

LSI CORP
Form S-8 POS
May 21, 2014

Registration No. 333-188773

Registration No. 333-179076

Registration No. 333-188773

Registration No. 333-167210

Registration No. 333-151311

Registration No. 333-142038

Registration No. 333-136560

Registration No. 333-126594

Registration No. 333-115762

Registration No. 333-106206

Registration No. 333-106205

Registration No. 333-98807

Registration No. 333-96555

Registration No. 333-96549

Registration No. 333-96543

Registration No. 333-71900

Registration No. 333-69380

Registration No. 333-66238

Registration No. 333-66240

Registration No. 333-62960

Registration No. 333-57152

Registration No. 333-53584

Registration No. 333-52050

Registration No. 333-46436

Registration No. 333-43306
Registration No. 333-42888
Registration No. 333-38746
Registration No. 333-95421
Registration No. 333-90951
Registration No. 333-81437
Registration No. 333-81433
Registration No. 333-81435
Registration No. 333-74627
Registration No. 333-62159
Registration No. 333-57563
Registration No. 333-34285
Registration No. 333-12887
Registration No. 33-59981
Registration No. 33-59987
Registration No. 33-59985
Registration No. 33-55697
Registration No. 33-55633
Registration No. 33-55631
Registration No. 33-66548
Registration No. 33-66546
Registration No. 33-53054
Registration No. 33-42000
Registration No. 33-41999
Registration No. 33-36249
Registration No. 33-17720

Registration No. 33-30386

Registration No. 33-30385

Registration No. 33-13265

Registration No. 33-6203

Registration No. 33-6188

Registration No. 2-98732

Registration No. 2-91907

Registration No. 2-86474

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-188773

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-179076

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-188773

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-167210

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-151311

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-142038

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-136560

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-126594

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-115762

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-106206

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-106205

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-98807

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-96555

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-96549

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-96543

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-71900

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-69380

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-66238

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-66240

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-62960

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-57152

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-53584

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-52050

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-46436

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-43306

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-42888

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-38746

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-95421

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-90951

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-81437

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-81433

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-81435

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-74627

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-62159

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-57563

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 333-34285

POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-12887
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-59981
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-59987
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-59985
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-55697
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-55633
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-55631
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-66548
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-66546
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-53054
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-42000
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-41999
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-36249
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-17720
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-30386
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 33-30385
POST-EFFECTIVE AMENDMENT NO. 2 TO FORM S-8 REGISTRATION STATEMENT NO. 33-13265
POST-EFFECTIVE AMENDMENT NO. 2 TO FORM S-8 REGISTRATION STATEMENT NO. 33-6203
POST-EFFECTIVE AMENDMENT NO. 2 TO FORM S-8 REGISTRATION STATEMENT NO. 33-6188
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 2-98732
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 2-91907
POST-EFFECTIVE AMENDMENT NO. 1 TO FORM S-8 REGISTRATION STATEMENT NO. 2-86474

UNDER

THE SECURITIES ACT OF 1933

LSI CORPORATION

(Exact Name of Registrant as Specified in Its Charter)

Delaware
(State or Other Jurisdiction of
Incorporation or Organization)

94-2712976
(I.R.S. Employer
Identification Number)

1320 Ridder Park Drive

San Jose, California 95131

(408) 433-8000

(Address of Principal Executive Offices including Zip Code)

LSI Corporation 2003 Equity Incentive Plan

SandForce, Inc. 2007 Stock Plan

Option to Purchase Syntax Stock Agreement with Joseph M. Martin

LSI Corporation Employee Stock Purchase Plan

Standalone SandForce, Inc. Restricted Stock Units Agreement with Farbod Michael Raam

Agere Systems Inc. Non-Employee Director Stock Plan

1996 Lucent Long Term Incentive Program for Agere Employees

1997 Lucent Long Term Incentive Plan for Agere Employees

Agere, Inc. 1998 Stock Plan for Agere Systems Inc. Employees

Ascend Communications, Inc. 1998 Stock Incentive Plan for Agere Employees

Ascend Communications, Inc. 1998 Supplemental Stock Incentive Plan for Agere Employees

1998 Global Stock Option Plan for Agere Employees

Herrmann Technology, Inc. 1999 Incentive Stock Option Plan for Agere Employees

Herrmann Technology, Inc. Stock Option Program for Agere Employees

International Network Services 1998 Nonstatutory Stock Option Plan for Agere Employees

Livingston Enterprises, Inc. 1994 Stock Option Plan for Agere Employees

1994 Equity Participation Plan of Ortel Corporation for Agere Employees

1999 Non-Qualified Stock Option Plan for Employees of Ortel Corporation for Agere Employees

Stratus Computer, Inc. 1997 Non-Qualified Common Stock Option Plan for Agere Employees

Agere Systems Inc. 2001 Long Term Incentive Plan

Yurie Systems, Inc. Amended and Restated 1996 Nonstatutory Stock Option Plan for Agere Employees

LSI Logic Corporation International Employee Stock Purchase Plan

Stand-Alone Stock Option Agreement

LSI Logic Corporation 1995 Director Option Plan

LSI Logic Corporation 1999 Nonstatutory Stock Option Plan

LSI Logic Corporation 1991 Equity Incentive Plan Amended and Restated

LSI Logic Corporation 2001 Supplemental Stock Issuance Plan

Options Granted Under the C-Cube Microsystems Inc. 2000 Stock Plan and Assumed by LSI Logic Corporation

Options Granted Under the C-Cube Microsystems Inc. Director Stock Option Plan and Assumed by LSI Logic Corporation

Syntax Systems, Inc. Restated Stock Option Plan of January 5, 1999

DataPath Systems, Inc. Amended 1994 Stock Option Plan

DataPath Systems, Inc. Amended and Restated 1997 Stock Option Plan

Two DataPath Systems, Inc. Individual Stock Option Agreements

IntraServer Technology, Inc. 1998 Stock Option Plan

SEEQ Technology, Inc. 1982 Stock Option Plan Amended and Restated

SEEQ Technology, Inc. 1989 Nonemployee Director Stock Option Plan Amended

Symbios Logic Inc. 1995 Stock Plan

1986 Directors Stock Option Plan

1982 Incentive Stock Option Plan

1982 Stock Purchase Plan

1983 Junior Incentive Stock Plan

(Full title of the plans)

Corporation Service Company

1090 Vermont Avenue NW

Washington, D.C. 20005

Tel: (800) 222-2122

**(Name and Address, Including Zip Code, and Telephone Number,
Including Area Code, of Agent for Service)**

Copy To:

**Anthony J. Richmond
Latham & Watkins LLP
Menlo Park, California 94025
Telephone: (650) 328-4600
Facsimile: (650) 463-2600**

**Anthony E. Maslowski
President, Treasurer and Secretary
LSI CORPORATION
350 West Trimble Road, Building 90
San Jose, California 95131**

(408) 435-7400

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 definition 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

Non-accelerated filer (do not check if a smaller reporting company)

Smaller reporting company

DEREGISTRATION OF SECURITIES

This Post-Effective Amendment (this Post-Effective Amendment) relates to the following registration statements of LSI Corporation (the Registrant) filed with the Securities and Exchange Commission (the Commission) on Form S-8 (the Registration Statements):

Registration Statement No. 333-188773 for the sale of 7,368,792 shares of the common stock of the Registrant, par value \$0.01 per share (the Common Stock) under the LSI Corporation 2003 Equity Incentive Plan (the 2003 Equity Plan).

Registration Statement No. 333-179076 for the sale of 8,766,088 shares of the Common Stock under the SandForce, Inc. 2007 Stock Plan.

Registration Statement No. 333-188773 for the sale of 10,167,806 shares of the Common Stock under the 2003 Equity Plan.

Registration Statement No. 333-188773 for the sale of 18,518,729 shares of the Common Stock under the LSI Corporation Employee Stock Purchase Plan (the Employee Plan).

Registration Statement No. 333-179076 for the sale of 466,847 shares of the Common Stock under the Standalone SandForce, Inc. Restricted Stock Units Agreement with Farbod Michael Raam.

Registration Statement No. 333-167210 for the sale of 42,701,769 shares of the Common Stock under the 2003 Equity Plan.

Registration Statement No. 333-167210 for the sale of 15,513,486 shares of the Common Stock under the Employee Plan.

Registration Statement No. 333-151311 for the sale of 44,690,524 shares of the Common Stock under the 2003 Equity Plan.

Registration Statement No. 333-151311 for the sale of 13,677,805 shares of the Common Stock under the Employee Plan.

Registration Statement No. 333-142038 for the sale of 49,781,196 shares of the Common Stock under the Agere Systems Inc. Non-Employee Director Stock Plan, 1996 Lucent Long Term Incentive Program for Agere Employees, 1997 Lucent Long Term Incentive Plan for Agere Employees, Agere, Inc. 1998 Stock Plan for Agere Systems Inc. Employees, Ascend Communications, Inc. 1998 Stock Incentive Plan for Agere Employees, Ascend Communications, Inc. 1998 Supplemental Stock Incentive Plan for Agere Employees,

Edgar Filing: LSI CORP - Form S-8 POS

1998 Global Stock Option Plan for Agere Employees, Herrmann Technology, Inc. 1999 Incentive Stock Option Plan for Agere Employees, Herrmann Technology, Inc. Stock Option Program for Agere Employees, International Network Services 1998 Nonstatutory Stock Option Plan for Agere Employees, Livingston Enterprises, Inc. 1994 Stock Option Plan for Agere Employees, 1994 Equity Participation Plan of Ortel Corporation for Agere Employees, 1999 Non-Qualified Stock Option Plan for Employees of Ortel Corporation for Agere Employees, Stratus Computer, Inc. 1997 Non-Qualified Common Stock Option Plan for Agere Employees, Agere Systems Inc. 2001 Long Term Incentive Plan and Yurie Systems, Inc. Amended and Restated 1996 Nonstatutory Stock Option Plan for Agere Employees.

