UNIVERSAL HEALTH REALTY INCOME TRUST
Form 10-K
March 11, 2011
Table of Contents

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE**

SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2010

OR

¨ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE**

SECURITIES EXCHANGE ACT OF 1934

For the transition period from to

Commission File No. 1-9321

UNIVERSAL HEALTH REALTY INCOME TRUST

(Exact name of registrant as specified in its charter)

Maryland **(State or other jurisdiction of incorporation or organization)**	**23-6858580** **(I.R.S. Employer Identification Number)**
Universal Corporate Center **367 South Gulph Road** **P.O. Box 61558** **King of Prussia, Pennsylvania** **(Address of principal executive offices)**	**19406-0958** **(Zip Code)**

Registrant s telephone number, including area code: (610) 265-0688

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

Title of each Class	**Name of each exchange on which registered**
Shares of beneficial interest, $.01 par value	**New York Stock Exchange**

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.

Yes ¨ **No** x

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

Yes ¨ **No** x

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Yes x **No** ¨

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

Yes ¨ **No** ¨

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

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

Large accelerated filer ¨	**Accelerated filer** x	**Non-accelerated filer** ¨ **(Do not check if a smaller reporting company)**	**Smaller reporting company** ¨

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

Yes ¨ No x

Aggregate market value of voting shares and non-voting shares held by non-affiliates as of June 30, 2010: $387,771,444. Number of shares of beneficial interest outstanding of registrant as of January 31, 2011: 12,653,250

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant s definitive proxy statement for our 2011 Annual Meeting of Shareholders, which will be filed with the Securities and Exchange Commission within 120 days after December 31, 2010 (incorporated by reference under Part III).

Table of Contents

UNIVERSAL HEALTH REALTY INCOME TRUST

2010 FORM 10-K ANNUAL REPORT

TABLE OF CONTENTS

Table of Contents

This Annual Report on Form 10-K is for the year ended December 31, 2010. This Annual Report modifies and supersedes documents filed prior to this Annual Report. Information that we file with the Securities and Exchange Commission (the SEC) in the future will automatically update and supersede information contained in this Annual Report. In this Annual Report, we, us, our and the Trust refer to Universal Health Realty Income Trust. In this Annual Report, the term revenues does not include the revenues of the unconsolidated limited liability companies (LLCs) in which we have various non-controlling equity interests ranging from 33% to 99%. We currently account for our share of the income/loss from these investments by the equity method (see Note 8 to the Consolidated Financial Statements included herein).

Table of Contents

PART I

ITEM 1. ***Business***

General

We are a real estate investment trust (REIT) which commenced operations in 1986. We invest in health care and human service related facilities including acute care hospitals, behavioral healthcare facilities, rehabilitation hospitals, sub-acute facilities, surgery centers, childcare centers and medical office buildings (MOBs). As of December 31, 2010 we have fifty-two real estate investments or commitments located in fifteen states in the United States consisting of: (i) seven hospital facilities including three acute care, one behavioral healthcare, one rehabilitation and two sub-acute; (ii) forty-one MOBs (including thirty-two owned by various LLCs), and; (iii) four preschool and childcare centers.

Available Information

We have our principal executive offices at Universal Corporate Center, 367 South Gulph Road, King of Prussia, PA 19406. Our telephone number is (610) 265-0688. Our website is located at http://www.uhrit.com. Copies of the annual, quarterly and current reports we file with the SEC, and any amendments to those reports, are available free of charge on our website. Additionally, we have adopted governance guidelines, a Code of Business Conduct and Ethics applicable to all of our officers and directors, a Code of Ethics for Senior Officers and charters for each of the Audit Committee, Compensation Committee and Nominating and Corporate Governance Committee of the Board of Trustees. These documents are also available free of charge on our website. Copies of such reports and charters are available in print to any shareholder who makes a request. Such requests should be made to our Secretary at our King of Prussia, PA corporate headquarters. We intend to satisfy the disclosure requirement under Item 10 of Form 8-K relating to amendments to or waivers of any provision of our Code of Ethics for Senior Officers by promptly posting this information on our website. The information posted on our website is not incorporated into this Annual Report.

In accordance with Section 303A.12(a) of The New York Stock Exchange Listed Company Manual, we submitted our CEO s Certification to the New York Stock Exchange in 2010. Additionally, contained in Exhibits 31.1 and 31.2 of this Annual Report are our CEO s and CFO s certifications regarding the quality of our public disclosure under Section 302 of the Sarbanes-Oxley Act of 2002.

Overview of Facilities

As of December 31, 2010, we have investments or commitments in fifty-two facilities, located in fifteen states and consisting of the following:

Facility Name	Location	Type of Facility	Ownership	Guarantor
Southwest Healthcare System, Inland Valley Campus(A)	Wildomar, CA	Acute Care	100%	Universal Health Services, Inc.
McAllen Medical Center(A)	McAllen, TX	Acute Care	100%	Universal Health Services, Inc.
Wellington Regional Medical Center(A)	W. Palm Beach, FL	Acute Care	100%	Universal Health Services, Inc.
The Bridgeway(A)	N.Little Rock, AR	Behavioral Health	100%	Universal Health Services, Inc.

Kindred Hospital Chicago Central(B)	Chicago, IL	Sub-Acute Care	100%	Kindred Healthcare, Inc.
Kindred Hospital Corpus Christi(B)	Corpus Christi, TX	Sub-Acute Care	100%	Kindred Healthcare, Inc.
HealthSouth Deaconess Rehabilitation Hospital(E)	Evansville, IN	Rehabilitation	100%	HealthSouth Corporation
Family Doctor s Medical Office Bldg.(B)	Shreveport, LA	MOB	100%	Christus Health Northern Louisiana
Kelsey-Seybold Clinic at Kings Crossing(B)	Kingwood, TX	MOB	100%	Kelsey-Seybold Medical Group, PLLC
Professional Bldgs. at Kings Crossing(B)	Kingwood, TX	MOB	100%	
Chesterbrook Academy(B)	Audubon, PA	Preschool & Childcare	100%	Nobel Learning Comm. & Subs.
Chesterbrook Academy(B)	New Britain, PA	Preschool & Childcare	100%	Nobel Learning Comm. & Subs.
Chesterbrook Academy(B)	Newtown, PA	Preschool & Childcare	100%	Nobel Learning Comm. & Subs.

Table of Contents

Facility Name	Location	Type of Facility	Ownership	Guarantor
Chesterbrook Academy(B)	Uwchlan, PA	Preschool & Childcare	100%	Nobel Learning Comm. & Subs.
Southern Crescent Center I(B,I)	Riverdale, GA	MOB	100%	
Southern Crescent Center, II(B,I)	Riverdale, GA	MOB	100%	
Desert Samaritan Hospital MOBs(C)	Mesa, AZ	MOB	76%	
Suburban Medical Plaza II(C)	Louisville, KY	MOB	33%	
Desert Valley Medical Center(C,G)	Phoenix, AZ	MOB	90%	
Thunderbird Paseo Medical Plaza I & II(C)	Glendale, AZ	MOB	75%	
Cypresswood Professional Center(B)	Spring, TX	MOB	100%	
Papago Medical Park(C)	Phoenix, AZ	MOB	89%	
Edwards Medical Plaza(C,G)	Phoenix, AZ	MOB	90%	
Desert Springs Medical Plaza(D)	Las Vegas, NV	MOB	99%	
Orthopaedic Specialists of Nevada Bldg.(B)	Las Vegas, NV	MOB	100%	
Santa Fe Professional Plaza(C,G)	Scottsdale, AZ	MOB	90%	
Sheffield Medical Building(B)	Atlanta, GA	MOB	100%	
Centinela Medical Building Complex(C,G)	Inglewood, CA	MOB	90%	
Summerlin Hospital MOB(D,H)	Las Vegas, NV	MOB	95%	
Summerlin Hospital MOB II	Las Vegas, NV	MOB	98%	
Medical Center of Western Connecticut(B)	Danbury, CT	MOB	100%	
Mid Coast Hospital MOB(C)	Brunswick, ME	MOB	74%	
Deer Valley Medical Office II(C)	Phoenix, AZ	MOB	90%	
Rosenberg Children s Medical Plaza(C)	Phoenix, AZ	MOB	85%	
700 Shadow Lane & Goldring MOBs(D)	Las Vegas, NV	MOB	98%	
St. Mary s Professional Office Building(C)	Reno, NV	MOB	75%	
Apache Junction Medical Plaza(C)	Apache Junction, AZ	MOB	85%	
Spring Valley Medical Office Building(D)	Las Vegas, NV	MOB	95%	
Spring Valley Hospital Medical Office Building II(D)	Las Vegas, NV	MOB	95%	
Sierra San Antonio Medical Plaza(C)	Fontana, CA	MOB	95%	
Phoenix Children s East Valley Care Center(C)	Phoenix, AZ	MOB	95%	
Centennial Hills Medical Office Building I(D)	Las Vegas, NV	MOB	95%	
Canyon Springs Medical Plaza(C)	Gilbert, AZ	MOB	95%	
Palmdale Medical Plaza(F)	Palmdale, CA	MOB	95%	
Cobre Valley Medical Plaza(C)	Globe, AZ	MOB	95%	
Deer Valley Medical Office Building III(C)	Phoenix, AZ	MOB	95%	
Summerlin Hospital Medical Office Building III	Las Vegas, NV	MOB	95%	
Vista Medical Terrace & The Sparks Medical Building(D)	Sparks, NV	MOB	95%	
Auburn Medical Office Building II(D)	Auburn, WA	MOB	95%	
Texoma Medical Plaza(J)	Denison, TX	MOB	95%	
BRB Medical Office Building(K)	Kingwood, TX	MOB	95%	
North Valley Medical Plaza (L)	Phoenix, AZ	MOB	95%	

(A) Real estate assets owned by us and leased to subsidiaries of Universal Health Services, Inc. (UHS).
(B) Real estate assets owned by us and leased to an unaffiliated third-party or parties.
(C) Real estate assets owned by a limited liability company (LLC) in which we have a non-controlling ownership interest as indicated above.
(D) Real estate assets owned by an LLC in which we have a non-controlling interest as indicated above and include tenants who are unaffiliated third-parties or subsidiaries of UHS.
(E) The lessee on the HealthSouth Deaconess Rehabilitation Hospital (Deaconess) is HealthSouth/Deaconess L.L.C., a joint venture between HealthSouth Properties Corporation and Deaconess Hospital, Inc. The lease with Deaconess was renewed during 2008 and is scheduled to expire on May 31, 2014.
(F) Real estate assets owned by an LLC in which we have a non-controlling ownership interest as indicated above. Tenants of this medical office building include subsidiaries of UHS. As a result of our related party relationship with UHS and a master lease agreement between UHS and this property, this LLC is considered to be a variable interest entity. Consequently, we consolidate the results of operations of this LLC in our consolidated financial statements.
(G) The membership interests of this entity are held by a master LLC in which we hold a 90% non-controlling ownership interest.
(H) The membership interests of this entity are held by a master LLC in which we hold a 95% non-controlling ownership interest.
(I) A property impairment charge was recorded on this MOB during 2008, as discussed herein.
(J) This MOB includes tenants which are subsidiaries of UHS and was completed and opened during the first quarter of 2010.
(K) This MOB was completed and opened during the fourth quarter of 2010.
(L) This MOB was acquired during the first quarter of 2010.

