some segments in which we operate, has caused the fill-up rate of newly constructed buildings to slow and the monthly rate that many newly built and previously existing facilities were able to obtain for their services to decrease. The profitability of healthcare facilities depends upon several factors, including the number of physicians using the healthcare facilities or referring patients there, competitive systems of healthcare delivery and the size and composition of the population in the surrounding area. Private, federal and state payment programs and the effect of other laws and regulations may also have a significant influence on the revenues and income of the properties. If our operators are not competitive with other healthcare providers and are unable to generate income, they may be unable to make rent and loan payments to us, which could adversely affect our cash flow and financial performance and condition.

The bankruptcy, insolvency or financial deterioration of our facility operators could significantly delay our ability to collect unpaid rents or require us to find new operators.

Our financial position and our ability to make distributions to our stockholders may be adversely affected by financial difficulties experienced by any of our major operators, including bankruptcy, insolvency or a general downturn in the business, or in the event any of our major operators do not renew or extend their relationship with us as their lease terms expire.

We are exposed to the risk that our operators may not be able to meet their obligations, which may result in their bankruptcy or insolvency. Although our leases and loans provide us the right to terminate an investment, evict an operator, demand immediate repayment and other remedies, the bankruptcy laws

afford certain rights to a party that has filed for bankruptcy or reorganization. An operator in bankruptcy may be able to restrict our ability to collect unpaid rents or interest during the bankruptcy proceeding.

Tenet Healthcare Corporation and Sunrise Senior Living account for a significant percentage of our revenues and are currently experiencing significant legal, financial and regulatory difficulties.

During 2006, Tenet Healthcare Corporation and Sunrise Senior Living accounted for approximately 9% and 5%, respectively, of our revenues. The properties managed by Sunrise were acquired from CRP on October 5, 2006. According to public disclosures, Tenet and Sunrise are experiencing significant legal, financial and regulatory difficulties. We cannot predict with certainty the impact, if any, of the outcome of these uncertainties on our consolidated financial statements. The failure or inability of Tenet or Sunrise to pay its obligations could materially reduce our revenue, net income and cash flows, which could adversely affect the value of our common stock and could cause us to incur impairment charges or a loss on the sale of the properties.

Our operators are faced with increased litigation and rising insurance costs that may affect their ability to make their lease or mortgage payments.

In some states, advocacy groups have been created to monitor the quality of care at healthcare facilities, and these groups have brought litigation against operators. Also, in several instances, private litigation by patients has succeeded in winning very large damage awards for alleged abuses. The effect of this litigation and potential litigation has been to materially increase the costs incurred by our operators for monitoring and reporting quality of care compliance. In addition, the cost of liability and medical malpractice insurance has increased and may continue to increase so long as the present litigation environment affecting the operations of healthcare facilities continues. Continued cost increases could cause our operators to be unable to make their lease or mortgage payments, potentially decreasing our revenue and increasing our collection and litigation costs. Moreover, to the extent we are required to take back the affected facilities, our revenue from those facilities could be reduced or eliminated for an extended period of time.

Decline in the skilled nursing sector and changes to Medicare and Medicaid reimbursement rates may have significant adverse consequences to us.

During 2006, our skilled nursing properties accounted for approximately 7% of our revenues. Certain of our skilled nursing operators and facilities continue to experience operating problems in part due to a national nursing shortage, increased liability insurance costs, and low levels of Medicare and Medicaid reimbursement. Due to economic challenges facing many states, nursing homes will likely continue to be under-funded. These challenges have had, and may continue to have, an adverse effect on our long-term care facilities and facility operators.

We may rely on credit enhancements to our leases for minimum rent payments.

Our leases may have credit enhancement provisions, such as guarantees or shortfall reserves provided by tenants or operators. These credit enhancement provisions may terminate at either a specific time during the lease term or once net operating income of the property exceeds a specified amount. These provisions may also have limits on the overall amount of the credit enhancement. After the termination of a credit enhancement, or in the event that the maximum limit of a credit enhancement is reached, we may only look to the tenant to make lease payments. In the event that a credit enhancement has expired or the maximum limit has been reached, or in the event that a provider of a credit enhancement is unable to meet its obligations, our results of operations and our cash available for distribution could be adversely affected if our properties are unable to generate sufficient funds from operations to meet minimum rent payments and the tenants do not otherwise have the resources to make the rent payments. Our tenants may be thinly

capitalized entities that rely on the cash flow generated from the properties to fund rent obligations under their lease.