Registration Statement No. 333-136560 for the sale of 9,000,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 333-136560 for the sale of 1,000,000 shares of the Common Stock under the LSI Logic Corporation International Employee Stock Purchase Plan (the International Plan).

Registration Statement No. 333-126594 for the sale of 500,000 shares of the Common Stock under the Stand-Alone Stock Option Agreement.

Registration Statement No. 333-115762 for the sale of 9,000,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 333-115762 for the sale of 1,000,000 shares of the Common Stock under the International Plan.

Registration Statement No. 333-106206 for the sale of 11,000,000 shares of the Common Stock under the 2003 Equity Plan.

Registration Statement No. 333-106205 for the sale of 1,000,000 shares of the Common Stock under the LSI Logic Corporation 1995 Director Option Plan (the 1995 Director Plan).

Registration Statement No. 333-98807 for the sale of 1,000,000 shares of the Common Stock under the International Plan.

Registration Statement No. 333-96555 for the sale of 10,000,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 333-96549 for the sale of 10,000,000 shares of the Common Stock under the LSI Logic Corporation 1999 Nonstatutory Stock Option Plan (the 1999 Plan).

Registration Statement No. 333-96543 for the sale of 6,000,000 shares of the Common Stock under the LSI Logic Corporation 1991 Equity Incentive Plan Amended and Restated (the 1991 Plan).

Registration Statement No. 333-71900 for the sale of 316,042 shares of the Common Stock under the LSI Logic Corporation 2001 Supplemental Stock Issuance Plan.

Registration Statement No. 333-69380 for the sale of 13,000,000 shares of the Common Stock under the 1999 Plan.

Registration Statement No. 333-66238 for the sale of 5,000,000 shares of the Common Stock under the 1991 Plan.

Registration Statement No. 333-66240 for the sale of 10,000,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 333-62960 for the sale of 10,490,240 shares of the Common Stock under the Options Granted Under the C-Cube Microsystems Inc. 2000 Stock Plan and Assumed by LSI Logic Corporation.

Registration Statement No. 333-62960 for the sale of 126,400 shares of the Common Stock under the Options Granted Under the C-Cube Microsystems Inc. Director Stock Option Plan and Assumed by LSI Logic Corporation.

Registration Statement No. 333-57152 for the sale of 2,403,643 shares of the Common Stock under the Employee Plan.

Registration Statement No. 333-53584 for the sale of 12,000,000 shares of the Common Stock under the 1999 Plan.

Registration Statement No. 333-52050 for the sale of 611,241 shares of the Common Stock under the Syntax Systems, Inc. Restated Stock Option Plan of January 5, 1999.

Registration Statement No. 333-46436 for the sale of 2,500,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 333-43306 for the sale of 10,000,000 shares of the Common Stock under the 1991 Plan.

Edgar Filing: LSI CORP - Form S-8 POS

Registration Statement No. 333-42888 for the sale of 470,052 shares of the Common Stock under the DataPath Systems, Inc. Amended 1994 Stock Option Plan.

Registration Statement No. 333-42888 for the sale of 1,058,752 shares of the Common Stock under the DataPath Systems, Inc. Amended and Restated 1997 Stock Option Plan.

Registration Statement No. 333-42888 for the sale of 32,019 shares of the Common Stock under the Two DataPath Systems, Inc. Individual Stock Option Agreements.

Registration Statement No. 333-38746 for the sale of 154,709 shares of the Common Stock under the IntraServer Technology, Inc. 1998 Stock Option Plan.

Registration Statement No. 333-95421 for the sale of 1,307,474 shares of the Common Stock under the Employee Plan.

Registration Statement No. 333-90951 for the sale of 7,000,000 shares of the Common Stock under the 1999 Plan.

Registration Statement No. 333-81437 for the sale of 6,250,000 shares of the Common Stock under the 1991 Plan.

Registration Statement No. 333-81433 for the sale of 750,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 333-81435 for the sale of 378,043 shares of the Common Stock under the SEEQ Technology, Inc. 1982 Stock Option Plan Amended and Restated and the SEEQ Technology, Inc. 1989 Nonemployee Director Stock Option Plan Amended.

Registration Statement No. 333-74627 for the sale of 1,449,473 shares of the Common Stock under the Employee Plan and the International Plan.

Registration Statement No. 333-62159 for the sale of 2,076,118 shares of the Common Stock under the Symbios Logic Inc. 1995 Stock Plan.

Registration Statement No. 333-57563 for the sale of 7,000,000 shares of the Common Stock under the 1991 Plan.

Registration Statement No. 333-34285 for the sale of 4,191,460 shares of the Common Stock under the Employee Plan and the 1991 Plan.

Edgar Filing: LSI CORP - Form S-8 POS

Registration Statement No. 333-12887 for the sale of 300,000 shares of the Common Stock under the International Plan.

Registration Statement No. 33-59981 for the sale of 3,000,000 shares of the Common Stock under the 1991 Plan.

Registration Statement No. 33-59987 for the sale of 250,000 shares of the Common Stock under the 1995 Director Plan.

Registration Statement No. 33-59985 for the sale of 750,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 33-55697 for the sale of 500,000 shares of the Common Stock under the 1991 Plan.

Registration Statement No. 33-55633 for the sale of 1,000,000 shares of the Common Stock under the 1991 Plan.

Registration Statement No. 33-55631 for the sale of 700,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 33-66548 for the sale of 1,000,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 33-66546 for the sale of 1,000,000 shares of the Common Stock under the 1991 Plan.

Registration Statement No. 33-53054 for the sale of 1,500,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 33-42000 for the sale of 2,000,000 shares of the Common Stock under the 1991 Plan.

Registration Statement No. 33-41999 for the sale of 1,000,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 33-36249 for the sale of 1,000,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 33-17720 for the sale of 150,000 shares of the Common Stock under the 1986 Directors Stock Option Plan.

Registration Statement No. 33-30386 for the sale of 500,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 33-30385 for the sale of 500,000 shares of the Common Stock under the 1982 Incentive Stock Option Plan (the 1982 Incentive Plan).

Edgar Filing: LSI CORP - Form S-8 POS

Registration Statement No. 33-13265 for the sale of 1,275,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 33-6203 for the sale of 860,487 shares of the Common Stock under the Employee Plan.

Registration Statement No. 33-6188 for the sale of 7,537,586 shares of the Common Stock under the 1982 Plan.

Registration Statement No. 2-98732 for the sale of 1,100,000 shares of the Common Stock under the Employee Plan, the 1982 Stock Purchase Plan (the 1982 Purchase Plan), the 1982 Incentive Plan and the 1983 Junior Incentive Stock Plan (the 1983 Plan).

Registration Statement No. 2-91907 for the sale of 1,500,000 shares of the Common Stock under the Employee Plan, the 1982 Purchase Plan, the 1982 Incentive Plan and the 1983 Plan.

Registration Statement No. 2-86474 for the sale of 150,000 shares of the Common Stock under the Employee Plan.

Registration Statement No. 2-86474 for the sale of 213,551 shares of the Common Stock under the 1982 Purchase Plan.

Registration Statement No. 2-86474 for the sale of 694,700 shares of the Common Stock under the 1982 Incentive Plan.

Registration Statement No. 2-86474 for the sale of 300,000 shares of the Series B common stock, no par value, under the 1983 Plan.

Registration Statement No. 2-86474 for the sale of 300,000 shares of the Common Stock under the 1983 Plan.

On May 6, 2014, pursuant to the terms of the Agreement and Plan of Merger (the Merger Agreement), dated as of December 15, 2013, by and among Registrant Avago Technologies Limited (the Registrant), Avago Technologies Wireless (U.S.A.) Manufacturing Inc. (Parent) and Leopold Merger Sub, Inc. (Merger Sub), Merger Sub merged with and into the Registrant, and the Registrant became a wholly owned subsidiary of Parent (the Merger). As a result of the Merger, any offering pursuant to the Registration Statements has been terminated and the Registrant hereby terminates the effectiveness of the Registration Statements. In accordance with an undertaking made by the Registrant in the Registration Statements to remove from registration, by means of a post-effective amendment, any of the securities registered under each Registration Statement that remain unsold at the termination of the offerings, the Registrant hereby removes from registration the securities registered but unsold under the Registration Statements, if any.

SIGNATURES

Pursuant to the requirements of the Securities Act of 1933, as amended, the Registrant certifies that it has reasonable grounds to believe that it meets all of the requirements for filing on Form S-8 and has duly caused this Post-Effective Amendment No. 1 to the Registration Statement on Form S-8 to be signed on its behalf by the undersigned, thereunto duly authorized in the City of San Jose, State of California, on this 21st day of May 2014.

LSI CORPORATION

By: /s/ Anthony E. Maslowski
Anthony E. Maslowski
*Director, President, Secretary and
Treasurer*

Pursuant to the requirements of the Securities Act of 1933, this registration statement has been signed by the following persons in the capacities and on the date indicated.

Signature	Title	Date
/s/ Anthony E. Maslowski	Director, President, Secretary and Treasurer (Principal Executive Officer, Principal Financial Officer and Principal Accounting Officer)	May 21, 2014
Anthony E. Maslowski		
/s/ Ivy Pong		May 21, 2014
Ivy Pong	Director	
Vibra Hospital of Corpus Christi(B)(I)		

Corpus Christi, TX

Sub-Acute Care

100%

Kindred Healthcare, Inc.