Table of Contents

Other Information

Included in our portfolio at December 31, 2010 are seven hospital facilities with an aggregate investment of $142.0 million. The leases with respect to these hospital facilities comprised approximately 66% of our revenue in 2010, approximately 61% of our revenue in 2009 and approximately 65%, of our revenue in 2008. As of December 31, 2010, these leases have fixed terms with an average of 3.5 years remaining and include renewal options ranging from two to five, five-year terms. The remaining lease terms for each hospital facility, which vary by hospital, are included herein in *Item 2. Properties.*

We believe a facility s earnings before interest, taxes, depreciation, amortization and lease rental expense (EBITDAR) and a facility s EBITDAR divided by the sum of minimum rent plus additional rent payable to us (Coverage Ratio), which are non-GAAP financial measures, are helpful to us and our investors as a measure of the operating performance of a hospital facility. EBITDAR, which is used as an indicator of a facility s estimated cash flow generated from operations (before rent expense, capital additions and debt service), is used by us in evaluating a facility s financial viability and its ability to pay rent. For the hospital facilities owned by us at the end of each respective year, the combined weighted average Coverage Ratio was approximately 5.1 (ranging from 2.3 to 11.4) during 2010, 6.7 (ranging from 2.9 to 10.4) during 2009 and 6.1 (ranging from 2.5 to 8.7) during 2008. The Coverage Ratio for individual facilities varies. See Relationship with Universal Health Services, Inc. below for Coverage Ratio information related to the four hospital facilities leased to subsidiaries of UHS.

Pursuant to the terms of our leases for our hospital facilities and the preschool and childcare centers, each lessee, including subsidiaries of UHS, is responsible for building operations, maintenance, renovations and property insurance. We, or the LLCs in which we have invested, are responsible for the building operations, maintenance and renovations of the MOBs, however, a portion, or in some cases all, of the expenses associated with the MOBs are passed on directly to the tenants. Cash reserves have been established to fund required building maintenance and renovations at the multi-tenant MOBs. Lessees are required to maintain all risk, replacement cost and commercial property insurance policies on the leased properties and we, or the LLC in which we have invested, are also named insureds on these policies. In addition, we, UHS or the LLCs in which we have invested, maintain property insurance on all properties. For additional information on the terms of our leases, see Relationship with Universal Health Services, Inc.

See our consolidated financial statements and accompanying notes to the consolidated financial statements included in this Annual Report for our total assets, liabilities, debt, revenues, income and other operating information.

Relationship with Universal Health Services, Inc. (UHS)

Leases: We commenced operations in 1986 by purchasing properties of certain subsidiaries from UHS and immediately leasing the properties back to the respective subsidiaries. Most of the leases were entered into at the time we commenced operations and provided for initial terms of 13 to 15 years with up to six additional 5-year renewal terms. The current base rentals and lease and rental terms for each facility are provided below. The base rents are paid monthly and each lease also provides for additional or bonus rents which are computed and paid on a quarterly basis based upon a computation that compares current quarter revenue to a corresponding quarter in the base year. The leases with subsidiaries of UHS are unconditionally guaranteed by UHS and are cross-defaulted with one another.

The combined revenues generated from the leases on the UHS hospital facilities accounted for approximately 54% of our total revenue for the five years ended December 31, 2010 (approximately 56%, 51% and 55% for the years ended December 31, 2010, 2009 and 2008, respectively). Including 100% of the revenues generated at the unconsolidated LLCs in which we have various non-controlling equity interests ranging from 33% to 99%, the leases on the UHS hospital facilities accounted for approximately 21% of the combined consolidated and unconsolidated

revenue for the five years ended December 31, 2010 (approximately 19%, 20%

Table of Contents

and 21% for the years ended December 31, 2010, 2009 and 2008, respectively). In addition, twelve MOBs, owned by LLCs in which we hold various non-controlling equity interests, include or will include tenants which are subsidiaries of UHS.

Pursuant to the Master Lease Document by and among us and certain subsidiaries of UHS, dated December 24, 1986 (the Master Lease), which governs the leases of all hospital properties with subsidiaries of UHS, UHS has the option to renew the leases at the lease terms described below by providing notice to us at least 90 days prior to the termination of the then current term. In addition, UHS has rights of first refusal to: (i) purchase the respective leased facilities during and for 180 days after the lease terms at the same price, terms and conditions of any third-party offer, or; (ii) renew the lease on the respective leased facility at the end of, and for 180 days after, the lease term at the same terms and conditions pursuant to any third-party offer. UHS also has the right to purchase the respective leased facilities at the end of the lease terms or any renewal terms at the appraised fair market value. In addition, the Master Lease, as amended during 2006, includes a change of control provision whereby UHS has the right, upon one month s notice should a change of control of the Trust occur, to purchase any or all of the four leased hospital properties at their appraised fair market value.

The table below details the renewal options and terms for each of the four UHS hospital facilities:

Hospital Name	Type of Facility	Annual Minimum Rent	End of Lease Term	Renewal Term (years)
McAllen Medical Center	Acute Care	$ 5,485,000	December, 2011	20(a)
Wellington Regional Medical Center	Acute Care	$ 3,030,000	December, 2011	20(b)
Southwest Healthcare System, Inland Valley Campus	Acute Care	$ 2,648,000	December, 2011	20(b)
The Bridgeway	Behavioral Health	$ 930,000	December, 2014	10(c)

(a) UHS has four 5-year renewal options at existing lease rates (through 2031).
(b) UHS has two 5-year renewal options at existing lease rates (through 2021) and two 5-year renewal options at fair market value lease rates (2022 through 2031).
(c) UHS has two 5-year renewal options at fair market value lease rates (2015 through 2024).

Advisory Agreement: UHS of Delaware, Inc. (the Advisor), a wholly-owned subsidiary of UHS, serves as Advisor to us under an Advisory Agreement (the Advisory Agreement) dated December 24, 1986. Pursuant to the Advisory Agreement, the Advisor is obligated to present an investment program to us, to use its best efforts to obtain investments suitable for such program (although it is not obligated to present any particular investment opportunity to us), to provide administrative services to us and to conduct our day-to-day affairs. All transactions between us and UHS must be approved by the Trustees who are unaffiliated with UHS (the Independent Trustees). In performing its services under the Advisory Agreement, the Advisor may utilize independent professional services, including accounting, legal, tax and other services, for which the Advisor is reimbursed directly by us. The Advisory Agreement may be terminated for any reason upon sixty days written notice by us or the Advisor. The Advisory Agreement expires on December 31 of each year; however, it is renewable by us, subject to a determination by the Independent Trustees, that the Advisor s performance has been satisfactory. In December of 2009, based upon a review of our advisory fee and other general and administrative expenses, as compared to an industry peer group, the fee was increased, effective January 1, 2010, to 0.65% (from 0.60%) of our average invested real estate assets, as derived from our consolidated balance sheet. The Advisory Agreement was renewed for 2011 at the same terms and conditions.

The average real estate assets for advisory fee calculation purposes exclude certain items from our consolidated balance sheet such as, among other things, accumulated depreciation, cash and cash equivalents, base and bonus rent receivables, deferred charges and other assets. The advisory fee is payable quarterly, subject to adjustment at year-end based upon our audited financial statements. In addition, the Advisor is entitled to an annual incentive fee equal to 20% of the amount by which cash available for distribution to shareholders for each

4

Table of Contents

year, as defined in the Advisory Agreement, exceeds 15% of our equity as shown on our consolidated balance sheet, determined in accordance with generally accepted accounting principles without reduction for return of capital dividends. The Advisory Agreement defines cash available for distribution to shareholders as net cash flow from operations less deductions for, among other things, amounts required to discharge our debt and liabilities and reserves for replacement and capital improvements to our properties and investments. No incentive fees were paid during 2010, 2009 or 2008 since the incentive fee requirements were not achieved. Advisory fees incurred and paid (or payable) to UHS amounted to $1.9 million during 2010 and $1.6 million during each of 2009 and 2008 and were based upon average invested real estate assets of $285 million, $268 million and $261 million during 2010, 2009 and 2008, respectively.

Officers and Employees: Our officers are all employees of UHS and although as of December 31, 2010 we had no salaried employees, our officers do receive stock-based compensation.

Share Ownership: As of December 31, 2010 and 2009, UHS owned 6.2% and 6.5% of our outstanding shares of beneficial interest, respectively.

SEC reporting requirements of UHS: UHS is subject to the reporting requirements of the SEC and is required to file annual reports containing audited financial information and quarterly reports containing unaudited financial information. Since the leases on the hospital facilities leased to wholly-owned subsidiaries of UHS comprised approximately 56%, 51% and 55% of our consolidated revenues for the years ended December 31, 2010, 2009 and 2008, respectively, and since a subsidiary of UHS is our Advisor, you are encouraged to obtain the publicly available filings for Universal Health Services, Inc. from the SEC s website at www.sec.gov. These filings are the sole responsibility of UHS and are not incorporated by reference herein.

UHS Other Matters:

Southwest Healthcare System: During the third quarter of 2009, UHS advised us that Southwest Healthcare System (SWHCS), a wholly-owned subsidiary of UHS which operates Rancho Springs Medical Center (the real property of which is not owned by the Trust) and Inland Valley Regional Medical Center (Inland Valley , the real property of which is owned by the Trust) located in Riverside County, California, entered into an agreement with the Center for Medicare and Medicaid Services (CMS). The agreement required SWHCS to engage an independent quality monitor to assist SWHCS in meeting all CMS conditions of participation. Further, the agreement provided that, during the last 60 days of the agreement, CMS would conduct a full Medicare certification survey. That survey took place the week of January 11, 2010.

In April, 2010, SWHCS received notification from CMS that it intended to effectuate the termination of SWHCS s Medicare provider agreement effective June 1, 2010. In May, 2010, UHS entered into an agreement with CMS which abated the termination action scheduled for June 1, 2010. The agreement is one year in duration and required SWHCS to engage independent experts in various disciplines to analyze and develop implementation plans for SWHCS to meet the Medicare conditions of participation. At the conclusion of the agreement, CMS will conduct a full certification survey to determine if SWHCS has achieved substantial compliance with the Medicare conditions of participation. During the term of the agreement, SWHCS remains eligible to receive reimbursements from Medicare for services rendered to Medicare beneficiaries.