Risks Related to Real Estate Investment and Our Structure

We rely on external sources of capital to fund future capital needs, and if our access to such capital is difficult or on commercially unreasonable terms, we may not be able to meet maturing commitments or make future investments necessary to grow our business.

In order to qualify as a REIT under the Internal Revenue Code, we are required, among other things, to distribute to our stockholders each year at least 90% of our REIT taxable income. Because of this distribution requirement, we may not be able to fund all future capital needs, including capital needs in connection with acquisitions, from cash retained from operations. As a result, we rely on external sources of capital. If we are unable to obtain needed capital at all or only on unfavorable terms from these sources, we might not be able to make the investments needed to grow our business, or to meet our obligations and commitments as they mature, which could negatively affect the ratings of our debt and even, in extreme circumstances, affect our ability to continue operations. Our access to capital depends upon a number of factors over which we have little or no control, including:

- general market conditions;
- the market s perception of our growth potential;
- our current and potential future earnings and cash distributions; and
- the market price of the shares of our capital stock.

If we are unable to identify and purchase suitable healthcare facilities at a favorable cost, we will be unable to continue to grow through acquisitions.

Our ability to grow through acquisitions is integral to our business strategy and requires us to identify suitable acquisition candidates that meet our criteria and are compatible with our growth strategy. The acquisition and financing of healthcare facilities at favorable costs is highly competitive. We may not be successful in identifying suitable property or other assets that meet our acquisition criteria or in consummating acquisitions on satisfactory terms or at all. If we cannot identify and purchase a sufficient quantity of healthcare facilities at favorable prices, or if we are unable to finance such acquisitions on commercially favorable terms, our business will suffer.

Unforeseen costs associated with the acquisition of new properties could reduce our profitability.

Our business strategy contemplates future acquisitions. The acquisitions we make may not prove to be successful. We might encounter unanticipated difficulties and expenditures relating to any acquired properties, including contingent liabilities. Further, newly acquired properties might require significant management attention that would otherwise be devoted to our ongoing business. We might never realize the anticipated benefits of an acquisition, which could adversely affect our profitability.

Since real estate investments are illiquid, we may not be able to sell properties when we desire.

Real estate investments generally cannot be sold quickly. We may not be able to vary our portfolio promptly in response to changes in the real estate market. This inability to respond to changes in the performance of our investments could adversely affect our ability to service our debt. The real estate market is affected by many factors that are beyond our control, including:

- adverse changes in national and local economic and market conditions;
- changes in interest rates and in the availability, costs and terms of financing;

- changes in governmental laws and regulations, fiscal policies and zoning and other ordinances and costs of compliance with laws and regulations;

- the ongoing need for capital improvements, particularly in older structures;

- changes in operating expenses; and

- civil unrest, acts of war and natural disasters, including earthquakes and floods, which may result in uninsured and underinsured losses.

We cannot predict whether we will be able to sell any property for the price or on the terms set by us, or whether any price or other terms offered by a prospective purchaser would be acceptable to us. We also cannot predict the length of time needed to find a willing purchaser and to close the sale of a property. In addition, there are provisions under the federal income tax laws applicable to REITs that may limit our ability to recognize the full economic benefit from a sale of our assets. These factors and any others that would impede our ability to respond to adverse changes in the performance of our properties could have a material adverse effect on our operating results and financial condition.

Transfers of healthcare facilities generally require regulatory approvals, and alternative uses of healthcare facilities are limited.

Because transfers of healthcare facilities may be subject to regulatory approvals not required for transfers of other types of commercial operations and other types of real estate, there may be delays in transferring operations of our facilities to successor operators or we may be prohibited from transferring operations to a successor operator. In addition, substantially all of our properties are healthcare facilities that may not be easily adapted to non-healthcare-related uses. If we are unable to transfer properties at times opportune to us, our revenue and operations may suffer.