Encompass Health Deaconess Rehabilitation Hospital, LLC(F)

Evansville, IN

Rehabilitation

100%

Encompass Health Corporation

Family Doctor's Medical Office Bldg.(B)

Shreveport, LA

MOB

100%

Christus Health Northern Louisiana

Kings Crossing II(B)

Kingwood, TX

MOB

100%

—

Professional Buildings at Kings Crossing

Building A(B)

Kingwood, TX

MOB

100%

—

Building B(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.

Chesterbrook Academy(B)

Uwchlan, PA

Preschool & Childcare

100%

Nobel Learning Comm. & Subs.

Southern Crescent Center I(B)

Riverdale, GA

MOB

100%

—

Southern Crescent Center, II(D)

Riverdale, GA

MOB

100%

—

St. Matthews Medical Plaza II(C)

Louisville, KY

MOB

33%

—

Desert Valley Medical Center(E)

Phoenix, AZ

MOB

100%

—

Cypresswood Professional Center(B)

8101

Spring, TX

MOB

100%

—

8111

Spring, TX

MOB

100%

—

Desert Springs Medical Plaza(D)

Las Vegas, NV

MOB

100%

—

701 South Tonopah Bldg.(A)

Las Vegas, NV

MOB

100%

—

Santa Fe Professional Plaza(E)

Scottsdale, AZ

MOB

100%

Summerlin Hospital MOB I(D)

Las Vegas, NV

MOB

100%

Summerlin Hospital MOB II(D)

Las Vegas, NV

MOB

100%

Danbury Medical Plaza(B)

Danbury, CT

MOB

100%

—

Mid Coast Hospital MOB(C)

Brunswick, ME

MOB

74%

—

Rosenberg Children's Medical Plaza(E)

Phoenix, AZ

MOB

100%

—

Gold Shadow(D)

700 Shadow Lane MOB

Las Vegas, NV

MOB

100%

—

2010 & 2020 Goldring MOBs

Las Vegas, NV

MOB

100%

—

Apache Junction Medical Plaza(E)

Apache Junction, AZ

MOB

100%

—

Spring Valley Medical Office Building(D)

Las Vegas, NV

MOB

100%

—

Spring Valley Hospital Medical Office Building II(D)

Las Vegas, NV

MOB

100%

—

Sierra San Antonio Medical Plaza(E)

Fontana, CA

MOB

100%

—

Phoenix Children's East Valley Care Center(E)

Phoenix, AZ

MOB

100%

—

Centennial Hills Medical Office Building(D)

Las Vegas, NV

MOB

100%

—

Palmdale Medical Plaza(D)

Palmdale, CA

MOB

100%

—

Summerlin Hospital Medical Office Building III(D)

Las Vegas, NV

MOB

100%

—

Vista Medical Terrace(D)

Sparks, NV

MOB

100%

—

The Sparks Medical Building(D)

Sparks, NV

MOB

100%

—

Auburn Medical Office Building II(E)

Auburn, WA

MOB

100%

—

Texoma Medical Plaza(G)

Denison, TX

MOB

95%

—

BRB Medical Office Building(E)

Kingwood, TX

MOB

100%

—

3811 E. Bell(E)

Phoenix, AZ

MOB

100%

—

Lake Pointe Medical Arts Building(E)

Rowlett, TX

MOB

100%

—

Forney Medical Plaza(E)

Forney, TX

MOB

100%

—

Tuscan Professional Building(E)

Irving, TX

MOB

100%

—

Emory at Dunwoody Building(E)

Atlanta, GA

MOB

100%

—

PeaceHealth Medical Clinic(E)

Bellingham, WA

MOB

100%

—

Forney Medical Plaza II(C)

Forney, TX

MOB

95%

—

Northwest Texas Professional Office Tower(E)

Amarillo, TX

MOB

100%

—

5004 Poole Road MOB(A)

Denison, TX

MOB

100%

—

Ward Eagle Office Village(E)

Farmington Hills, MI

MOB

100%

—

The Children's Clinic at Springdale(E)

Springdale, AR

MOB

100%

—

2

Edgar Filing: LSI CORP - Form S-8 POS

The Northwest Medical Center at Sugar Creek(E)	Bentonville, AR	MOB	100%	—
Hanover Emergency Center(E)	Mechanicsville, VA	FED	100%	—
South Texas ER at Weslaco(A)	Weslaco, TX	FED	100%	—
South Texas ER at Mission(A)	Mission, TX	FED	100%	—
				Regional Hospital Partners
Haas Medical Office Park(E)	Ottumwa, IA	MOB	100%	—
Piedmont - Roswell Physician Center(E)	Sandy Springs, GA	MOB	100%	—
Piedmont - Vinings Physician Center(E)	Vinings, GA	MOB	100%	—
Madison Professional Office Building(E)	Madison, AL	MOB	100%	—
Chandler Corporate Center III(E)	Chandler, AZ	MOB	100%	—
Frederick Crestwood MOB(E)	Frederick, MD	MOB	100%	—
2704 North Tenaya Way(E)	Las Vegas, NV	MOB	100%	—
Henderson Medical Plaza(D)	Henderson, NV	MOB	100%	—
Health Center at Hamburg(E)	Hamburg, PA	MOB	100%	—
Las Palmas Del Sol Emergency Center - West(E)	El Paso, TX	FED	100%	—
Beaumont Medical Sleep Center Building(H)	Southfield, MI	MOB	100%	—

- (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”) or a limited partnership (“LP”) in which we have a noncontrolling ownership interests and include tenants who are unaffiliated third-parties.
- (D) Real estate assets owned by us or an LLC in which we hold 100% ownership interests and include tenants who are subsidiaries of UHS.
- (E) Real estate assets owned by us or an LLC in which we hold 100% ownership interests and include tenants who are unaffiliated third-parties.
- (F) This lease with Encompass Health Deaconess Rehabilitation Hospital, LLC, which has an annualized current rental of approximately \$714,000, is scheduled to expire on May 31, 2019 and the tenant has provided verbal notice to us that they do not intend to renew the lease. However, although we can provide no assurance that an agreement will be finalized, we are currently in discussions with the tenant to potentially enter into a short-term lease, at a substantially increased lease rate as compared to the existing lease, that would likely be scheduled to expire during the fourth quarter of 2019. Encompass Health Corporation is the guarantor of the existing lease. We are working on marketing the property for lease to a new tenant.
- (G) Real estate assets owned by an LLC or an LP in which we have a noncontrolling ownership interest and include tenants who are subsidiaries of UHS.
- (H) This property was acquired during the second quarter of 2018.
- (I) This lease with Vibra Hospital of Corpus Christi, which has an annualized current rental of approximately \$857,000, is scheduled to expire on June 1, 2019 and the tenant has provided verbal notice to us that they do not intend to renew the lease and plan to vacate the property by that date. We are working on marketing the property for lease to a new tenant.

Other Information

Included in our portfolio at December 31, 2018 and 2017 are six hospital facilities with an aggregate investment of \$130.4 million. The leases with respect to the six hospital facilities comprised approximately 25%, 26% and 28% of our consolidated revenues in 2018, 2017 and 2016, respectively.

As of January 1, 2019, the leases on our six hospital facilities have fixed terms with an average of 3.0 years remaining and include renewal options ranging from zero to two, five-year terms. The remaining lease terms for each hospital facility, which vary by hospital, are included herein in Item 2. Properties. We have received notification from the tenants of two of these hospital facilities (a rehabilitation and a sub-acute hospital, as noted above), which comprise in

the aggregate approximately 2% of our consolidated revenues during each of 2018, 2017 and 2016, and have lease terms that are scheduled to expire in late May and early June of 2019, that they do not intend to renew their leases upon the scheduled expiration dates. Although we can provide no assurance that an agreement will be finalized, we are currently in discussions with the tenant of the rehabilitation hospital to potentially enter into a short-term lease, at a substantially increased lease rate as compared to the existing lease, that would likely be scheduled to expire during the fourth quarter of 2019.

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 7.0 (ranging from -0.7 to 17.1) during 2018, 7.5 (ranging from -0.8 to 18.0) during 2017 and 8.3 (ranging from 0.6 to 18.1) during 2016. The Coverage Ratio for individual facilities varies.

Pursuant to the terms of the leases for our hospital facilities, free-standing emergency departments, some single-tenant MOBs 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 remaining 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 may be established to fund required building maintenance and

renovations at the multi-tenant MOB. 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 from certain subsidiaries of 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 renewal terms for each of the three hospital facilities leased to subsidiaries of UHS 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 three hospital 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 24% of our consolidated revenue for the five years ended December 31, 2018 (approximately 21%, 22% and 24% for the years ended December 31, 2018, 2017 and 2016 respectively). In addition, we have seventeen MOB, or free-standing emergency departments (“FEDs”), that are either wholly or jointly-owned by us, that include tenants which are subsidiaries of UHS. The aggregate revenues generated from UHS-related tenants comprised approximately 32% of our consolidated revenue for the five years ended December 31, 2018 (approximately 30%, 32% and 33% for the years ended December 31, 2018, 2017 and 2016, respectively).

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. 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 three leased hospital properties listed below at their appraised fair market value. Additionally, 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.

The table below details the existing lease terms and renewal options for our three acute care hospitals operated by wholly-owned subsidiaries of UHS:

Hospital Name	Annual		Renewal
	Minimum	End of	Term
	Rent	Lease Term	(years)
McAllen Medical Center	\$5,485,000	December, 2026	5 (a)
Wellington Regional Medical Center	\$3,030,000	December, 2021	10 (b)
Southwest Healthcare System, Inland Valley Campus	\$2,648,000	December, 2021	10 (b)

(a) UHS has one 5-year renewal option at existing lease rates (through 2031).

(b) UHS has two 5-year renewal options at fair market value lease rates (2022 through 2031).