Also in April, 2010, SWHCS received notification from the California Department of Public Health (CDPH) indicating that it planned to initiate a process to revoke SWHCS s hospital license. In May, 2010, SWHCS received the formal document related to the revocation action. In September, 2010, SWHCS entered into an agreement with CDPH relating to the license revocation. The terms of the CDPH agreement are substantially similar to those contained in the agreement with CMS. As a result of the agreement, SWHCS s hospital license remains in effect

pending the outcome of the CMS full certification survey which will occur at the end of the agreement. Pursuant to the results of the CMS full certification survey, which SWHCS anticipates occurring in mid-year, 2011, should SWHCS be deemed to have achieved substantial compliance with the

Table of Contents

Medicare conditions of participation, CDPH shall deem SWHCS s license to be in good standing. Failure of SWHCS to achieve substantial compliance with the Medicare conditions of participation, pursuant to CMS s full certification survey, will likely have a material adverse impact on SWHCS s ability to continue to operate the facilities.

As a result of the matters discussed above, SWHCS had not been permitted to open newly constructed capacity at Rancho Springs Medical Center and Inland Valley Medical Center. However, in February, 2011, SWHC received permission from CDPH to begin accessing the new capacity. Unrelated to these developments, SWHCS expects a competitor to open a newly constructed acute care hospital during the first quarter of 2011. UHS is unable to predict the net impact of these developments on SWHCS s results of operations in 2011 and beyond.

UHS has advised us that Rancho Springs Medical Center and Inland Valley Regional Medical Center remain fully committed to providing high-quality healthcare to their patients and the communities they serve. UHS therefore intends to work expeditiously and collaboratively with both CMS and CDPH in an effort to resolve these matters, although there can be no assurance they will be able to do so. Failure to resolve these matters could have a material adverse effect on UHS and, in turn, us. While the $2.6 million annual base rentals on Inland Valley are guaranteed by UHS through the end of the existing lease term (December, 2011), should this matter, or the opening of the above-mentioned newly constructed acute care facility by a competitor, adversely impact the future revenues and/or operating results of SWHCS, the future bonus rental earned by us on Inland Valley, as well as the underlying value of the property, may be materially adversely impacted. At December 31, 2010, the book value of the property was $19.0 million. Bonus rental revenue earned by us from Inland Valley amounted to $1.1 million during each of the years ended December 31, 2010 and 2009 and $1.0 million during the year ended December 31, 2008.

Psychiatric Solutions, Inc.: In connection with the acquisition of Psychiatric Solutions, Inc. (PSI) by UHS, UHS has substantially increased its level of indebtedness which could, among other things, adversely affect its ability to raise additional capital to fund operations, limit its ability to react to changes in the economy or its industry and could potentially prevent it from meeting its obligations under the agreements related to its indebtedness. If UHS experiences financial difficulties and, as a result, operations of its existing facilities suffer, or UHS otherwise fails to make payments to us, our revenues will significantly decline.

Although we do not expect to be directly impacted by UHS acquisition of PSI, UHS is substantially more leveraged and we cannot assure you that UHS will continue to satisfy its obligations to us. The failure or inability of UHS to satisfy its obligations to us could materially reduce our revenues and net income, which could in turn reduce the amount of dividends we pay and cause our stock price to decline.

Taxation

We believe we have operated in such a manner as to qualify for taxation as a REIT under Sections 856 through 860 of the Internal Revenue Code of 1986, and we intend to continue to operate in such a manner. If we qualify for taxation as a REIT, we will generally not be subject to federal corporate income taxes on our net income that is currently distributed to shareholders. This treatment substantially eliminates the double taxation *, e.g.* at the corporate and shareholder levels, that usually results from investment in the stock of a corporation. Please see the heading *If we fail to maintain our REIT status, we will become subject to federal income tax on our taxable income at regular corporate rates* under Risk Factors for more information.

Competition

We compete for the acquisition, leasing and financing of health care related facilities. Our competitors include, but are not limited to, other REITs, banks and other companies, including UHS. Some of these competitors are larger and may have a lower cost of capital than we do. These developments could result in fewer investment opportunities for us and lower spreads over the cost of our capital, which would hurt our growth.

Table of Contents

In most geographical areas in which our facilities operate, there are other facilities that provide services comparable to those offered by our facilities. In addition, some competing facilities are owned by tax-supported governmental agencies or by nonprofit corporations and may be supported by endowments and charitable contributions and exempt from property, sales and income taxes. Such exemptions and support are not available to certain operators of our facilities. In some markets, certain competing facilities may have greater financial resources, be better equipped and offer a broader range of services than those available at our facilities. Certain hospitals that are located in the areas served by our facilities are specialty hospitals that provide medical, surgical and behavioral health services, facilities and equipment that are not available at our hospitals. The increase in outpatient treatment and diagnostic facilities, outpatient surgical centers and freestanding ambulatory surgical centers also increases competition for us.

In addition, the number and quality of the physicians on a hospital s staff are important factors in determining a hospital s success and competitive advantage. Typically, physicians are responsible for making hospital admissions decisions and for directing the course of patient treatment. The operators of our facilities also compete with other health care providers in recruiting and retaining qualified hospital management, nurses and other medical personnel. From time-to-time, the operators of our acute care and behavioral health care facilities may experience the effects of a shortage of skilled nursing staff nationwide, which has caused and may continue to cause an increase in salaries, wages and benefits expense in excess of the inflation rate. Our operators may experience difficulties attracting and retaining qualified physicians, nurses and medical support personnel. We anticipate that our operators, including UHS, will continue to encounter increased competition in the future that could lead to a decline in patient volumes and harm their businesses, which in turn, could harm our business.

A large portion of our non-hospital properties consist of MOBs which are located either close to or on the campuses of hospital facilities. These properties are either directly or indirectly affected by the factors discussed above as well as general real estate factors such as the supply and demand of office space and market rental rates. To improve our competitive position, we anticipate that we will continue investing in additional healthcare related facilities and leasing the facilities to qualified operators, perhaps including UHS and subsidiaries of UHS.

Regulation and Other Factors

During 2010, 2009 and 2008, 52%, 48% and 51%, respectively, of our revenues were earned pursuant to leases with operators of acute care services hospitals, all of which are subsidiaries of UHS. A significant portion of the revenue earned by the operators of our acute care hospitals is derived from federal and state healthcare programs, including Medicare and Medicaid (excluding managed Medicare and Medicaid programs).

The healthcare industry is subject to numerous laws, regulations and rules including, among others, those related to government healthcare participation requirements, various licensure and accreditations, reimbursement for patient services, health information privacy and security rules, and Medicare and Medicaid fraud and abuse provisions (including, but not limited to, federal statutes and regulations prohibiting kickbacks and other illegal inducements to potential referral sources, false claims submitted to federal health care programs and self-referrals by physicians). Providers that are found to have violated any of these laws and regulations may be excluded from participating in government healthcare programs, subjected to significant fines or penalties and/or required to repay amounts received from the government for previously billed patient services. This government regulation of the healthcare industry affects us because:

(i) The financial ability of lessees to make rent payments to us may be affected by governmental regulations such as licensure, certification for participation in government programs, and government reimbursement, and;

(ii) Our bonus rents are based on our lessees net revenues which in turn are affected by the amount of reimbursement such lessees receive from the government.

Although UHS and the other operators of our acute care facilities believe that their policies, procedures and practices comply with governmental regulations, no assurance can be given that they will not be subjected to additional governmental inquiries or actions, or that they would not be faced with sanctions, fines or penalties if

Table of Contents

so subjected. Even if they were to ultimately prevail, a significant governmental inquiry or action under one of the above laws, regulations or rules could have a material adverse effect upon them, and in turn, us. See *Relationship with Universal Health Services, Inc.-UHS Other Matters* for disclosure related to Southwest Healthcare System.

A significant portion of the revenue earned by the operators of our acute care hospitals is derived from federal and state healthcare programs, including Medicare and Medicaid. Under the statutory framework of the Medicare and Medicaid programs, many of the general acute care operations are subject to administrative rulings, interpretations and discretion that may affect payments made under either or both of such programs as well as by other third party payors. The federal government makes payments to participating hospitals under its Medicare program based on various formulas. For inpatient services, the operators of our acute care hospitals are subject to a inpatient prospective payment system (IPPS). Under IPPS, hospitals are paid a predetermined fixed payment amount for each hospital discharge. The fixed payment amount is based upon each patient s Medicare severity diagnosis related group (MS-DRG). Every MS-DRG is assigned a payment rate based upon the estimated intensity of hospital resources necessary to treat the average patient with that particular diagnosis. These rates are based upon historical national average costs and do not consider the actual costs incurred by a hospital in providing care. The MS-DRG rates are adjusted annually based on geographic region and are weighted based upon a statistically normal distribution of severity.

For outpatient services, both general acute and behavioral health hospitals are paid under an outpatient PPS according to ambulatory procedure codes. Outpatient services were traditionally paid at the lower of customary charges or on a reasonable cost basis. The outpatient PPS rate is an unadjusted national payment amount that includes the Medicare payment and the beneficiary co-payment. Special payments under the outpatient PPS may be made for certain new technology items and services through transitional pass-through payments and special reimbursement rates.

Three of our acute care hospital facilities operated by subsidiaries of UHS and two sub-acute care hospital facilities operated by an unaffiliated third-party are located in Texas, Florida, California and Illinois. The majority of these states have reported significant budget deficits that have resulted in reductions of Medicaid funding for 2009 and 2010. Furthermore, many states are currently working to effectuate further significant reductions in the level of Medicaid funding due to significant state budget deficits projected for 2011, which could adversely affect future levels of Medicaid reimbursement received by certain operators of our facilities, including the operators of our hospital facilities. We can provide no assurance that reductions to Medicaid revenues earned by operators of certain of our facilities, particularly our hospital operators in the above-mentioned states, will not have a material adverse effect on the future operating results of those operators which, in turn, could have a material adverse effect on us. In addition, the uncertainty and fiscal pressures placed upon the federal government as a result of, among other things, the War on Terrorism, economic recovery stimulus packages, responses to natural disasters, the expansion of a Medicare drug benefit and the federal budget deficit in general may affect the availability of federal funds to provide additional relief to the operators of our facilities in the future. We are unable to predict the effect of future policy changes on the operators of our facilities.

In March, 2010, the Health Care and Education Reconciliation Act of 2010 (H.R. 4872, P.L. 111-152), (the Reconciliation Act) and the Patient Protection and Affordable Care Act (P.L. 111-148), (the Affordable Care Act), were enacted into law and created significant changes to health insurance coverage for U.S. citizens as well as material revisions to the federal Medicare and state Medicaid programs. Medicare, Medicaid and other health care industry changes which are scheduled to be implemented at various times during this decade are noted below. We cannot predict the effect, if any, these enactments will have on the operators of our facilities and, thus, our business.