We may experience uninsured or underinsured losses.

We generally require our operators to secure and maintain comprehensive liability and property insurance that covers us, as well as the operators, on most of our properties. Some types of losses, however, either may be uninsurable or too expensive to insure against. Should an uninsured loss or a loss in excess of insured limits occur, we could lose all or a portion of the capital we have invested in a property, as well as the anticipated future revenue from the property. In such an event, we might nevertheless remain obligated for any mortgage debt or other financial obligations related to the property. We cannot assure you that material losses in excess of insurance proceeds will not occur in the future.

Increases in interest rates may increase our interest expense and adversely affect our cash flow and our ability to service our indebtedness.

At December 31, 2006, our total consolidated indebtedness was approximately $6.2 billion, of which approximately $1.7 billion, or 27%, is subject to variable interest rates. This variable rate debt had a weighted average interest rate of approximately 6.1% per annum. Increases in interest rates on this variable rate debt would increase our interest expense, which could harm our cash flow and our ability to service our indebtedness.

Our acquisition of additional properties may have an adverse effect on our business, liquidity, financial position, credit ratings and/or results of operations

As part of our business strategy, we actively acquire healthcare facilities. Our recent acquisition of CRP and CRC is an example of the execution of this strategy. We may acquire healthcare facilities through various structures, including transactions involving portfolios, single assets, joint ventures and acquisitions of all or substantially all of the securities or assets of other REITs or similar real estate entities. We

anticipate that our acquisitions will be financed through a combination of methods, including proceeds from equity and/or debt offerings, advances under our credit facilities and other incurrence or assumption of indebtedness. Any significant acquisition or series of acquisitions financed by incurrence of indebtedness may cause us to become highly leveraged and/or have a negative impact on the credit ratings of our senior debt and preferred stock. Additionally, newly acquired properties may fail to perform as expected. Inaccurate assumptions regarding future rental or occupancy rates could result in overly optimistic estimates of future revenues. Similarly, we may underestimate future operating expenses or the costs necessary to bring an acquired property up to standards established for its intended market position.

If we are unable to successfully integrate the operations of CRP and other target companies, our business and earnings may be negatively affected.

Mergers involve the integration of companies that have previously operated independently. Successful integration of the operations of these companies depend primarily on our ability to consolidate operations, systems, procedures, properties and personnel and to eliminate redundancies and costs. Mergers also pose other risks commonly associated with similar transactions, including unanticipated liabilities, unexpected costs and the diversion of management s attention to the integration of our operations with those of the target companies. We cannot assure you that we will be able to integrate CRP or other target companies operations without encountering difficulties, including, but not limited to, the loss of key employees, the disruption of its respective ongoing businesses or possible inconsistencies in standards, controls, procedures and policies. Estimated cost savings are projected to come from various areas that our management has identified through the due diligence and integration planning process. If we have difficulties with any of these areas, we might not achieve the economic benefits we expect to result from the merger, and this may hurt our business and earnings. In addition, we may experience greater than expected costs or difficulties relating to the integration of the business of CRP or other target companies and/or may not realize expected cost savings from mergers within the expected time frame, if at all.

Our business could be adversely impacted if we have deficiencies in our disclosure controls and procedures or internal control over financial reporting.

The design and effectiveness of our disclosure controls and procedures and internal control over financial reporting may not prevent all errors, misstatements or misrepresentations. While management will continue to review the effectiveness of our disclosure controls and procedures and internal control over financial reporting, there can be no guarantee that our internal control over financial reporting will be effective in accomplishing all control objectives all of the time. In certain circumstances, the effectiveness of internal controls is dependent on information received from independent third parties. For example, we consolidate our investments in certain variable interest entities (VIEs) when it is determined that we are the primary beneficiary of the VIE. If management of the consolidated VIEs fails to provide us necessary financial information either in a timely manner or at all, it could adversely impact our financial reporting and our internal controls over financial reporting. Deficiencies, including any material weakness, in our internal controls over financial reporting, which may occur in the future, could result in misstatements of our results of operations, restatements of our financial statements, a decline in our stock price, or otherwise materially adversely affect our business, reputation, results of operations, financial condition or liquidity.