Management cannot predict whether the leases with subsidiaries of UHS, which have renewal options at existing lease rates or fair market value lease rates, or any of our other leases, will be renewed at the end of their lease term. If the leases are not renewed at their current rates or the fair market value lease rates, we would be required to find other operators for those facilities and/or enter into leases on terms potentially less favorable to us than the current leases. In addition, if subsidiaries of UHS exercise their options to purchase the respective leased hospital or FED facilities upon expiration of the lease terms, our future revenues could decrease if we were unable to earn a favorable rate of return on the sale proceeds received, as compared to the rental revenue currently earned pursuant to these leases.

In April, 2017, the recently constructed Henderson Medical Plaza MOB received its certificate of occupancy. Henderson Medical Plaza is located on the campus of the Henderson Hospital Medical Center, a newly constructed acute care hospital that is owned and operated by a subsidiary of UHS and was completed and opened during the fourth quarter of 2016. A ground lease has been executed between the limited liability company that owns the MOB and a subsidiary of UHS, the terms of which include a seventy-five year lease term with two, ten-year renewal options at the lessee's option at an adjusting lease rate. We have invested net cash of approximately \$12.8 million on the development and construction of this MOB as of December 31, 2018.

Officers and Employees: Our officers are all employees of a wholly-owned subsidiary of UHS and although as of December 31, 2018 we had no salaried employees, our officers do typically receive annual stock-based compensation awards in the form of restricted stock. In special circumstances, if warranted and deemed appropriate by the Compensation Committee of the Board of Trustees, our officers may also receive one-time compensation awards in the form of restricted stock and/or cash bonuses.

Advisory Agreement: UHS of Delaware, Inc. (the "Advisor"), a wholly-owned subsidiary of UHS, serves as Advisor to us under an advisory agreement dated December 24, 1986, and as amended and restated as of January 1, 2019 (the "Advisory Agreement"). 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.

Pursuant to the terms of the original advisory agreement, which was in effect from inception through December 31, 2018, in addition to the advisory fee as discussed below, the Advisor was entitled to an annual incentive fee equal to 20% of the amount by which cash available for distribution to shareholders for each year, as defined in the agreement, exceeded 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. Cash available for distribution to shareholders was defined 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. Since the incentive fee requirements were not achieved at any time from our inception through December 31, 2018, no incentive fees were paid during that time. Given that the incentive fee requirements have never been achieved, and were deemed unlikely to be achieved in the future, the amended and restated advisory agreement that became effective on January 1, 2019, among other things, eliminated the incentive fee provision.

Our advisory fee for 2018, 2017 and 2016 was computed at 0.70% of our average invested real estate assets, as derived from our consolidated balance sheet. Based upon a review of our advisory fee and other general and administrative expenses, as compared to an industry peer group, the advisory fee computation remained unchanged for 2019, as compared to the last three years. 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. Advisory fees incurred and paid (or payable) to UHS amounted to \$3.8 million during 2018, \$3.6 million during 2017 and \$3.3 million during 2016 and were based upon average invested real estate assets of \$544 million, \$511 million and \$466 million during 2018, 2017 and 2016, respectively.

Share Ownership: As of December 31, 2018 and 2017, UHS owned 5.7% of our outstanding shares of beneficial interest.

SEC reporting requirements of UHS: UHS is subject to the reporting requirements of the Securities and Exchange Commission (“SEC”) and is required to file annual reports containing audited financial information and quarterly reports containing unaudited financial information. Since the aggregate revenues generated from UHS-related tenants comprised approximately 32% of our consolidated revenue for the five years ended December 31, 2018 (approximately 30%, 32% and 33% for the years ended December 31, 2018, 2017 and 2016, 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. These filings are the sole responsibility of UHS and are not incorporated by reference herein. Please see the heading “A substantial portion of our revenues are dependent upon one operator. If UHS experiences financial difficulties, or otherwise fails to make payments to us, or elects not to renew the leases on our three acute care hospitals, our revenues could be materially reduced” under “Risk Factors” for more information.

Taxation

No provision has been made for federal income tax purposes since we qualify as a REIT under Sections 856 to 860 of the Internal Revenue Code of 1986, and intend to continue to remain so qualified. To qualify as a REIT, we must meet certain organizational and operational requirements, including a requirement to distribute at least 90% of our annual REIT taxable income to

shareholders. As a REIT, we generally will not be subject to federal, state or local income tax on income that we distribute as dividends to our shareholders. We have historically distributed, and intend to continue to distribute, 100% of our annual REIT taxable income to our shareholders.

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.

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, including UHS. 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 that may not be provided by the operators of our hospitals. The increase in outpatient treatment and diagnostic facilities, ambulatory surgical centers and freestanding emergency departments 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 admission 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 hospitals 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 MOB’s 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 subsidiaries of UHS.

Regulation and Other Factors

During 2018, 2017 and 2016, 24%, 25% and 26%, respectively, of our revenues were earned pursuant to leases with operators of acute care services hospitals and free-standing emergency departments (“FEDs”), the majority of which are subsidiaries of UHS. A significant portion of the revenue earned by the operators of our acute care hospitals and FEDs is derived from federal and state healthcare programs, including Medicare and Medicaid (excluding managed Medicare and Medicaid programs).

Our acute care facilities 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 healthcare 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. Neither we nor the operators of our hospital facilities are able to predict the effect of recent and future policy changes on our respective results of operations. In addition, the uncertainty and fiscal pressures placed upon federal and state governments as a result of, among other things, the funding requirements and other provisions of the Patient Protection and Affordable Care Act (the "PPACA"), may affect the availability of taxpayer funds for Medicare and Medicaid programs. In addition, possible repeal or replacement of the PPACA may have significant impact on the reimbursement for healthcare services. While attempts to repeal the entirety of the PPACA have not been successful to date, a key provision of the PPACA was repealed as part of the Tax Cuts and Jobs Act and on December 14, 2018, a federal U.S. District Court judge in Texas ruled the entire ACA is unconstitutional. While that ruling is stayed and has been appealed, it has caused greater uncertainty regarding the future status of the PPACA. If all or any parts of the PPACA are found to be unconstitutional, it

could have a material adverse effect on hospitals. If the rates paid or the scope of services covered by government payors are reduced, there could be a material adverse effect on the business, financial position and results of operations of the operators of our hospital facilities, and in turn, ours.

In addition, the healthcare industry is required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things: hospital billing practices and prices for services; relationships with physicians and other referral sources; adequacy of medical care and quality of medical equipment and services; ownership of facilities; qualifications of medical and support personnel; confidentiality, maintenance, privacy and security issues associated with health-related information and patient medical records; the screening, stabilization and transfer, by hospitals with an emergency department, 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.

These laws and regulations are extremely complex, and, in many cases, the operators of our facilities do not 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 the current or past practices of our operators to allegations of impropriety or illegality or could require them to make changes in their facilities, equipment, personnel, services, capital expenditure programs and operating expenses. Although UHS and other operators of our hospitals and FEDs 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 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.

Each of our hospital facilities is deemed certified, meaning that they are accredited, properly licensed under the relevant state laws and regulations and certified under the Medicare program. The effect of maintaining certified facilities is to allow such facilities to participate in the Medicare and Medicaid programs. The operators of our hospital facilities believe that the facilities are in material compliance with applicable federal, state, local and other relevant regulations and standards. However, should any of our hospital facilities lose their deemed certified status and thereby lose certification under the Medicare or Medicaid programs, such facilities would be unable to receive reimbursement from either of those programs and their business, and in turn, ours, could be materially adversely affected.

The various factors and government regulation related to the healthcare industry, such as those outlined above, 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 on the three acute care hospitals operated by subsidiaries of UHS are based on our lessees' net revenues which in turn are affected by the amount of reimbursement such lessees receive from the government.

A significant portion of the revenue earned by the operators of our acute care hospitals and FEDs 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 an 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, acute care hospitals are paid under an outpatient prospective payment system (“PPS”) according to ambulatory procedure codes. The outpatient PPS rate is a geographic adjusted 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.

Our three acute care hospitals and two FEDs 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 at various times during the last few years and 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

7

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.

Executive Officers of the Registrant

Name	Age	Position
Alan B. Miller	81	Chairman of the Board, Chief Executive Officer and President
Charles F. Boyle	59	Vice President and Chief Financial Officer
Cheryl K. Ramagano	56	Vice President, Treasurer and Secretary
Timothy J. Fowler	63	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, 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. 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 our Vice President and Chief Financial Officer in 2003 and had served as our Vice President and Controller since 1991. Mr. Boyle has held various positions at UHS since 1983. He was appointed Senior Vice President of UHS in 2017 and continues to serve as its Controller. He had served as Vice President and Controller of UHS since 2003 and as its Assistant Vice President-Corporate Accounting since 1994.

Ms. Cheryl K. Ramagano was appointed Secretary of the Trust in 2003 and has served as our Vice President and Treasurer since 1992. Ms. Ramagano has held various positions at UHS since 1983. She was appointed Senior Vice President of UHS in 2017 and continues to serve as its Treasurer. She had served as Vice President and Treasurer of UHS since 2003 and 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.

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.

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, FEDs 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 recent and future policy changes on their operations.

Our three acute care hospitals and two FEDs 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 at various times during the last few years and 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 funding requirements and other provisions of the Patient Protection and Affordable Care Act, 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 the business, financial position and results of operations of the operators of our hospital facilities, and in turn, ours.

In addition to changes in government reimbursement programs, the ability of our hospital operators to negotiate favorable contracts with private payors, including managed care organizations, significantly affects the revenues and operating results of those facilities. Private payors, including managed care organizations, 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.

Reductions or changes in Medicare and Medicaid funding could have a material adverse effect on the future operating results of the operators of our facilities, including UHS, which could, in turn, materially reduce our revenues and net income.