Immediate Medicare Reductions:

The Reconciliation Act reduced the market basket update for inpatient and outpatient hospitals and inpatient behavioral health facilities in each of 2010 and 2011 by 0.25%. Further, the Affordable Care Act implements certain reforms to Medicare Advantage payments, effective in 2011.

Table of Contents

Future Medicare Reductions:

Future changes to the Medicare program include:

Implement a Medicare shared savings program (effective 2012)

Implement a hospital readmissions reduction program (effective 2012)

Implement a national pilot program on payment bundling (effective 2013)

Implement a value-based purchasing program for hospitals (effective 2012)

Reduction to Medicare disproportionate share hospital (DSH) payments (effective 2014)

Medicaid Revisions:

Expanded Medicaid eligibility and related special federal payments (effective 2014)

Reduction to Medicaid DSH (effective 2014)

Health Insurance Revisions:

Large employer insurance reforms (effective 2014)

Individual insurance mandate and related federal subsidies (effective 2014)

Federally mandated insurance coverage reforms (2010 and forward)

Executive Officers of the Registrant

Name	Age	Position
Alan B. Miller	73	Chairman of the Board, Chief Executive Officer and President
Charles F. Boyle	51	Vice President and Chief Financial Officer

Cheryl K. Ramagano	48	Vice President, Treasurer and Secretary
Timothy J. Fowler	55	Vice President, Acquisition and Development

Mr. Alan B. Miller has been our Chairman of the Board and Chief Executive Officer since our inception in 1986 and was appointed President in February of 2003. He had previously served as our President until 1990. Mr. Miller has been Chairman of the Board and Chief Executive Officer of UHS since its inception in 1978. He previously held the title of President of UHS as well, until 2009 when Marc D. Miller was elected as President of UHS. Mr. Miller also serves as a Director of Penn Mutual Life Insurance Company. He is the father of Marc D. Miller, who was elected to our Board of Trustees in December, 2008 and also serves as President and a member of the Board of Directors of UHS.

Mr. Charles F. Boyle was appointed Chief Financial Officer in February of 2003 and had served as our Vice President and Controller since 1991. Mr. Boyle has held various positions at UHS since 1983 and currently serves as its Vice President and Controller. He was appointed Controller of UHS in 2003 and had served as its Assistant Vice President-Corporate Accounting since 1994.

Ms. Cheryl K. Ramagano was appointed Secretary in February of 2003 and served as our Vice President and Treasurer since 1992. Ms. Ramagano has held various positions at UHS since 1983 and currently serves as its Vice President and Treasurer. She was appointed Treasurer of UHS in 2003 and had served as its Assistant Treasurer since 1994.

Mr. Timothy J. Fowler was elected as our Vice President of Acquisition and Development upon the commencement of his employment with UHS in 1993.

Table of Contents

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

We are subject to numerous known and unknown risks, many of which are described below and elsewhere in this Annual Report. Any of the events described below could have a material adverse effect on our business, financial condition and results of operations. Additional risks and uncertainties that we are not aware of, or that we currently deem to be immaterial, could also impact our business and results of operations.

A worsening of the economic and employment conditions in the United States could materially affect our business and future results of operations of the operators of our facilities which could, in turn, materially reduce our revenues and net income.

Our future results of operations could be unfavorably impacted by continued deterioration in general economic conditions which could result in increases in the number of people unemployed and/or uninsured. Our operators patient volumes, revenues and financial results depend significantly on the universe of patients with health insurance, which to a large extent is dependent on the employment status of individuals in certain markets. A continuation or worsening of economic conditions may result in a continued increase in the unemployment rate which will likely increase the number of individuals without health insurance. As a result, the operators of our facilities may experience a decrease in patient volumes. Should that occur, it may result in decreased occupancy rates at our medical office buildings as well as a reduction in the revenues earned by the operators of our hospital facilities which would unfavorably impact our future bonus rentals (on the UHS hospital facilities) and may potentially have a negative impact on the future lease renewal terms and the underlying value of the hospital properties. Additionally, the general real estate market has been unfavorably impacted by the deterioration in economic and credit market conditions which may adversely impact the underlying value of our properties.

The revenues and results of operations of the tenants of our hospital facilities, including UHS, and our medical office buildings, are significantly affected by payments received from the government and other third party payors.

The operators of our hospital facilities and tenants of our medical office buildings derive a significant portion of their revenue from third party payors, including the Medicare and Medicaid programs. Changes in these government programs in recent years have resulted in limitations on reimbursement and, in some cases, reduced levels of reimbursement for health care services. Payments from federal and state government programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease program payments, as well as affect the cost of providing service to patients and the timing of payments to facilities. Our tenants are unable to predict the effect of future policy changes on their operations.

Three of our acute care hospital facilities operated by subsidiaries of UHS and two sub-acute care hospital facilities operated by an unaffiliated third-party are located in Texas, Florida, California and Illinois. The majority of these states have reported significant budget deficits that have resulted in reductions of Medicaid funding for 2009 and 2010. Furthermore, many states are currently working to effectuate further significant reductions in the level of Medicaid funding due to significant state budget deficits projected for 2011, which could adversely affect future levels of Medicaid reimbursement received by certain operators of our facilities, including the operators of our hospital facilities. We can provide no assurance that reductions to Medicaid revenues earned by operators of certain of our facilities, particularly our hospital operators in the above-mentioned states, will not have a material adverse effect on the future operating results of those operators which, in turn, could have a material adverse effect on us. In addition, the uncertainty and fiscal pressures placed upon federal and state governments as a result of, among other things, the substantial deterioration in general economic conditions, the funding requirements from the federal government s stimulus package, the War on Terrorism and the relief efforts related to hurricanes and other disasters, may affect the availability of taxpayer funds for Medicare and Medicaid programs. If the rates paid or the scope of services covered by government payors are reduced, there could be a material adverse effect on our tenants business, financial position and results of operations, and in turn, ours.

10

Table of Contents

In addition to changes in government reimbursement programs, the ability of our hospital operators to negotiate favorable contracts with private payors, including managed care providers, significantly affects the revenues and operating results of those facilities. Private payors, including managed care providers, increasingly are demanding that hospitals accept lower rates of payment. Our hospital operators expect continued third party efforts to aggressively manage reimbursement levels and cost controls. Reductions in reimbursement amounts received from third party payors could have a material adverse effect on the financial position and results of operations of our hospital operators.

The uncertainties of health care reform could materially affect the business and future results of operations of the operators of our facilities, including UHS, which could, in turn, materially reduce our revenues and net income.

In March, 2010, the Health Care and Education Reconciliation Act of 2010, (the Reconciliation Act) and the Patient Protection and Affordable Care Act, (the Affordable Care Act), were enacted into law and created significant changes to health insurance coverage for U.S. citizens as well as material revisions to the federal Medicare and state Medicaid programs. The two combined primary goals of these Acts are to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses. Medicare, Medicaid and other health care industry changes are scheduled to be implemented at various times during this decade. We cannot predict the effect, if any, these enactments will have on operators and, thus, our business.

Increased competition in the health care industry has resulted in lower revenues and higher costs for our operators, including UHS, and may affect our revenues, property values and lease renewal terms.

The health care industry is highly competitive and competition among hospitals and other health care providers for patients has intensified in recent years. In most geographical areas in which our facilities are operated, there are other facilities that provide services comparable to those offered by our facilities. In addition, some competing facilities are owned by tax-supported governmental agencies or by nonprofit corporations and may be supported by endowments and charitable contributions and exempt from property, sales and income taxes. Such exemptions and support are not available to certain operators of our facilities. In some markets, certain competing facilities may have greater financial resources, be better equipped and offer a broader range of services than those available at our facilities. Certain hospitals that are located in the areas served by our operators facilities are specialty or large hospitals that provide medical, surgical and behavioral health services, facilities and equipment that are not available at our operators hospitals. The increase in outpatient treatment and diagnostic facilities, outpatient surgical centers and freestanding ambulatory surgical centers also increases competition for our operators.

In addition, the number and quality of the physicians on a hospital s staff are important factors in determining a hospital s competitive advantage. Typically, physicians are responsible for making hospital admissions decisions and for directing the course of patient treatment. The operators of our facilities also compete with other health care providers in recruiting and retaining qualified hospital management, nurses and other medical personnel. The operators of our acute care and behavioral health care facilities are experiencing the effects of a shortage of skilled nursing staff nationwide, which has caused and may continue to cause an increase in salaries, wages and benefits expense in excess of the inflation rate. Our operators may experience difficulties attracting and retaining qualified physicians, nurses and medical support personnel. We anticipate that our operators, including UHS, will continue to encounter increased competition in the future that could lead to a decline in patient volumes and harm their businesses, which in turn, could harm our business.

Operators that fail to comply with governmental reimbursement programs such as Medicare or Medicaid, licensing and certification requirements, fraud and abuse regulations or new legislative developments may be unable to meet their obligations to us.

Our operators, including UHS and its subsidiaries, are subject to numerous federal, state and local laws and regulations that are subject to frequent and substantial changes (sometimes applied retroactively) resulting from

Table of Contents

legislation, adoption of rules and regulations, and administrative and judicial interpretations of existing law. The ultimate timing or effect of these changes cannot be predicted. Government regulation may have a dramatic effect on our operators costs of doing business and the amount of reimbursement received by both government and other third-party payors. The failure of any of our operators to comply with these laws, requirements and regulations could adversely affect their ability to meet their obligations to us. These regulations include, among other items: hospital billing practices and prices for service; relationships with physicians and other referral sources; adequacy of medical care; quality of medical equipment and services; qualifications of medical and support personnel; the implementation of an electronic health records application by 2015; confidentiality, maintenance and security issues associated with health-related information and patient medical records; the screening, stabilization and transfer of patients who have emergency medical conditions; certification, licensure and accreditation of our facilities; operating policies and procedures, and; construction or expansion of facilities and services.

If our operators fail to comply with applicable laws and regulations, they could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of their licenses to operate one or more facilities), and exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs. The imposition of such penalties could jeopardize that operator s ability to make lease or mortgage payments to us or to continue operating its facility. In addition, our bonus rents are based on our operators net revenues, which in turn are affected by the amount of reimbursement that such lessees receive from the government.

Although UHS and the other operators of our acute care facilities, believe that their policies, procedures and practices comply with governmental regulations, no assurance can be given that they will not be subjected to governmental inquiries or actions, or that they would not be faced with sanctions, fines or penalties if so subjected. Because many of these laws and regulations are relatively new, in many cases, our operators don t have the benefit of regulatory or judicial interpretation. In the future, it is possible that different interpretations or enforcement of these laws and regulations could subject their current or past practices to allegations of impropriety or illegality or could require them to make changes in the facilities, equipment, personnel, services, capital expenditure programs and operating expenses. Even if they were to ultimately prevail, a significant governmental inquiry or action under one of the above laws, regulations or rules could have a material adverse effect upon them, and in turn, us.