We lease 76 properties to a total of 9 tenants that have been identified as VIEs. We acquired these leases (variable interests) on October 5, 2006 in our acquisition of CRP. CRP determined they were not the primary beneficiary of the VIEs, and we are generally required to carry forward CRP s accounting conclusions after the acquisition relative to their primary beneficiary assessment. We may need to reassess whether we are the primary beneficiary in the future upon the occurrence of a reconsideration event, as defined by FIN 46R. If we determine that we are the primary beneficiary in the future and consolidate the

tenant, our financial statements would reflect the tenant s facility level revenues and expenses rather than lease revenue.

Federal Income Tax Risks

Loss of our tax status as a REIT would have significant adverse consequences to us.

We currently operate and have operated commencing with our taxable year ended December 31, 1985 in a manner that is intended to allow us to qualify as a REIT for federal income tax purposes under the Internal Revenue Code of 1986, as amended.

Qualification as a REIT involves the application of highly technical and complex Internal Revenue Code provisions for which there are only limited judicial and administrative interpretations. The determination of various factual matters and circumstances not entirely within our control may affect our ability to qualify as a REIT. For example, in order to qualify as a REIT, at least 95% of our gross income in any year must be derived from qualifying sources, and we must satisfy a number of requirements regarding the composition of our assets. Also, we must make distributions to stockholders aggregating annually at least 90% of our REIT taxable income, excluding capital gains. In addition, new legislation, regulations, administrative interpretations or court decisions may adversely affect our investors or our ability to qualify as a REIT for tax purposes. Although we believe that we have been organized and have operated in such manner, we can give no assurance that we have qualified or will continue to qualify as a REIT for tax purposes.

If we lose our REIT status, we will face serious tax consequences that will substantially reduce the funds available to make payments of principal and interest on the debt securities we issue and to make distributions to our stockholders. If we fail to qualify as a REIT:

- we would not be allowed a deduction for distributions to stockholders in computing our taxable income and would be subject to federal income tax at regular corporate rates;

- 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 could not elect to be subject to tax as a REIT for four taxable years following the year during which we were disqualified.

In addition, if we fail to qualify as a REIT, all distributions to stockholders would be subject to tax as regular corporate dividends to the extent of our current and accumulated earnings and profits and we would not be required to make distributions to stockholders.

As a result of all these factors, our failure to qualify as a REIT also could impair our ability to expand our business and raise capital, and could adversely affect the value of our common stock.

Certain property transfers may generate prohibited transaction income, resulting in a penalty tax on gain attributable to the transaction.

From time to time, we may transfer or otherwise dispose of some of our properties. Under the Internal Revenue Code, any gain resulting from transfers of properties that we hold as inventory or primarily for sale to customers in the ordinary course of business would be treated as income from a prohibited transaction subject to a 100% penalty tax. Since we acquire properties for investment purposes, we do not believe that our occasional transfers or disposals of property are properly treated as prohibited transactions. However, whether property is held for investment purposes is a question of fact that depends on all the facts and circumstances surrounding the particular transaction. The Internal Revenue Service may contend that certain transfers or disposals of properties by us are prohibited transactions. While we believe that the Internal Revenue Service would not prevail in any such dispute, if the Internal Revenue Service were to argue successfully that a transfer or disposition of property constituted a prohibited transaction, then we would be required to pay a 100% penalty tax on any gain allocable to us from the

prohibited transaction. In addition, income from a prohibited transaction might adversely affect our ability to satisfy the income tests for qualification as a real estate investment trust for federal income tax purposes.

As a result of the CRP merger and the CRC merger, we may have inherited tax liabilities and attributes from CRP and CRC.