On January 3, 2013, the American Taxpayer Relief Act of 2012 (the “2012 Act”) was signed into law. The 2012 Act postponed for two months sequestration cuts mandated under the Budget Control Act of 2011. The postponed sequestration cuts include a 2% annual reduction over ten years in Medicare spending to providers. Medicaid is exempt from sequestration. In order to offset the cost of the legislation, the 2012 Act reduces payments to other providers totaling almost \$26 billion over ten years. Approximately half of those funds will come from reductions in Medicare reimbursement to hospitals. Although the Bipartisan Budget Act of 2013 has reduced certain sequestration-related budgetary cuts, spending reductions related to the Medicare program remain in place. On December 26, 2013, H.J. Res. 59, the Bipartisan Budget Act of 2013, which includes the Pathway for SGR Reform Act of 2013 (“the Act”), was signed into law. In addition, on February 15, 2014, Public Law 113-082 was enacted. The 2012 Act and subsequent federal legislation achieves new savings by extending sequestration for mandatory programs – including Medicare – for another three years, through 2027.

The 2012 Act includes a document and coding (“DCI”) adjustment and a reduction in Medicaid disproportionate share hospital (“DSH”) payments. Expected to save \$10.5 billion over 10 years, the DCI adjustment decreases projected Medicare hospital payments for inpatient and overnight care through a downward adjustment in annual base payment increases. These reductions are meant to recoup what Medicare authorities consider to be “overpayments” to hospitals that occurred as a result of the transition to Medicare Severity Diagnosis Related Groups. The reduction in Medicaid DSH payments was expected to save \$4.2 billion over 10 years. This provision extends the changes regarding DSH payments established by the Legislation and determines future allotments off of the rebased level. On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018, which eliminated the DSH cuts scheduled for 2018 and 2019 but added additional DSH reductions of \$4 billion in 2020 and \$8 billion a year between 2021 and 2025. We cannot predict the effect this enactment will have on operators (including UHS), and, thus, our business.

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.

On March 23, 2010, the Patient Protection and Affordable Care Act (the “PPACA”) was signed into law. The Healthcare and Education Reconciliation Act of 2010 (the “Reconciliation Act”), which contains a number of amendments to the PPACA, was signed into law on March 30, 2010. Two primary goals of the PPACA, combined with the Reconciliation Act (collectively referred to as the “Legislation”), are to provide for increased access to coverage for healthcare and to reduce healthcare-related expenses.

Although it was expected that the Legislation would result in a reduction in uninsured patients in the U.S., which would reduce the operators’ of our facilities’ expense from uncollectible accounts receivable, the Legislation made a number of other changes to Medicare and Medicaid which we believe may have an adverse impact on the operators of our facilities. It has been projected that the Legislation will result in a net reduction in Medicare and Medicaid payments to hospitals totaling \$155 billion over 10 years. The Legislation revises reimbursement under the Medicare and Medicaid programs to emphasize the efficient delivery of high quality care and contains a number of incentives and penalties under these programs to achieve these goals. The Legislation provides for decreases in the annual market

basket update for federal fiscal years 2010 through 2019, a productivity offset to the market basket update beginning October 1, 2011 for Medicare Part B reimbursable items and services and beginning October 1, 2012 for Medicare inpatient hospital services. The Legislation and subsequent revisions provide for reductions to both Medicare DSH and Medicaid DSH payments. The Medicare DSH reductions began in October, 2013 while Medicaid DSH reimbursements are scheduled to begin in 2020. The Legislation implements a value-based purchasing program, which will reward the delivery of efficient care. Conversely, certain facilities will receive reduced reimbursement for failing to meet quality parameters; such hospitals will include those with excessive readmission or hospital-acquired condition rates.

A 2012 U.S. Supreme Court ruling limited the federal government's ability to expand health insurance coverage by holding unconstitutional sections of the Legislation that sought to withdraw federal funding for state noncompliance with certain Medicaid coverage requirements. Pursuant to that decision, the federal government may not penalize states that choose not to participate in the Medicaid expansion program by reducing their existing Medicaid funding. Therefore, states can choose to accept or not to participate without risking the loss of federal Medicaid funding. As a result, many states, including Texas, have not expanded their Medicaid programs without the threat of loss of federal funding. CMS has granted, and is expected to grant additional, section 1115 demonstration waivers providing for work and community engagement requirements for certain Medicaid eligible individuals. It is

anticipated this will lead to reductions in coverage, and likely increases in uncompensated care for the operators of our facilities, in states where these demonstration waivers are granted.

The various provisions in the Legislation that directly or indirectly affect Medicare and Medicaid reimbursement are scheduled to take effect over a number of years. The impact of the Legislation on healthcare providers will be subject to implementing regulations, interpretive guidance and possible future legislation or legal challenges. Certain Legislation provisions, such as that creating the Medicare Shared Savings Program create uncertainty in how healthcare may be reimbursed by federal programs in the future. Thus, at this time, we cannot predict the impact of the Legislation on the future reimbursement of our hospital operators and we can provide no assurance that the Legislation will not have a material adverse effect on the future results of operations of the tenants/operators of our properties and, thus, our business.

The Legislation also contained provisions aimed at reducing fraud and abuse in healthcare. The Legislation amends several existing laws, including the federal Anti-Kickback Statute and the False Claims Act, making it easier for government agencies and private plaintiffs to prevail in lawsuits brought against healthcare providers. While Congress had previously revised the intent requirement of the Anti-Kickback Statute to provide that a person is not required to “have actual knowledge or specific intent to commit a violation of” the Anti-Kickback Statute in order to be found in violation of such law, the Legislation also provides that any claims for items or services that violate the Anti-Kickback Statute are also considered false claims for purposes of the federal civil False Claims Act. The Legislation provides that a healthcare provider that retains an overpayment in excess of 60 days is subject to the federal civil False Claims Act, although certain final regulations implementing this statutory requirement remain pending. The Legislation also expands the Recovery Audit Contractor program to Medicaid. These amendments also make it easier for severe fines and penalties to be imposed on healthcare providers that violate applicable laws and regulations.

The impact of the Legislation on hospitals may vary. Because Legislation provisions are effective at various times over the next several years, we anticipate that many of the provisions in the Legislation may be subject to further revision. Initiatives to repeal the Legislation, in whole or in part, to delay elements of implementation or funding, and to offer amendments or supplements to modify its provisions have been persistent. The ultimate outcomes of legislative attempts to repeal or amend the Legislation and legal challenges to the Legislation are unknown. Legislation has already been enacted that has eliminated the penalty for failing to maintain health coverage that was part of the original Legislation. In addition, Congress has considered legislation that would, if enacted, in material part (i) eliminate the large employer mandates to obtain or provide health insurance coverage, respectively; (ii) permit insurers to impose a surcharge up to 30 percent on individuals who go uninsured for more than two months and then purchase coverage; (iii) provide tax credits towards the purchase of health insurance, with a phase-out of tax credits according to income level; (iv) expand health savings accounts; (v) impose a per capita cap on federal funding of state Medicaid programs, or, if elected by a state, transition federal funding to block grants, and; (vi) permit states to seek a waiver of certain federal requirements that would allow such state to define essential health benefits differently from federal standards and that would allow certain commercial health plans to take health status, including pre-existing conditions, into account in setting premiums.

In addition to legislative changes, the Legislation can be significantly impacted by executive branch actions. In relevant part, President Trump has already taken executive actions: (i) requiring all federal agencies with authorities and responsibilities under the Legislation to “exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay” parts of the Legislation that place “unwarranted economic and regulatory burdens” on states, individuals or health care providers; (ii) the issuance of a final rule in June, 2018 by the Department of Labor to enable the formation of association health plans that would be exempt from certain Legislation requirements such as the provision of essential health benefits; (iii) the issuance of a final rule in August, 2018 by the Department of Labor, Treasury, and Health and Human Services to expand the availability of short-term, limited duration health insurance, (iv) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level; (v) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and

lead to additional enrollment in short-term, limited duration insurance and association health plans; and (vi) the issuance of a proposed rule by the Department of Labor, Treasury, and Health and Human Services that would be incentivize the use of health reimbursement accounts by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these Executive Branch policies has led to reduced Exchange enrollment in 2018 and 2019 and is expected to further worsen the individual and small group market risk pools in future years. It is also anticipated that these and future policies may create additional cost and reimbursement pressures on hospitals.

It remains unclear what portions of the Legislation may remain, or what any replacement or alternative programs may be created by any future legislation. Any such future repeal or replacement may have significant impact on the reimbursement for healthcare services generally, and may create reimbursement for services competing with the services offered by the operators of our hospitals. Accordingly, there can be no assurance that the adoption of any future federal or state healthcare reform legislation will not have a negative financial impact on the operators of our hospitals, including their ability to compete with alternative healthcare services funded by such potential legislation, or for the operators of our hospitals to receive payment for services.

While attempts to repeal the entirety of the ACA have not been successful to date, a key provision of the ACA was repealed as part of the Tax Cuts and Jobs Act and on December 14, 2018, a federal U.S. District Court judge in Texas ruled the entire ACA is unconstitutional. While that ruling is stayed and has been appealed, it has caused greater uncertainty regarding the future status of the ACA. If all or any parts of the ACA are found to be unconstitutional, it could have a material adverse effect on hospitals.

The trend toward value-based purchasing may negatively impact the revenues of our hospital operators.