UHS s Southwest Healthcare System: During the third quarter of 2009, UHS advised us that Southwest Healthcare System (SWHCS), a wholly-owned subsidiary of UHS which operates Rancho Springs Medical Center (the real property of which is not owned by the Trust) and Inland Valley Regional Medical Center (Inland Valley , the real property of which is owned by the Trust) located in Riverside County, California, entered into an agreement with the Center for Medicare and Medicaid Services (CMS). The agreement required SWHCS to engage an independent quality monitor to assist SWHCS in meeting all CMS conditions of participation. Further, the agreement provided that, during the last 60 days of the agreement, CMS would conduct a full Medicare certification survey. That survey took place the week of January 11, 2010.

In April, 2010, SWHCS received notification from CMS that it intended to effectuate the termination of SWHCS s Medicare provider agreement effective June 1, 2010. In May, 2010, UHS entered into an agreement with CMS which abated the termination action scheduled for June 1, 2010. The agreement is one year in duration and required SWHCS to engage independent experts in various disciplines to analyze and develop implementation plans for SWHCS to meet the Medicare conditions of participation. At the conclusion of the agreement, CMS will conduct a full certification survey to determine if SWHCS has achieved substantial compliance with the Medicare conditions of participation. During the term of the agreement, SWHCS remains eligible to receive reimbursements from Medicare for services rendered to Medicare beneficiaries.

Also in April, 2010, SWHCS received notification from the California Department of Public Health (CDPH) indicating that it planned to initiate a process to revoke SWHCS s hospital license. In May, 2010, SWHCS received the formal document related to the revocation action. In September, 2010, SWHCS entered

Table of Contents

into an agreement with CDPH relating to the license revocation. The terms of the CDPH agreement are substantially similar to those contained in the agreement with CMS. As a result of the agreement, SWHCS s hospital license remains in effect pending the outcome of the CMS full certification survey which will occur at the end of the agreement. Pursuant to the results of the CMS full certification survey, which SWHCS anticipates occurring in mid-year, 2011, should SWHCS be deemed to have achieved substantial compliance with the Medicare conditions of participation, CDPH shall deem SWHCS s license to be in good standing. Failure of SWHCS to achieve substantial compliance with the Medicare conditions of participation, pursuant to CMS s full certification survey, will likely have a material adverse impact on SWHCS s ability to continue to operate the facilities.

As a result of the matters discussed above, SWHCS had not been permitted to open newly constructed capacity at Rancho Springs Medical Center and Inland Valley Medical Center. However, in February, 2011, SWHC received permission from CDPH to begin accessing the new capacity. Unrelated to these developments, SWHCS expects a competitor to open a newly constructed acute care hospital during the first quarter of 2011. UHS is unable to predict the net impact of these developments on SWHCS s results of operations in 2011 and beyond.

UHS has advised us that Rancho Springs Medical Center and Inland Valley Regional Medical Center remain fully committed to providing high-quality healthcare to their patients and the communities they serve. UHS therefore intends to work expeditiously and collaboratively with both CMS and CDPH in an effort to resolve these matters, although there can be no assurance they will be able to do so. Failure to resolve these matters could have a material adverse effect on UHS and, in turn, us. While the $2.6 million annual base rentals on Inland Valley are guaranteed by UHS through the end of the existing lease term (December, 2011), should this matter, or the opening of the above-mentioned newly constructed acute care facility by a competitor, adversely impact the future revenues and/or operating results of SWHCS, the future bonus rental earned by us on Inland Valley, as well as the underlying value of the property, may be materially adversely impacted. At December 31, 2010, the book value of the property was $19.0 million. Bonus rental revenue earned by us from Inland Valley amounted to $1.1 million during each of the years ended December 31, 2010 and 2009 and $1.0 million during the year ended December 31, 2008.

The deterioration of credit and capital markets may adversely affect our access to sources of funding and we cannot be certain of the availability and terms of capital to fund the growth of our business when needed.

To retain our status as a REIT, we are required to distribute 90% of our taxable income to shareholders and, therefore, we generally cannot use income from operations to fund our growth. Accordingly, our growth strategy depends, in part, upon our ability to raise additional capital at reasonable costs to fund new investments. We believe we will be able to raise additional debt and equity capital at reasonable costs to refinance our debts (including third-party debt held by various LLCs in which we own non-controlling equity interests) at or prior to their maturities and to invest at yields which exceed our cost of capital. Although the tightening in the credit markets has not had a material impact on us, we can provide no assurance that financing will be available to us on satisfactory terms when needed, which could harm our business. Given these uncertainties, our growth strategy is not assured and may fail.

To fund all or a portion of our future financing needs, we rely on borrowings from various sources including fixed rate, long-term debt as well as borrowings pursuant to our revolving credit agreement. If any of the lenders were unable to fulfill their future commitments, our liquidity could be impacted, which could have a material unfavorable impact our results of operations and financial condition.

In addition, the degree to which we are, or in the future may become, leveraged, our ability to obtain financing could be adversely impacted and could make us more vulnerable to competitive pressures. Our ability to meet existing and future debt obligations, depends upon our future performance and our ability to secure additional financing on satisfactory terms, each of which is subject to financial, business and other factors that are beyond our control. Any failure by us to meet our financial obligations would harm our business.

13

Table of Contents

In addition, global capital markets have experienced volatility that has tightened access to capital markets and other sources of funding. In the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

A substantial portion of our revenues are dependent upon one operator. If UHS experiences financial difficulties, or otherwise fails to make payments to us, our revenues will significantly decline.

For the year ended December 31, 2010, UHS accounted for 60% of our consolidated revenues. In addition, as of December 31, 2010, subsidiaries of UHS leased four of the seven hospital facilities owned by us with terms expiring in 2011 or 2014. We cannot assure you that UHS will renew the leases or continue to satisfy its obligations to us. The failure or inability of UHS to satisfy its obligations to us could materially reduce our revenues and net income, which could in turn reduce the amount of dividends we pay and cause our stock price to decline.

UHS s acquisition of Psychiatric Solutions, Inc.

In connection with the acquisition of Psychiatric Solutions, Inc. (PSI) by UHS during the fourth quarter of 2010, UHS has substantially increased its level of indebtedness which could, among other things, adversely affect its ability to raise additional capital to fund operations, limit its ability to react to changes in the economy or its industry and could potentially prevent them from meeting their obligations under the agreements related to their indebtedness. If UHS experiences financial difficulties and, as a result, operations of its existing facilities suffer, or UHS otherwise fails to make payments to us, our revenues will significantly decline.

Although we do not expect to be directly impacted by UHS acquisition of PSI, UHS is substantially more leveraged and we cannot assure you that UHS will continue to satisfy its obligations to us. The failure or inability of UHS to satisfy its obligations to us could materially reduce our revenues and net income, which could in turn reduce the amount of dividends we pay and cause our stock price to decline.

Our relationship with UHS may create conflicts of interest.

In addition to being dependent upon UHS for a substantial portion of our revenues and leases, since 1986, UHS of Delaware, Inc. (the Advisor), a wholly-owned subsidiary of UHS, has served as our Advisor. Pursuant to our Advisory Agreement, the Advisor is obligated to present an investment program to us, to use its best efforts to obtain investments suitable for such program (although it is not obligated to present any particular investment opportunity to us), to provide administrative services to us and to conduct our day-to-day affairs. Further, all of our officers are employees of UHS. As of December 31, 2010, we had no salaried employees although our officers do receive stock-based compensation. We believe that the quality and depth of the management and advisory services provided to us by our Advisor and UHS could not be replicated by contracting with unrelated third parties or by being self-advised without considerable cost increases. We believe that these relationships have been beneficial to us in the past, but we cannot guarantee that they will not become detrimental to us in the future.

All transactions with UHS must be approved by a majority of our Independent Trustees. We believe that our current leases and business dealings with UHS have been entered into on commercially reasonable terms. However, because of our historical and continuing relationship with UHS and its subsidiaries, in the future, our business dealings may not be on the same or as favorable terms as we might achieve with a third party with whom we do not have such a relationship. Disputes may arise between us and UHS that we are unable to resolve or the resolution of these

disputes may not be as favorable to us as a resolution we might achieve with a third party.

Table of Contents

We hold significant, non-controlling equity ownership interests in various LLCs.

For the year ended December 31, 2010, 66% of our consolidated and unconsolidated revenues were generated by LLCs in which we hold a majority, non-controlling equity ownership interest. Our level of investment and lack of control exposes us to potential losses of our investments and revenues. Although our ownership arrangements have been beneficial to us in the past, we cannot guarantee that they will continue to be beneficial in the future.

Pursuant to the operating agreements of most of the LLCs, the third-party member and the Trust, at any time, have the right to make an offer (Offering Member) to the other member(s) (Non-Offering Member) in which it either agrees to: (i) sell the entire ownership interest of the Offering Member to the Non-Offering Member (Offer to Sell) at a price as determined by the Offering Member (Transfer Price), or; (ii) purchase the entire ownership interest of the Non-Offering Member (Offer to Purchase) at the equivalent proportionate Transfer Price. The Non-Offering Member has 60 days to either: (i) purchase the entire ownership interest of the Offering Member at the Transfer Price, or; (ii) sell its entire ownership interest to the Offering Member at the equivalent proportionate Transfer Price. The closing of the transfer must occur within 60 days of the acceptance by the Non-Offering Member.

In addition to the above-mentioned rights of the third-party members, from time to time, we have had discussions with third-party members about purchasing or selling the interests to each other or a third party. If we were to sell our interests, we may not be able to redeploy the proceeds into assets at the same or greater return as we currently receive. During any such time that we were not able to do so, our ability to increase or maintain our dividend at current levels could be adversely affected which could cause our stock price to decline.

The bankruptcy, default, insolvency or financial deterioration of our tenants 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 shareholders may be adversely affected by financial difficulties experienced by any of our major tenants, including bankruptcy, insolvency or a general downturn in the business. 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.

Real estate ownership creates risks and liabilities that may result in unanticipated losses or expenses.

Our business is subject to risks associated with real estate acquisitions and ownership, including:

- general liability, property and casualty losses, some of which may be uninsured;
- the illiquid nature of real estate and the real estate market that impairs our ability to purchase or sell our assets rapidly to respond to changing economic conditions;

real estate market factors, such as the supply and demand of office space and market rental rates, changes in interest rates as well as an increase in the development of medical office condominiums in certain markets;

costs that may be incurred relating to maintenance and repair, and the need to make expenditures due to changes in governmental regulations, including the Americans with Disabilities Act;

environmental hazards at our properties for which we may be liable, including those created by prior owners or occupants, existing tenants, mortgagors or other persons, and;

defaults and bankruptcies by our tenants.