Prior to the CRP merger, CRP was organized as a REIT for federal income tax purposes. If CRP failed to qualify as a REIT for any of its taxable years, it would be required to pay federal income tax (including any applicable alternative minimum tax) on its taxable income at regular corporate rates. Unless statutory relief provisions apply, CRP would have been disqualified from treatment as a REIT for the four taxable years following the year during which it lost qualification. Because the CRP merger was treated for income tax purposes as if CRP sold all of its assets in a taxable transaction to us, if CRP did not qualify as a REIT for the taxable year of the merger, it would be subject to tax in respect of the built-in gain in all of its assets. Built-in gain generally means the excess of the fair market value of an asset over its adjusted tax basis. As successor-in-interest to CRP, we would be required to pay these taxes. After the merger, the nature of the assets that we acquired from CRP and the income we derive from those assets may have an effect on our tax status as a REIT.

In connection with the CRP merger, CRP s REIT counsel rendered an opinion to us, dated as of the closing date of the merger, to the effect that CRP qualified as a REIT under the Code for the taxable years ending December 31, 1999 generally through December 31, 2005, CRP was organized in conformity with the requirements for qualification as a REIT, and CRP s method of operation had enabled CRP to satisfy the requirements for qualification as a REIT under the Code for the taxable years ending on or prior to the closing date of the merger. This opinion was based on various assumptions and representations as to factual matters, including representations made by CRP in a factual certificate provided by one of its officers, as well as other oral and written statements of officers and other representatives of CRP and others as to the existence and consequence of certain factual and other matters.

As a result of the CRC merger, we succeeded to the assets and the liabilities of CRC, including any liabilities for unpaid taxes and any tax liabilities created in connection with the CRC merger. At the closing of the CRC merger, we received an opinion of CRC s counsel, and CRC and its stockholders received an opinion of their counsel, substantially to the effect that, on the basis of the facts, representations and assumptions set forth or referred to in such opinions, for federal income tax purposes the CRC merger qualified as a reorganization within the meaning of Section 368(a) of the Code. To the extent that the CRC merger so qualified, no gain or loss was recognized by CRC or us in the CRC merger. If the CRC merger did not qualify as a reorganization within the meaning of Section 368(a) of the Code, the CRC merger would have been treated as a sale of CRC s assets to HCP in a taxable transaction, and CRC would have recognized taxable gain. In such a case, as CRC s successor-in-interest, we would be required to pay the tax on any such gain.

Assuming that the CRC merger qualified as a reorganization under the Code, we succeeded to the tax attributes and earnings and profits of CRC. To qualify as a REIT, we must distribute such earnings and profits by the close of the taxable year in which the CRC merger occurred. Any adjustments of CRC s income for taxable years ending on or before the CRC merger, including as a result of an examination of CRC s tax returns by the Internal Revenue Service, could affect the calculation of CRC s earnings and profits. If the Internal Revenue Service were to determine that we acquired earnings and profits from CRC that we failed to distribute prior to the end of the taxable year in which the CRC merger occurred, we could avoid disqualification as a REIT by using deficiency dividend procedures. Under these procedures, we generally would be required to distribute any such earnings and profits to our stockholders within 90 days of the determination and pay a statutory interest charge at a specified rate to the Internal Revenue Service.

The opinions of counsel delivered in connection with the CRP merger and the CRC merger represent the best legal judgment of counsel and are not binding on the Internal Revenue Service or the courts. None of us, CRP or CRC has requested nor will request a ruling from the Internal Revenue Service as to the status of CRP as a REIT or the tax consequences of the CRC merger, and there can be no assurance that the Internal Revenue Service will agree with the conclusions in the above-described opinions.

ITEM 1B. Unresolved Staff Comments

None

ITEM 2. Properties

We are organized to invest in income-producing healthcare-related facilities. In evaluating potential investments, we consider such factors as:

- Location, construction quality, age, condition and design of the property;
- Geographic area, proximity to other healthcare facilities, type of property and demographic profile;
- Whether the rent provides a competitive market return to our investors;
- Duration, rental rates, tenant quality and other attributes of in-place leases;
- Current and anticipated cash flow and its adequacy to meet our operational needs;
- Availability of security such as letters of credit, security deposits, and guarantees;
- Potential for capital appreciation;
- Expertise and reputation of the operator;
- Occupancy and demand for similar health facilities in the same or nearby communities;
- An adequate mix between private and government sponsored patients at health facilities;
- Availability of qualified operators or property managers or whether we can manage the property;
- Potential alternative uses of the facilities;
- Regulatory and reimbursement environment in which the properties operate;
- Tax laws related to real estate investment trusts;
- Prospects for liquidity through financing or refinancing; and
- Our cost of capital.