We believe that value-based purchasing initiatives of both governmental and private payers tying financial incentives to quality and efficiency of care will increasingly affect the results of operations of our hospitals and other healthcare facilities and may negatively impact their revenues if they are unable to meet expected quality standards. The Legislation contains a number of provisions intended to promote value-based purchasing in federal healthcare programs. Medicare now requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically. In addition, hospitals that meet or exceed certain quality performance standards will receive increased reimbursement payments, and hospitals that have “excess readmissions” for specified conditions will receive reduced reimbursement. Furthermore, Medicare no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions unless the conditions were present at admission. Beginning in Federal Fiscal Year (FFY) 2015, hospitals that rank in the worst 25% of all hospitals nationally for hospital acquired conditions in the previous year will receive reduced Medicare reimbursements. The Legislation also prohibits the use of federal funds under the Medicaid program to reimburse providers for treating certain provider-preventable conditions.

There is a trend among private payers toward value-based purchasing of healthcare services, as well. Many large commercial payers require hospitals to report quality data, and several of these payers will not reimburse hospitals for certain preventable adverse events. We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect the results of operations of the operators of our hospitals, but it could negatively impact their revenues if they are unable to meet quality standards established by both governmental and private payers.

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 healthcare industry is highly competitive and competition among hospitals and other health care providers for patients and physicians 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, including UHS.

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 that may not be

provided by the operators of our 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 operators of our facilities face competition from other health care providers, including physician owned facilities and other competing facilities, including certain facilities operated by UHS but the real property of which is not owned by us. Such competition is experienced in markets including, but not limited to, McAllen, Texas, the site of our McAllen Medical Center, a 370-bed acute care hospital, and Riverside County, California, the site of our Southwest Healthcare System-Inland Valley Campus, a 130-bed acute care hospital.

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 admission decisions and for directing the course of patient treatment. Since the operators of our facilities also compete with other health care providers, they may experience difficulties in recruiting and retaining qualified hospital management, nurses and other medical 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 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, and continued compliance with, electronic health records' regulations; confidentiality, maintenance and security issues associated with health-related information and patient medical records; the screening, stabilization and transfer, by hospitals with an emergency department, 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 net revenues of the UHS hospital facilities, 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.

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 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 worsening of economic conditions may result in a higher 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.

U.S. federal tax reform legislation now and in the future could affect REITs, both positively and negatively, in ways that are difficult to anticipate.

The Tax Cuts and Jobs Act of 2017 (the “2017 Tax Act”), signed into law on December 22, 2017, represents sweeping tax reform legislation that makes significant changes to corporate and individual tax rates and the calculation of taxes. While we currently do not expect the 2017 Tax Act will have a significant direct impact on us, it may impact us indirectly as our tenants and the jurisdictions in which we do business as well as the overall investment thesis for REITs may be impacted both positively and negatively in ways that are difficult to predict. Additionally, the overall impact of the 2017 Tax Act depends on future interpretations and regulations that may be issued by federal tax authorities, as well as changes in state and local taxation in response to the 2017 Tax Act, and it is possible that such future interpretations, regulations and other changes could adversely impact us.

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. 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 on 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.

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.

The LIBOR calculation method may change and LIBOR is expected to be phased out after 2021.

Our Credit Agreement permits interest on borrowings to be calculated based on LIBOR. On July 27, 2017, the United Kingdom Financial Conduct Authority (the "FCA") announced that it will no longer require banks to submit rates for the calculation of LIBOR after 2021. In the meantime, actions by the FCA, other regulators, or law enforcement agencies may result in changes to the method by which LIBOR is calculated. At this time, it is not possible to predict the effect of any such changes or any other reforms to LIBOR that may be enacted in the United Kingdom or elsewhere.

A substantial portion of our revenues are dependent upon one operator. If UHS experiences financial difficulties, or otherwise fails to make payments to us, or elects not to renew the leases on our three acute care hospitals, our revenues could be materially reduced.

For the year ended December 31, 2018, lease payments from UHS comprised approximately 30% of our consolidated revenues. In addition, as of December 31, 2018, subsidiaries of UHS leased three of the six hospital facilities owned by us with terms expiring in 2021 and 2026. We cannot assure you that UHS will continue to satisfy its obligations to us or renew existing leases upon their scheduled maturity. In addition, if subsidiaries of UHS exercise their options to purchase the respective three leased hospitals, or two leased FEDs, upon expiration of the lease terms, our future revenues could decrease if we were unable to earn a favorable rate of return on the sale proceeds received, as compared to the rental revenue currently earned pursuant to the leases on the facilities. The failure or inability of UHS to satisfy its obligations to us, or should UHS elect not to renew the leases on the three acute care hospitals or two FEDs, our revenues and net income could be materially reduced, 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, as amended and restated effective January 1, 2019, 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 the Advisor. As of December 31, 2018, we had no salaried employees although our officers do typically receive annual stock-based compensation awards in the form of restricted stock. In special circumstances, if warranted and deemed appropriate by the Compensation Committee of the Board of Trustees, our officers may also receive one-time compensation awards in the form of restricted stock and/or cash bonuses. 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. 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.

UHS and its subsidiaries, are subject to pending legal actions, purported stockholder class actions, governmental investigations and regulatory actions.

UHS and its subsidiaries are subject to pending legal actions, purported shareholder class actions, governmental investigations and regulatory actions. Since UHS comprised approximately 30%, 32% and 33% of our consolidated revenues for the years ended December 31, 2018, 2017 and 2016, respectively, and since a subsidiary of UHS is our Advisor, you are encouraged to obtain and review the disclosures contained in the Legal Proceedings section of Universal Health Services, Inc.'s Forms 10-K and 10-Q, as publicly filed with the Securities and Exchange Commission. These filings are the sole responsibility of UHS and are not incorporated by reference herein

Defending itself against the allegations in the lawsuits and governmental investigations, or similar matters and any related publicity, could potentially entail significant costs and could require significant attention from UHS management and UHS' reputation could suffer significantly. UHS has stated that it is unable to predict the outcome of these matters or to reasonably estimate the amount or range of any such loss; however, the outcome of these lawsuits and the related investigations, publicity and news articles that have been published concerning these matters, could have a material adverse effect on their business, financial condition, results of operations and/or cash flows.

UHS is and may become subject to other loss contingencies, both known and unknown, which may relate to past, present and future facts, events, circumstances and occurrences. Should an unfavorable outcome occur in some or all of the legal proceedings or other loss contingencies, or if successful claims and other actions are brought against UHS in the future, there could be a material adverse impact on their financial position, results of operations and liquidity, which in turn could have a material adverse effect on us.

In particular, government investigations, as well as qui tam and stockholder lawsuits, may lead to material fines, penalties, damages payments or other sanctions, including exclusion from government healthcare programs. Settlements of lawsuits involving Medicare and Medicaid issues routinely require both monetary payments and corporate integrity agreements, each of which could have a material adverse effect on UHS's business, financial condition, results of operations and/or cash flows, which in turn could have a material adverse effect on us.

We hold non-controlling equity ownership interests in various joint-ventures.

For the year ended December 31, 2018, 11% of our consolidated and unconsolidated revenues were generated by four jointly-owned LLCs/LPs in which we hold non-controlling equity ownership interests ranging from 33% to 95%. 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 and/or partnership agreements of the four LLCs/LPs in which we continue to hold non-controlling ownership interests, the third-party member and the Trust, at any time, potentially subject to certain conditions, 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 to 90 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 to 90 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 or the underlying property to each other or a third party. If we were to sell our interests or underlying property, 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.

Required regulatory approvals can delay or prohibit transfers of our healthcare facilities.

Transfers of healthcare facilities to successor tenants or operators may be subject to regulatory approvals or ratifications, including, but not limited to, change of ownership approvals under certificate of need laws and Medicare and Medicaid provider arrangements that are not required for transfers of other types of commercial operations and other types of real estate. The replacement of any tenant or operator could be delayed by the regulatory approval process of any federal, state or local government agency necessary for the transfer of the facility or the replacement of the operator licensed to manage the facility. If we are unable to find a suitable replacement tenant or operator upon favorable terms, or at all, we may take possession of a facility, which might expose us to successor liability or require us to indemnify subsequent operators to whom we might transfer the operating rights and licenses, all of which may materially adversely affect our business, results of operations, and financial condition.

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.

In addition to the foregoing risks, we cannot predict whether the leases on our properties, including the leases on the hospitals 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 or fair market value lease rates at the end of the lease terms in 2021 or 2026. If the leases are not renewed, we may be required to find other operators for these hospitals and/or enter into leases with less favorable terms. The exercise of purchase options for our hospitals 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 hospitals, after the expiration of the lease term, may adversely affect our ability to sell or lease a hospital, 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 and, in turn, us.

Property insurance rates, particularly for earthquake insurance in California, have also continued to increase. 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. Also, if disqualified, we will not be allowed a deduction for distributions to stockholders in computing our taxable income and we could be subject to increased state and local income taxes.

Even if we remain qualified as a REIT, we may face other tax liabilities that reduce our cash flow.

Even if we remain qualified for taxation as a REIT, we may be subject to certain federal, state and local taxes on our income and assets, including taxes on any undistributed income, tax on income from some activities conducted as a result of a foreclosure, and state or local income, property and transfer taxes. Any of these taxes would decrease cash available for the payment of our debt obligations.

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

In general, dividends (qualified) paid by a U.S. corporation to individual U.S. shareholders are subject to Federal income tax at a maximum rate of 20% for 2018 (subject to certain additional taxes for certain taxpayers). In contrast, since we are a REIT, our distributions to individual U.S. shareholders are not eligible for the reduced rates which apply to distributions from regular corporations, and thus may be subject to Federal income tax at a rate as high as 37% for 2018 (subject to certain additional taxes for certain taxpayers). The differing treatment of dividends received from REITs and other corporations might cause individual investors to view an investment in REITs as less attractive relative to other corporations, which might negatively affect the value of our shares.