Table of Contents

In addition to the foregoing risks, we cannot predict whether the leases on our properties, including the leases on the properties leased to subsidiaries of UHS, which have options to purchase the respective leased facilities at the end of the lease or renewal terms at the appraised fair market value, will be renewed at their current rates at the end of the lease terms in 2011 or 2014. If the leases are not renewed, we may be required to find other operators for these facilities and/or enter into leases with less favorable terms. The exercise of purchase options for our facilities may result in a less favorable rate of return for us than the rental revenue currently earned on such facilities. Further, the purchase options and rights of first refusal granted to the respective lessees to purchase or lease the respective leased facilities, after the expiration of the lease term, may adversely affect our ability to sell or lease a facility, and may present a potential conflict of interest between us and UHS since the price and terms offered by a third-party are likely to be dependent, in part, upon the financial performance of the facility during the final years of the lease term.

Significant potential liabilities and rising insurance costs and availability may have an adverse effect on the operations of our operators, which may negatively impact their ability to meet their obligations to us.

As is typical in the healthcare industry, in the ordinary course of business, our operators, including UHS, are subject to medical malpractice lawsuits, product liability lawsuits, class action lawsuits and other legal actions. Some of these actions may involve large claims, as well as significant defense costs. If their ultimate liability for professional and general liability claims could change materially from current estimates, if such policy limitations should be partially or fully exhausted in the future, or payments of claims exceed estimates or are not covered by insurance, it could have a material adverse effect on the operations of our operators.

In addition, the malpractice expenses of our operators, including UHS, have increased in recent years which may increase their self-insured exposure for professional and general liability claims. There can be no assurance that insurance will continue to be available at reasonable prices that allow them to maintain adequate coverage. If these trends continue, they could have a material adverse effect on their operations. Property insurance rates, particularly for earthquake insurance in California, have also continued to increase. Three LLCs that own properties in California, in which we have various non-controlling equity interests, could not obtain earthquake insurance at rates which are economically beneficial in relation to the risks covered.

Our tenants and operators, including UHS, may be unable to fulfill their insurance, indemnification and other obligations to us under their leases and mortgages and thereby potentially expose us to those risks. In addition, our tenants and operators may be unable to pay their lease or mortgage payments, which could potentially decrease our revenues and increase our collection and litigation costs. Moreover, to the extent we are required to foreclose on the affected facilities, our revenues from those facilities could be reduced or eliminated for an extended period of time. In addition, we may in some circumstances be named as a defendant in litigation involving the actions of our operators. Although we have no involvement in the activities of our operators and our standard leases generally require our operators to carry insurance to cover us in certain cases, a significant judgment against us in such litigation could exceed our and our operators insurance coverage, which would require us to make payments to cover the judgment.

If we fail to maintain our REIT status, we will become subject to federal income tax on our taxable income at regular corporate rates.

In order to qualify as a REIT, we must comply with certain highly technical and complex Internal Revenue Code provisions. Although we believe we have been qualified as a REIT since our inception, there can be no assurance that we have been so qualified or will remain qualified in the future. Failure to qualify as a REIT may subject us to income tax liabilities, including federal income tax at regular corporate rates. The additional income tax incurred may significantly reduce the cash flow available for distribution to shareholders and for debt service. In addition, if disqualified, we might be barred from qualification as a REIT for four years following disqualification.

16

Table of Contents

Dividends paid by REITs generally do not qualify for reduced tax rates.

In general, the maximum U.S. federal income tax rate for dividends paid to individual U.S. shareholders is 15% (through 2010). Unlike dividends received from a corporation that is not a REIT, our distributions to individual shareholders generally are not eligible for the reduced rates.

Should we be unable to comply with the strict income distribution requirements applicable to REITs utilizing only cash generated by operating activities, we would be required to generate cash from other sources which could adversely affect our financial condition.

To obtain the favorable tax treatment associated with qualifying as a REIT, in general, we are required each year to distribute to our shareholders at least 90% of our net taxable income. In addition, we are subject to a tax on any undistributed portion of our income at regular corporate rates and might also be subject to a 4% excise tax on this undistributed income. To meet the distribution requirements necessary to achieve the tax benefits associated with qualifying as a REIT, we could be required to: (i) seek borrowed funds even if conditions are not favorable for borrowing; (ii) issue equity which could have a dilutive effect on the future dividends and share value of our existing shareholders; (iii) divest assets that we might have otherwise decided to retain, and/or; (iv) forgo attractive investment opportunities that we might have otherwise pursued. Securing funds through these other non-operating means could adversely affect our financial condition and future results of operations.

The market value of our common stock could be substantially affected by various factors.

Many factors, certain of which are outside of our control, could have an adverse effect on the share price of our common stock. These factors include certain of the risks discussed herein, our financial condition, performance and prospects, the market for similar securities issued by REITs, demographic changes, operating results of our operators and other hospital companies, changes in our financial estimates or recommendations of securities analysts, speculation in the press or investment community, the possible effects of war, terrorist and other hostilities, adverse weather conditions, the level of seasonal illnesses, changes in general conditions in the economy or the financial markets, or other developments affecting the health care industry.

Ownership limitations and anti-takeover provisions in our declaration of trust and bylaws and under Maryland law and in our Leases with UHS may delay, defer or prevent a change in control or other transactions that could provide shareholders with a take-over premium. We are subject to significant anti-takeover provisions.

In order to protect us against the risk of losing our REIT status for federal income tax purposes, our declaration of trust permits our Trustees to redeem shares acquired or held in excess of 9.8% of the issued and outstanding shares of our voting stock and, which in the opinion of the Trustees would jeopardize our REIT status. In addition, any acquisition of our common or preferred shares that would result in our disqualification as a REIT is null and void. The right of redemption may have the effect of delaying, deferring or preventing a change in control of our company and could adversely affect our shareholders ability to realize a premium over the market price for the shares of our common stock.

Our declaration of trust authorizes our Board of Trustees to issue additional shares of common and preferred stock and to establish the preferences, rights and other terms of any series of preferred stock that we issue. Although our Board of Trustees has no intention to do so at the present time, it could establish a series of preferred stock that could delay, defer or prevent a transaction or a change in control that might

involve the payment of a premium over the market price for our common stock or otherwise be in the best interests of our shareholders.

Pursuant to the Master Lease Document by and among us and certain subsidiaries of UHS, which governs the leases of all hospital properties with subsidiaries of UHS includes a change of control provision. The change of control provision grants UHS the right, upon one month s notice should a change of control of the Trust occur,

Table of Contents

to purchase any or all of the four leased hospital properties at their appraised fair market values. The exercise of this purchase option may result in a less favorable rate of return than the rental revenue currently earned on such facilities.

These provisions could discourage unsolicited acquisition proposals or make it more difficult for a third-party to gain control of us, which could adversely affect the market price of our securities and prevent shareholders from receiving a take-over premium.

We depend heavily on key management personnel and the departure of one or more of our key executives or a significant portion of our operators local hospital management personnel could harm our business.

The expertise and efforts of our senior executives and key members of our operators local hospital management personnel are critical to the success of our business. The loss of the services of one or more of our senior executives or of a significant portion of our operators local hospital management personnel could significantly undermine our management expertise and our operators ability to provide efficient, quality health care services at our facilities, which could harm their business, and in turn, harm our business.

Increasing investor interest in our sector and consolidation at the operator or REIT level could increase competition and reduce our profitability.

Our business is highly competitive and we expect that it may become more competitive in the future. We compete for the acquisition, leasing and financing of health care related facilities. Our competitors include, but are not limited to, other REITs, banks and other companies, including UHS, some of which are larger and may have a lower cost of capital than we do. These developments could result in fewer investment opportunities for us and lower spreads over our cost of our capital, which would hurt our growth.

We are subject to significant corporate regulation as a public company and failure to comply with all applicable regulations could subject us to liability or negatively affect our stock price.

As a publicly traded company, we are subject to a significant body of regulation, including the Sarbanes-Oxley Act of 2002. While we have developed and instituted a corporate compliance program based on what we believe are the current best practices in corporate governance and continue to update this program in response to newly implemented or changing regulatory requirements, we cannot provide assurance that we are or will be in compliance with all potentially applicable corporate regulations. For example, we cannot provide assurance that in the future our management will not find a material weakness in connection with its annual review of our internal control over financial reporting pursuant to Section 404 of the Sarbanes-Oxley Act. We also cannot provide assurance that we could correct any such weakness to allow our management to assess the effectiveness of our internal control over financial reporting as of the end of our fiscal year in time to enable our independent registered public accounting firm to state that we have maintained effective internal control over financial reporting as of the end of our fiscal year. If we fail to comply with any of these regulations, we could be subject to a range of regulatory actions, fines or other sanctions or litigation. If we must disclose any material weakness in our internal control over financial reporting, our stock price could decline.

Different interpretations of accounting principles could have a material adverse effect on our results of operations or financial condition.

Generally accepted accounting principles are complex, continually evolving and may be subject to varied interpretation by us, our independent registered public accounting firm and the SEC. Such varied interpretations could result from differing views related to specific facts and circumstances. Differences in interpretation of generally accepted accounting principles could have a material adverse effect on our financial position or results of operations.

Item 1B. ***Unresolved Staff Comments***

None.

Table of Contents

ITEM 2. ***Properties***

The following table shows our investments in hospital facilities leased to UHS and other non-related parties. The table on the next page provides information related to various properties in which we have significant investments, some of which are accounted for by the equity method. The capacity in terms of beds (for the hospital facilities) and the five-year occupancy levels are based on information provided by the lessees.