The following summarizes our direct property investments and interests held through consolidated joint ventures and mortgage loans as of and for the year ended December 31, 2006 (square feet and dollars in thousands).

Facility Location	Number of Facilities	Capacity(1)	Investment(2)	2006 Rental Revenues	Operating Expenses
Owned Properties:					
Hospitals:		*(Beds)*			
California	4	745	$ 237,805	$ 27,105	$
Florida	2	312	75,719	9,896	
Kansas	2	145	27,021	3,523	
Louisiana	4	412	73,780	5,948	
Texas	7	326	108,888	7,349	
Other (11 States)	14	1,416	348,181	40,660	
	33	3,356	$ 871,394	$ 94,481	$
Skilled Nursing:		*(Beds)*			
California	8	819	$ 24,430	$ 3,519	$ 27
Colorado	2	240	8,342	1,466	
Indiana	15	1,554	78,495	10,700	
Kentucky	2	188	8,082	1,178	
Michigan	3	335	10,347	970	
Nevada	2	266	13,100	1,971	
Ohio	9	1,194	45,109	6,885	
Tennessee	4	572	12,754	3,594	
Texas	4	570	24,484	2,678	
Virginia	9	934	63,100	6,259	
Other (6 States)	7	732	24,937	3,033	67
	65	7,404	$ 313,180	$ 42,253	$ 94
Senior Housing:		*(Units)*			
Alabama	4	683	$ 143,123	$ 4,084	$ 1,700
California	35	3,778	652,371	26,712	111
Colorado	5	871	168,931	6,285	
Florida	44	4,979	566,406	34,395	3,083
Illinois	9	686	131,600	2,368	
New Jersey	10	888	182,329	6,049	
Pennsylvania	3	700	131,955	4,184	
Texas	38	4,067	391,172	30,674	
Virginia	10	1,321	272,652	4,900	
Washington	12	888	154,707	7,546	
Other (28 States)	101	9,472	1,173,591	54,303	7,597
	271	28,333	$ 3,968,837	$ 181,500	$ 12,491
Medical Office Buildings:		*(Sq. Ft.)*			
Arizona	11	589	$ 100,415	$ 8,429	$ 2,964
California	16	899	223,615	20,867	6,252
Colorado	17	913	168,000	15,619	6,902
Florida	28	1,435	215,610	8,482	3,417
Indiana	14	763	90,616	12,764	6,350
Kentucky	7	682	102,569	10,938	3,737

Tennessee	18	1,560	$ 151,215	$ 8,251	$ 2,969
Texas	61	4,249	646,846	30,829	12,247
Utah	22	950	128,796	17,176	4,084
Washington	6	586	133,293	21,182	8,455
Other (17 States and Mexico)	46	2,326	405,717	22,303	9,151
	246	14,952	$ 2,366,692	$ 176,840	$ 66,528
Other		*(Sq. Ft.)*			
California	7	581	$ 118,445	$ 14,938	$ 4,165
Connecticut	3	137	9,303	1,188	
North Carolina	4	111	23,600	451	40
Rhode Island	2	75	4,274	520	
Tennessee	2	101	12,991	1,535	
Other (9 States)	12	621	94,285	10,392	1,804
	30	1,626	262,898	29,024	6,009
	645		$ 7,783,001	$ 524,098	$ 85,122
Senior Housing Facilities held for contribution(3):		*(Units)*			
California	2	353	$ 74,100	$ 1,474	$
Florida	6	1,270	308,200	5,961	
Illinois	3	773	191,300	4,099	
Rhode Island	7	901	201,400	3,379	