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, and/or; (iii) divest assets that we might have otherwise decided to retain. Securing funds through these

other non-operating means could adversely affect our financial condition and future results of operations.

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

To qualify as a REIT for federal income tax purposes, we continually must satisfy tests concerning, among other things, the sources of our income, the nature and diversification of our assets, the amounts we distribute to our stockholders and the ownership of our stock. We may be unable to pursue investments that would be otherwise advantageous to us in order to satisfy the source-of-income, asset-diversification or distribution requirements for qualifying as a REIT. Thus, compliance with the REIT requirements may hinder our ability to make certain attractive investments.

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, financial markets or overall interest rate environment, or other developments affecting the health care industry.

When interest rates increase, our common stock may decline in price.

Our common stock, like other dividend stocks, is sensitive to changes in market interest rates. In response to changing interest rates the price of our common stock may behave like a long-term fixed-income security and, compared to shorter-term instruments, may have more volatility. A wide variety of market factors can cause interest rates to rise, including central bank monetary policy, an uptick in inflation and changes in general economic conditions. The risks associated with increasing rates are intensified given that interest rates have been near historic lows but may be expected to increase in the future, with unpredictable effects on the markets and on the price of our common stock. Consequential effects of a general rise in interest rates may hamper our access to capital markets, affect the liquidity of our underlying investments in real estate, and, by extension, limit management's effective range of responses to changing tenant circumstances or in answer to investment opportunities. Limited operational alternatives may further hinder our ability to maintain or increase our dividend, and the market price of our common stock may experience further declines as the result.

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.

The Master Lease Documents by and among us and certain subsidiaries of UHS, which governs the three acute care hospital properties and the freestanding emergency departments leased to 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, to purchase any or all of the leased hospital properties at their appraised fair market values. The exercise of this purchase option may result in a less favorable rate of return earned on the sales proceeds received 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. Increased competition makes it more challenging for us to identify and successfully capitalize on opportunities that meet our business goals and could improve the bargaining power of property owners seeking to sell, thereby impeding our investment, acquisition and development activities. If we cannot capitalize on our development pipeline, identify and purchase a sufficient quantity of healthcare facilities at favorable prices or if we are unable to finance acquisitions on commercially favorable terms, our business, results of operations and financial condition may be materially adversely affected.

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

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

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.

A cyber security incident could cause a violation of HIPAA, breach of member privacy, or other negative impacts.

We and UHS rely extensively on our information technology ("IT") systems to manage clinical and financial data, communicate with our patients, payors, vendors and other third parties and summarize and analyze operating results. In addition, UHS has made significant investments in technology to adopt and utilize electronic health records and to become a meaningful user of health information technology pursuant to the American Recovery and Reinvestment Act of 2009. A cyber-attack that bypasses our IT security systems causing an IT security breach, loss of protected

health information or other data subject to privacy laws, loss of proprietary business information, or a material disruption of our IT business systems, could have a material adverse impact on our business and result of operations. In addition, our future results of operations, as well as our reputation, could be adversely impacted by theft, destruction, loss, or misappropriation of public health information, other confidential data or proprietary business information.

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.

ITEM 2. Properties

The following table shows our investments in hospital facilities leased to UHS and other non-related parties and also 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 @ 12/31/2018	Average Occupancy(1)					Minimum rent(6)	Lease Term		% of RSF under lease with guaranteed escalators	Range of guaranteed escalation	
			2018	2017	2016	2015	2014		End of initial or renewed term (years)	Renewal			
Southwest Healthcare System: Inland Valley Campus(2)(5)(7) Wildomar, California	Acute Care	130	59%	62%	64%	63%	59%	\$2,648,000	2021	10	0	%	—
McAllen Medical Center(3)(5)(7) McAllen, Texas	Acute Care	370	44%	45%	47%	48%	44%	5,485,000	2026	5	0	%	—
Wellington Regional Medical Center(4)(5)(7) West Palm Beach, Florida	Acute Care	153	59%	57%	55%	56%	59%	3,030,000	2021	10	0	%	—
Encompass Health Deaconess Rehab. Hospital(8) Evansville, Indiana	Rehabilitation	85	75%	73%	75%	80%	80%	297,000	2019	—	0	%	—
Vibra Hospital of Corpus Christi(12) Christi Corpus Christi, Texas	Sub-Acute Care	74	46%	50%	51%	56%	58%	357,000	2019	—	100	%	3%
	Sub-	68	35%	39%	46%	52%	54%	1,525,000	2021	—	0	%	—

Kindred Hospital Acute Care
Chicago

Central(9)

Chicago,
Illinois

Facility Name and Location	Type of facility	Average Occupancy(1)					Lease Term Minimum rent(6)	End of initial or renewed term	Renewal term (years)	% of RSF under lease with guarantee	Range of guaranteed escalation
		2018	2017	2016	2015	2014					
Spring Valley MOB I(5) Las Vegas, Nevada	MOB	81 %	72 %	72 %	61 %	60 %	\$796,000	2019-2028	Various	100 %	2%-3%
Spring Valley MOB II(5) Las Vegas, Nevada	MOB	71 %	85 %	85 %	84 %	77 %	735,000	2019-2024	Various	85 %	1%-3%
Summerlin Hospital MOB I(5) Las Vegas, Nevada	MOB	72 %	65 %	64 %	62 %	66 %	1,315,000	2019-2028	Various	96 %	2%-3%
Summerlin Hospital MOB II(5) Las Vegas, Nevada	MOB	79 %	80 %	78 %	74 %	78 %	1,392,000	2019-2023	Various	89 %	2%-5%
Summerlin Hospital MOB III(5) Las Vegas, Nevada	MOB	99 %	100 %	100 %	100 %	90 %	1,649,000	2019-2024	Various	76 %	2%-3%
Rosenberg Children's	MOB	100 %	99 %	99 %	99 %	99 %	2,207,000	2019-2028	Various	94 %	3%

Edgar Filing: LSI CORP - Form S-8 POS

Medical
Plaza

Phoenix,
Arizona

Centennial Hills MOB(5)	MOB	75 %	75 %	73 %	73 %	71 %	1,602,000	2019-2024	Various	71 %	2%-3%
-------------------------	-----	------	------	------	------	------	-----------	-----------	---------	------	-------

Las Vegas,
Nevada

PeaceHealth Medical Clinic	MOB	100 %	100 %	100 %	100 %	100 %	2,573,000	2021	20	100 %	1%
----------------------------	-----	-------	-------	-------	-------	-------	-----------	------	----	-------	----

Bellingham,
Washington

Lake Pointe Medical Arts Building	MOB	95 %	100 %	100 %	100 %	100 %	1,282,000	2019-2029	Various	81 %	3%-4%
-----------------------------------	-----	------	-------	-------	-------	-------	-----------	-----------	---------	------	-------

Rowlett,
Texas

Chandler Corporate Center III(10)	MOB	92 %	92 %	92 %	-	-	1,249,000	2027	Various	100 %	2%
-----------------------------------	-----	------	------	------	---	---	-----------	------	---------	-------	----

Chandler,
Arizona

Frederick Crestwood MOB(10)	MOB	100 %	100 %	100 %	-	-	1,696,000	2026-2030	Various	100 %	3%-4%
-----------------------------	-----	-------	-------	-------	---	---	-----------	-----------	---------	-------	-------

Frederick,
Maryland

2704 North Tenaya Way(10)	MOB	100 %	100 %	100 %	-	-	1,130,000	2023	18	100 %	3%
---------------------------	-----	-------	-------	-------	---	---	-----------	------	----	-------	----

Las Vegas,
Nevada

Henderson Union Village MOB(5)(11)	MOB	37 %	24 %	-	-	-	859,000	2022-2028	Various	100 %	3%
------------------------------------	-----	------	------	---	---	---	---------	-----------	---------	-------	----

Henderson,
Nevada

	MOB	100 %	100 %	100 %	100 %	100 %	975,728	2022-2023	Various	100 %	2%-3%
--	-----	-------	-------	-------	-------	-------	---------	-----------	---------	-------	-------

Northwest
Texas
Professional
Office Tower

Amarillo,
Texas

(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, 2018. 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). No assurance can be given as to the effect, if any, the merger of Inland Valley and Rancho Springs had on the underlying value of Inland Valley. Base rental commitments and the guarantee by UHS under the original lease continue for the remainder of the lease term. 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 acquisition by UHS, the Heart Hospital began operating under the same license as McAllen Medical Center (which has 370 available beds as of December 31, 2018). The net revenues of the combined operations included revenues generated by the Heart Hospital, the real property of which is not owned by us. Accordingly, 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). During 2000, UHS purchased the South Texas Behavioral Health Center, a behavioral health care facility located in McAllen, Texas. In 2006, a newly constructed, 134-bed replacement facility for the South Texas Behavioral Health Center was completed and opened. We do not own the real property of South Texas Behavioral Health Center. Upon UHS’s acquisition of the South Texas Behavioral Health Center in 2000, the facility’s license was merged into the operating license of McAllen Medical Center/McAllen Heart Hospital. There was no amendment to the McAllen Medical Center lease related to the operations of the South Texas Behavioral Health Center and its net revenues are distinct and excluded from the bonus rent calculation. In 2007, the operations of each of the above-mentioned facilities, as well as the operations of Edinburg Regional Medical Center/Children’s Hospital, a 235-bed facility located in Edinburg, Texas, were merged into one license operating as the South Texas Health System (“STHS”). The real property of Edinburg Regional Medical Center/Children’s Hospital is not owned by us and its net revenues are distinct and excluded from the bonus rent calculation. In 2015, the newly constructed South Texas ER at Weslaco and South Texas ER at Mission (Free-standing Emergency Departments (“FEDs”)) were completed and opened. These facilities also operate under the STHS license. The real property of these two FEDs was purchased by us and leased back to STHS. The average occupancy rates reflected above are based upon the combined occupancy and combined number of beds at McAllen Medical Center and McAllen Heart Hospital. No assurance can be given as to the effect, if any, the consolidation of the facilities into one operating license, 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.
- (4) In 2014, an 80-bed expansion was added to Wellington Regional Medical Center increasing the hospital’s total available beds from 153 to 233. Pursuant to terms of the Wellington Regional Medical Center lease, we are entitled to bonus rental on the net revenues generated from the 80-bed expansion. However, since we did not acquire the property associated with the additional 80-beds, the hospital’s base rental remained unchanged and the additional beds are not included in the number of available beds reflected above.
- (5) The real estate assets of this facility are owned by us (either directly or through an LLC in which we hold 100% of the ownership interest) and include tenants who are subsidiaries of UHS.