Hospital Facility Name and Location	Type of facility	Number of available beds @ 12/31/10	Average Occupancy(1)					Lease Term		
			2010	2009	2008	2007	2006	Minimum rent	End of initial or renewed term	Renewal term (years)
Southwest Healthcare System: Inland Valley Campus(2) Wildomar, California	Acute Care	122	78%	77%	77%	67%	85%	$ 2,648,000	2011	20
McAllen Medical Center(3) McAllen, Texas	Acute Care	428	47%	50%	50%	51%	52%	5,485,000	2011	20
Wellington Regional Medical Center West Palm Beach, Florida	Acute Care	158	70%	71%	74%	78%	77%	3,030,000	2011	20
The Bridgeway North Little Rock, Arkansas	Behavioral Health	112	77%	79%	83%	94%	92%	930,000	2014	10
HealthSouth Deaconess Rehabilitation Hospital Evansville, Indiana	Rehabilitation	80	71%	60%	55%	57%	53%	775,000	2014	10
Kindred Hospital Corpus Christi Corpus Christi, Texas	Sub-Acute Care	74	64%	61%	63%			687,000	2019	25
Kindred Hospital Chicago Central Chicago, Illinois	Sub-Acute Care	84	40%	45%	44%	38%	46%	1,412,000	2016	10

Facility Name and Location	Type of facility	Average Occupancy(1)					Lease Term		
		2010	2009	2008	2007	2006	Minimum rent(5)	End of initial or renewed term(4)	Renewal term (years)
Desert Springs Medical Plaza(4) Las Vegas, Nevada	MOB	65%	74%	78%	77%	96%	1,105,000	2011-2025	Various
Deer Valley Medical Office I Phoenix, Arizona	MOB	95%	100%	100%	100%	100%	2,006,000	2012-2017	Various
Deer Valley Medical Office II Phoenix, Arizona	MOB	78%	53%				1,475,000	2017-2024	Various
Spring Valley MOB I(4) Las Vegas, Nevada	MOB	93%	96%	96%	95%	91%	732,000	2011-2018	Various
Spring Valley MOB II(4) Las Vegas, Nevada	MOB	53%	51%	50%	50%		861,000	2014-2020	Various
	MOB	91%	95%	98%	98%	98%	1,459,000	2011-2016	Various

Summerlin Hospital MOB I(4) Las Vegas, Nevada									
Summerlin Hospital MOB II(4) Las Vegas, Nevada	MOB	97%	100%	100%	100%	100%	1,301,000	2011-2015	Various
Summerlin Hospital MOB III(4) Las Vegas, Nevada	MOB	63%	63%				1,299,000	2014-2021	Various
Sheffield Medical Building Atlanta, Georgia	MOB	66%	73%	77%	82%	86%	1,170,000	2011-2021	Various
St. Mary s Professional Office Building Reno, Nevada	MOB	99%	99%	97%	95%	92%	4,182,000	2012-2025	Various
Rosenberg Children s Medical Plaza Phoenix, Arizona	MOB	100%	100%	99%	97%	94%	1,948,000	2012-2018	Various
Palmdale Medical Plaza Palmdale, California	MOB	75%	75%				1,090,000	2013-2014	Various

Table of Contents

N/A Not Applicable

(1) Average occupancy rate for the hospital facilities is based on the average number of available beds occupied during each of the five years ended December 31, 2010. Average available beds is the number of beds which are actually in service at any given time for immediate patient use with the necessary equipment and staff available for patient care. A hospital may have appropriate licenses for more beds than are in service for a number of reasons, including lack of demand, incomplete construction and anticipation of future needs. The average occupancy rate of a hospital is affected by a number of factors, including the number of physicians using the hospital, changes in the number of beds, the composition and size of the population of the community in which the hospital is located, general and local economic conditions, variations in local medical and surgical practices and the degree of outpatient use of the hospital services. Average occupancy rate for the multi-tenant medical office buildings is based on the occupied square footage of each building, including any applicable master leases.

(2) In July, 2002, the operations of Inland Valley Regional Medical Center (Inland Valley) were merged with the operations of Rancho Springs Medical Center (Rancho Springs), an acute care hospital located in California and also operated by UHS, the real estate assets of which are not owned by us. Inland Valley, our lessee, was merged into Universal Health Services of Rancho Springs, Inc. The merged entity is now doing business as Southwest Healthcare System (Southwest Healthcare). As a result of merging the operations of the two facilities, the revenues of Southwest Healthcare include the revenues of both Inland Valley and Rancho Springs. Although we do not own the real estate assets of the Rancho Springs facility, Southwest Healthcare became the lessee on the lease relating to the real estate assets of the Inland Valley facility. Since the bonus rent calculation for the Inland Valley campus is based on net revenues and the financial results of the two facilities are no longer separable, the lease was amended during 2002 to exclude from the bonus rent calculation the estimated net revenues generated at the Rancho Springs campus (as calculated pursuant to a percentage based allocation determined at the time of the merger). The average occupancy rates shown for this facility for all years were based on the combined number of beds occupied at the Inland Valley and Rancho Springs campuses.

(3) During the first quarter of 2001, UHS purchased the assets and operations of the 60-bed McAllen Heart Hospital located in McAllen, Texas. Upon the acquisition by UHS, the Heart Hospital began operating under the same license as an integrated department of McAllen Medical Center. As a result of combining the operations of the two facilities, the revenues of McAllen Medical Center include revenues generated by the Heart Hospital, the real property of which is not owned by us. Accordingly, since the bonus rent calculation for McAllen Medical Center is based on the combined net revenues of the two facilities, the McAllen Medical Center lease was amended during 2001 to exclude from the bonus rent calculation, the estimated net revenues generated at the Heart Hospital (as calculated pursuant to a percentage based allocation determined at the time of the merger). In addition, during 2000, UHS purchased the South Texas Behavioral Health Center, a behavioral health care facility located in McAllen, Texas. In 2006, a newly constructed replacement facility for the South Texas Behavioral Health Center was completed and opened. The license for this facility, the real property of which is not owned by us, was also merged with the license for McAllen Medical Center. There was no amendment to the McAllen Medical Center lease related to the operations of the South Texas Behavioral Health Center. The revenues of South Texas Behavioral Health Center are excluded from the bonus rent calculation. No assurance can be given as to the effect, if any, the consolidation of the facilities as mentioned above, had on the underlying value of McAllen Medical Center. Base rental commitments and the guarantee by UHS under the original lease continue for the remainder of the lease terms. The average occupancy rates shown for this facility prior to 2009 were based on the combined number of beds at McAllen Medical Center, McAllen Heart Hospital and South Texas Behavioral Health Center. For 2009 and 2010, the occupancy rates were based upon the combined numbers of beds at McAllen Medical Center and McAllen Heart Hospital.

(4) The real estate assets of this facility are owned by an LLC in which we own a non-controlling equity interest and include tenants who are unaffiliated third-parties or subsidiaries of UHS.

(5) Minimum rent amounts include impact of straight-line rent adjustments.

Table of Contents

Set forth is information detailing the rentable square feet (RSF) associated with each of our investments and the percentage of RSF on which leases expire during the next five years and thereafter:

			Percentage of RSF with lease expirations					
	Total RSF	Available for Lease Jan. 1, 2011	2011	2012	2013	2014	2015	2016 and Later
Hospital Investments								
McAllen Medical Center	422,276	0%	100%	0%	0%	0%	0%	0%
Wellington Regional Medical Center	196,489	0%	100%	0%	0%	0%	0%	0%
Southwest Healthcare System Inland Valley Campus.	124,644	0%	100%	0%	0%	0%	0%	0%
Kindred Hospital Chicago Central	115,554	0%	0%	0%	0%	0%	0%	100%
The Bridgeway	77,901	0%	0%	0%	0%	100%	0%	0%
HealthSouth Deaconess Rehab. Hospital	77,440	0%	0%	0%	0%	100%	0%	0%
Kindred Hospital Corpus Christi	69,700	0%	0%	0%	0%	0%	0%	100%
Subtotal Hospitals	1,084,004	0%	69%	0%	0%	14%	0%	17%
Other Investments								
Medical Office Buildings:								
Desert Samaritan Hospital MOBs	201,108	28%	21%	15%	8%	7%	4%	17%
Saint Mary s Professional Office Building	190,754	0%	0%	2%	1%	0%	4%	93%
Edwards Medical Plaza	141,034	11%	11%	30%	20%	7%	5%	16%
700 Shadow Lane and Goldring MOBs	116,834	11%	11%	20%	35%	3%	5%	15%
Texoma Medical Plaza(b)	115,284	25%	0%	0%	0%	0%	27%	48%
Centinela Medical Buildings	103,388	27%	27%	9%	11%	19%	6%	1%
Suburban Medical Plaza II	102,818	0%	21%	6%	0%	21%	10%	42%
Desert Springs Medical Plaza	102,579	31%	5%	19%	11%	0%	19%	15%
Centennial Hills Medical Office Building I	96,713	30%	0%	0%	20%	15%	8%	27%
Thunderbird Paseo Medical Plaza I & II	96,569	1%	16%	27%	18%	5%	8%	25%
Summerlin Hospital Medical Office Building II	92,313	16%	17%	34%	16%	7%	2%	8%
Canyon Springs Medical Plaza	91,957	2%	0%	14%	0%	2%	6%	76%
Summerlin Hospital Medical Office Building I	89,636	15%	21%	14%	26%	10%	12%	2%
Vista Medical Terrace & The Sparks Medical Building.	85,668	36%	16%	22%	3%	2%	7%	14%
North Valley Medical Plaza	80,304	58%	6%	2%	7%	4%	14%	9%
Papago Medical Park	79,247	9%	0%	5%	48%	17%	9%	12%
Summerlin Hospital Medical Office Building III	77,713	37%	0%	0%	0%	18%	2%	43%
Deer Valley Medical Office II	77,264	8%	1%	46%	7%	0%	18%	20%
Deer Valley Medical Office III	76,921	19%	0%	0%	0%	0%	0%	81%
Mid Coast Hospital MOB	74,629	0%	16%	0%	12%	0%	0%	72%
Sheffield Medical Building	71,940	33%	8%	31%	6%	4%	3%	15%
Rosenberg Children s Medical Plaza	66,231	0%	0%	7%	53%	0%	3%	37%
Sierra San Antonio Medical Plaza	59,160	32%	18%	0%	12%	0%	4%	34%
Palmdale Medical Plaza(a)	58,150	25%	0%	0%	59%	16%	0%	0%
Spring Valley Medical Office Building	57,828	18%	16%	30%	24%	5%	4%	3%
Spring Valley Medical Office Building II	57,635	24%	0%	0%	0%	10%	0%	66%
Desert Valley Medical Center	53,734	28%	9%	8%	9%	5%	7%	34%
Southern Crescent Center II	53,680	82%	0%	8%	0%	0%	0%	10%
Southern Crescent Center I	41,400	30%	0%	22%	4%	22%	0%	22%
Auburn Medical II	41,311	16%	0%	0%	0%	0%	0%	84%
BRB Medical Office Building	40,733	10%	0%	0%	0%	0%	17%	73%
Cypresswood Professional Center	40,082	13%	0%	17%	0%	12%	58%	0%
Medical Center of Western Connecticut	36,341	6%	5%	0%	5%	17%	0%	67%
Phoenix Children s East Valley Care Center	30,960	0%	0%	0%	0%	0%	0%	100%
Apache Junction Medical Plaza	26,901	9%	13%	13%	34%	0%	31%	0%
Santa Fe Professional Plaza	25,294	39%	11%	27%	17%	0%	0%	6%
Professional Bldg at King s Crossing	24,318	32%	0%	6%	0%	0%	25%	37%
Cobre Valley Medical Plaza	21,882	0%	20%	63%	17%	0%	0%	0%
Kelsey-Seybold Clinic at King s Crossing	20,470	0%	0%	0%	0%	0%	0%	100%

Orthopaedic Specialists of Nevada Building	11,000	100%	0%	0%	0%	0%	0%	0%
Family Doctor s MOB	9,155	0%	100%	0%	0%	0%	0%	0%
Preschool and Childcare Centers:								
Chesterbrook Academy Audubon	8,300	0%	0%	0%	0%	0%	0%	100%
Chesterbrook Academy Uwchlan	8,163	0%	0%	0%	0%	0%	0%	100%
Chesterbrook Academy Newtown	8,100	0%	0%	0%	0%	0%	0%	100%
Chesterbrook Academy New Britain	7,998	0%	0%	0%	0%	0%	0%	100%
Sub-total Other Investments	2,973,499	19%	9%	13%	12%	6%	8%	33%
Total	4,057,503	14%	25%	9%	9%	8%	6%	29%

Table of Contents

a) The Palmdale Medical Plaza has a 75% master lease commitment from UHS that expires at the earlier of the commitment threshold being met or the scheduled expiration in June, 2013.
b) The Texoma Medical Plaza has a 75% master lease commitment from UHS that expires at the earlier of the commitment threshold being met or the scheduled expiration in February 14, 2015.

The average effective annual rental per square foot for our hospital properties was $17.64 during 2010 as compared to $17.81 during 2009, based upon consolidated revenues and total square footage for the hospital facilities. The average effective annual rental per square foot related to our MOBs and childcare centers was $26.96 during 2010 as compared to $26.67 during 2009, based upon the consolidated and unconsolidated revenues and the estimated average occupied square footage for all of our MOBs and childcare centers. On a combined basis, based upon all consolidated and unconsolidated revenues and estimated average occupied square footage, the average effective annual rental per square foot for our properties on a portfolio basis was $24.08 during 2010 as compared to $23.84 during 2009. The estimated average occupied square footage for 2010 was calculated by averaging the unavailable rentable square footage on January 1, 2010 and January 1, 2011. The estimated average occupied square footage for 2009 was calculated by averaging the unavailable rentable square footage on January 1, 2009 and January 1, 2010.

During 2010, each of three UHS-related hospitals (McAllen Medical Center, Wellington Regional Medical Center and Southwest Healthcare System-Inland Valley Campus) generated revenues that comprised more than 10% of our consolidated revenues. As of December 31, 2010, McAllen Medical Center and Wellington Regional Medical Center had book values of approximately 10% or greater of our total assets**.** Including 100% of the revenues generated at the properties owned by our unconsolidated LLCs, none of our unconsolidated LLCs had revenues greater than 10% of the combined consolidated and unconsolidated revenues during 2010. Including 100% of the book values of the properties owned by our unconsolidated LLCs, none of the properties had book values greater than 10% of the consolidated and unconsolidated assets.

The following table sets forth the average effective annual rental per square foot for 2010, based upon average occupied square feet for McAllen Medical Center, Wellington Regional Medical Center and Southwest Healthcare System-Inland Valley Campus:

Property	2010 Average Occupied Square Feet	2010 Revenues	2010 Average Effective Rental Per Square Foot
McAllen Medical Center	422,276	$ 7,070,000	$ 16.74
Wellington Regional Medical Center	196,489	$ 4,242,000	$ 21.59
Southwest Healthcare System-Inland Valley Campus	124,644	$ 3,768,000	$ 30.23

Table of Contents

The following table sets forth lease expirations for each of the next ten years:

	Expiring Square Feet	Number of Tenants	Annual Rental of Expiring Leases(1)	Percentage of Annual Rental(2)
Hospital properties				
2011	858,963	4	$ 12,563,000	16%
2012	0	0	$ 0	0%
2013	0	0	$ 0	0%
2014	155,341	2	$ 1,705,000	2%
2015	0	0	$ 0	0%
2016	0	0	$ 0	0%
2017	0	0	$ 0	0%
2018	0	0	$ 0	0%
2019	69,700	1	$ 668,000	1%
2020	0	0	$ 0	0%
Thereafter	0	0	$ 0	0%
Subtotal-hospital facilities	1,084,004	7	$ 14,936,000	19%
Other consolidated properties				
2011	18,682	7	$ 644,000	1%
2012	43,516	13	$ 1,240,000	2%
2013	8,094	5	$ 254,000	0%
2014	32,598	7	$ 877,000	1%
2015	31,487	6	$ 791,000	1%
2016	30,377	6	$ 678,000	1%
2017	6,588	1	$ 233,000	0%
2018	12,670	3	$ 294,000	0%
2019	19,200	2	$ 677,000	1%
2020	22,514	2	$ 514,000	1%
Thereafter	20,738	3	$ 462,000	1%
Subtotal-other consolidated properties	246,464	55	$ 6,664,000	9%
Other unconsolidated properties (MOBs)				
2011	242,402	106	$ 6,602,000	8%
2012	328,569	102	$ 9,027,000	11%
2013	319,178	100	$ 8,551,000	11%
2014	134,558	49	$ 3,576,000	4%
2015	174,073	57	$ 4,680,000	6%
2016	147,100	29	$ 3,906,000	5%
2017	144,429	23	$ 4,425,000	5%
2018	85,236	17	$ 2,187,000	3%
2019	46,760	12	$ 1,639,000	2%
2020	191,616	31	$ 5,327,000	7%
Thereafter	253,485	24	$ 7,369,000	10%
Subtotal-other unconsolidated properties	2,067,406	550	$ 57,289,000	72%
Total all properties	3,397,874	612	$ 78,889,000	100%

(1) Based upon 2010 rental revenue excluding the bonus rental revenue earned on the UHS hospital facilities and including 100% of the revenues generated at the unconsolidated LLCs in which we hold various non-controlling ownership interests.

(2) Percentages based upon 2010 rental revenues, excluding the bonus rental earned on the UHS hospital facilities and including 100% of the revenues generated at the unconsolidated LLCs in which we hold various non-controlling ownership interests.

Table of Contents

ITEM 3. ***Legal Proceedings***

None

ITEM 4. ***[Reserved]***

PART II

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

Market Information

Our shares of beneficial interest are listed on the New York Stock Exchange. The high and low closing sales prices for our shares of beneficial interest for each quarter in the years ended December 31, 2010 and 2009 are summarized below:

	2010		2009	
	High Price	Low Price	High Price	Low Price
First Quarter	$ 36.54	$ 31.92	$ 34.32	$ 25.11
Second Quarter	$ 36.00	$ 30.79	$ 33.94	$ 30.08
Third Quarter	$ 34.53	$ 31.50	$ 35.28	$ 29.49
Fourth Quarter	$ 38.40	$ 34.78	$ 32.55	$ 30.27

Holders

As of January 31, 2011, there were approximately 462 shareholders of record of our shares of beneficial interest.

Dividends

It is our intention to declare quarterly dividends to the holders of our shares of beneficial interest so as to comply with applicable sections of the Internal Revenue Code governing REITs. Our revolving credit facility limits our ability to increase dividends in excess of 95% of cash available for distribution, as defined in our revolving credit agreement, unless additional distributions are required to be made so as to comply with applicable sections of the Internal Revenue Code and related regulations governing REITs. In each of the past two years, dividends per share were declared as follows:

	2010	2009
First Quarter	$ .600	$ .590
Second Quarter	.605	.595
Third Quarter	.605	.595
Fourth Quarter	.605	.600
	$ 2.415	**$ 2.38**

Table of Contents

Stock Price Performance Graph

The following graph compares our performance with that of the S&P 500 and a group of peer companies, where performance has been weighted based on market capitalization. Companies in our peer group are as follows: HCP, Inc., Nationwide Health Properties, Inc., Omega Healthcare Investors, Inc., Health Care REIT, Inc., Healthcare Realty Trust, Inc., LTC Properties, Inc., National Health Investors, Inc. and National Health Realty, Inc. (included through 2006).

The Stock Price Performance Graph shall not be deemed incorporated by reference by any general statement incorporating by reference in this Form 10-K into any filing under the Securities Act of 1933 or under the Securities Exchange Act of 1934, except to the extent we specifically incorporate this information by reference, and shall not otherwise be deemed filed under such Acts.

The total cumulative return on investment (change in the year-end stock price plus reinvested dividends) for each of the periods for us, the peer group and the S&P 500 composite is based on the stock price or composite index at the end of fiscal 2005.

	Base Period	INDEXED RETURNS Years Ending				
Company Name/Index	**Dec 2005**	**Dec 2006**	**Dec 2007**	**Dec 2008**	**Dec 2009**	**Dec 2010**
Universal Health Realty Income Trust	**$ 100**	$ 132.50	$ 128.58	$ 127.97	$ 134.29	$ 164.16
S&P 500 Index	**$ 100**	$ 115.79	$ 122.16	$ 76.96	$ 97.33	$ 111.99
Peer Group	**$ 100**	$ 143.55	$ 143.45	$ 134.10	$ 161.33	$ 192.94

Table of Contents

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

The following table contains our selected financial data for, or at the end of, each of the five years ended December 31, 2010. You should read this table in conjunction with our consolidated financial statements and related notes contained elsewhere in this Annual Report and Part II, Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations.

	(000s, except per share amounts)				
	2010	**2009**	**2008**	**2007**	**2006**
Operating Results:					
Total revenue(1)	$ 28,878	$ 31,914	$ 29,184	$ 27,960	$ 31,714
Income from continuing operations	16,310	18,576	11,653	19,664	34,428
Income from discontinued operations, net (including gain on sale of real property of $2,270 during 2007)				2,527	269
Net income	$ 16,310	$ 18,576	$ 11,653	$ 22,191	$ 34,697
Balance Sheet Data:					
Real estate investments, net of accumulated depreciation(1)	$ 125,257	$ 154,540	$ 154,649	$ 143,797	$ 143,363
Investments in LLCs(1)	80,442	61,934	56,462	52,030	47,223
Total assets(1)	216,135	228,825	221,056	199,749	194,139
Total indebtedness(1)(2)	67,563	84,267	71,692	36,617	26,337
Other Data:					
Funds from operations(3)	$ 32,582	$ 33,325	$ 24,996	$ 29,066	$ 28,930
Cash provided by (used in):					
Operating activities	23,049	24,984	21,769	22,767	24,702
Investing activities	(17,302)	(12,362)	(26,923)	(4,336)	(2,404)
Financing activities	(7,798)	(10,202)	4,641	(18,098)	(23,217)
Per Share Data:					
Basic earnings per share:					
From continuing operations	$ 1.33	$ 1.56	$ 0.98	$ 1.66	$ 2.92
From discontinued operations				0.21	0.02
Total basic earnings per share	$ 1.33	$ 1.56	$ 0.98	$ 1.87	$ 2.94
Diluted earnings per share:					
From continuing operations	$ 1.33	$ 1.56	$ 0.98	$ 1.66	$ 2.90
From discontinued operations				0.21	0.02
Total diluted earnings per share	$ 1.33	$ 1.56	$ 0.98	$ 1.87	$ 2.92
Dividends per share	$ 2.415	$ 2.380	$ 2.340	$ 2.300	$ 2.260
Other Information (in thousands)					
Weighted average number of shares outstanding basic	12,259	11,891	11,851		