- (6) Minimum rent amounts contain impact of straight-line rent adjustments, if applicable.
- (7) See Note 2 to the consolidated financial statements-Relationship with UHS and Related Party Transactions, regarding UHS's purchase option, right of first refusal and change of control purchase option related to these properties. We believe the respective fair values for each of these hospitals exceeds the respective net book values as of December 31, 2018 amounting to: \$13.3 million for Southwest Healthcare System-Inland Valley Campus; \$18.2 million for McAllen Medical Center, and; \$12.7 million for Wellington Regional Medical Center.
- (8) This lease with Encompass Health Deaconess Rehabilitation Hospital, LLC, which has an annualized current rental of approximately \$714,000, is scheduled to expire on May 31, 2019 and the tenant has provided verbal notice to us that they do not intend to renew the lease. However, although we can provide no assurance that an agreement will be finalized, we are currently in discussions with the tenant to potentially enter into a short-term lease, at a substantially increased lease rate as compared to the existing lease, that would likely be scheduled to expire during the fourth quarter of 2019. Encompass Health Corporation is the guarantor of the existing lease. We are working on marketing the property for lease to a new tenant.
- (9) During the second quarter of 2016, the tenant of this facility provided the required notice to us, exercising the 5-year renewal option on the facility, extending the lease term to December, 2021 at existing lease rates. The lessee of this facility has a purchase option which is exercisable, subject to certain terms and conditions, at the expiration of each lease term. If exercised, the purchase option stipulates that the purchase price be the fair market value of the facility, subject to a stipulated minimum price. We believe the fair market value of the facility exceeds the \$158,000 net book value as of December 31, 2018. The lessee also has a first refusal to purchase right which, if applicable and subject to certain terms and conditions, grants the lessee the option to purchase the property at the same terms and conditions as an accepted third-party offer.
- (10) This property was acquired during 2016
- (11) This newly constructed MOB was completed and opened during the second quarter of 2017.

(12) This lease with Vibra Hospital of Corpus Christi, which has an annualized current rental of approximately \$857,000, is scheduled to expire on June 1, 2019 and the tenant has provided verbal notice to us that they do not intend to renew the lease and plan to vacate the property by that date. We are working on marketing the property for lease to a new tenant.

Leasing Trends at Our Significant Medical Office Buildings

During 2018, we had a total of 34 new or renewed leases related to the medical office buildings indicated above, in which we have significant investments, some of which are accounted for by the equity method. These leases comprised approximately 17% of the aggregate rentable square feet of these properties (14% related to renewed leases and 3% related to new leases). Rental rates, tenant improvement costs and rental concessions vary from property to property based upon factors such as, but not limited to, the current occupancy and age of our buildings, local overall economic conditions, proximity to hospital campuses and the vacancy rates, rental rates and capacity of our competitors in the market. The weighted-average tenant improvement costs associated with these new or renewed leases was approximately \$10 per square foot during 2018. The weighted-average leasing commissions on the new and renewed leases commencing during 2018 was approximately 4% of base rental revenue over the term of the leases. The average aggregate value of the tenant concessions, generally consisting of rent abatements, provided in connection with new and renewed leases commencing during 2018 was approximately 0.5% of the future aggregate base rental revenue over the lease terms. Rent abatements were, or will be, recognized in our results of operations under the straight-line method over the lease term regardless of when payments are due. In connection with lease renewals executed during 2018, the weighted-average rental rates, as compared to rental rates on the expired leases, decreased by approximately 3%.

Set forth is information detailing the rentable square feet (“RSF”) associated with each of our properties as of December 31, 2018 and the percentage of RSF on which leases expire during the next five years and thereafter. For the MOB’s that have scheduled lease expirations during 2019 of 10% or greater (of RSF), we have included information regarding estimated market rates relative to lease rates on the expiring leases.

Edgar Filing: LSI CORP - Form S-8 POS

	Total RSF	Percentage of RSF with lease expirations Available									
		for Lease									
		Jan. 1, 2019	2019	2020	2021	2022	2023	and Later	2024		
Hospital Investments:											
McAllen Medical Center	422,276	0	% 0	% 0	% 0	% 0	% 0	% 0	% 0	% 0	100 %
Wellington Regional Medical Center	196,489	0	% 0	% 0	% 0	% 100	% 0	% 0	% 0	% 0	0 %
Southwest Healthcare System - Inland Valley	164,377	0	% 0	% 0	% 100	% 0	% 0	% 0	% 0	% 0	0 %
Kindred Hospital Chicago Central	115,554	0	% 0	% 0	% 100	% 0	% 0	% 0	% 0	% 0	0 %
HealthSouth Deaconess Rehab. Hosital	77,440	0	% 100	% 0	% 0	% 0	% 0	% 0	% 0	% 0	0 %
Vibra Hospital Corpus Christi	69,700	0	% 100	% 0	% 0	% 0	% 0	% 0	% 0	% 0	0 %
Sub-total Hospitals	1,045,836	0	% 14	% 0	% 46	% 0	% 0	% 0	% 0	% 40	0 %
Medical Office Buildings:											
Goldshadow - 2010 - 2020 Goldring MOB's (a.)	74,774	14	% 10	% 12	% 17	% 7	% 2	% 38	% 0	% 0	0 %
Goldshadow - 700 Shadow Lane MOB (a.)	42,060	23	% 23	% 23	% 19	% 0	% 0	% 12	% 0	% 0	0 %
Texoma Medical Plaza	115,284	0	% 3	% 55	% 5	% 14	% 6	% 17	% 0	% 0	0 %
St. Matthews Medical Plaza II	103,011	0	% 2	% 0	% 11	% 18	% 0	% 69	% 0	% 0	0 %
Desert Springs Medical Plaza (a.)	102,579	43	% 13	% 0	% 6	% 0	% 15	% 23	% 0	% 0	0 %
Peace Health Medical Clinic	98,886	0	% 0	% 0	% 100	% 0	% 0	% 0	% 0	% 0	0 %
Centennial Hills Medical Office Building	96,573	24	% 9	% 22	% 12	% 11	% 17	% 5	% 0	% 0	0 %
Summerlin Hospital Medical Office Building II (b.)	92,313	23	% 17	% 13	% 38	% 6	% 3	% 0	% 0	% 0	0 %
Summerlin Hospital Medical Office Building I (a.)	89,636	24	% 18	% 29	% 9	% 0	% 0	% 20	% 0	% 0	0 %
Chandler Corporate Center III	81,770	8	% 0	% 0	% 0	% 0	% 0	% 92	% 0	% 0	0 %
3811 E. Bell	80,302	46	% 8	% 6	% 7	% 0	% 7	% 26	% 0	% 0	0 %
Henderson Union Village MOB	78,966	63	% 0	% 0	% 0	% 3	% 0	% 34	% 0	% 0	0 %
Summerlin Hospital Medical Office Building III (c.)	77,713	2	% 44	% 10	% 18	% 9	% 8	% 9	% 0	% 0	0 %
Mid Coast Hospital MOB	74,629	0	% 0	% 0	% 4	% 0	% 5	% 91	% 0	% 0	0 %
North West Texas Professional Office Tower	72,351	0	% 0	% 0	% 0	% 64	% 36	% 0	% 0	% 0	0 %
Rosenberg Children's Medical Plaza	66,231	0	% 6	% 3	% 0	% 0	% 51	% 40	% 0	% 0	0 %
Frederick Crestwood MOB	62,297	0	% 0	% 0	% 0	% 0	% 0	% 100	% 0	% 0	0 %
Palmdale Medical Plaza	59,405	44	% 9	% 16	% 12	% 0	% 9	% 10	% 0	% 0	0 %
Sierra San Antonio Medical Plaza	59,160	27	% 1	% 0	% 13	% 5	% 33	% 21	% 0	% 0	0 %
Spring Valley Medical Office Building (a.)	57,828	22	% 20	% 18	% 12	% 6	% 4	% 18	% 0	% 0	0 %
Spring Valley Medical Office Building II	57,265	34	% 3	% 17	% 20	% 15	% 0	% 11	% 0	% 0	0 %
Southern Crescent Center II	53,680	39	% 8	% 4	% 0	% 39	% 0	% 10	% 0	% 0	0 %
Desert Valley Medical Center (a.)	53,625	2	% 15	% 10	% 13	% 21	% 34	% 5	% 0	% 0	0 %
Tuscan Professional Building	53,231	3	% 5	% 30	% 19	% 39	% 4	% 0	% 0	% 0	0 %
Lake Pointe Medical Arts Building (d.)	50,974	0	% 14	% 22	% 33	% 15	% 4	% 12	% 0	% 0	0 %
Forney Medical Plaza	50,947	19	% 0	% 0	% 36	% 5	% 19	% 21	% 0	% 0	0 %

Edgar Filing: LSI CORP - Form S-8 POS

Vista Medical Terrace	50,921	56	% 8	% 6	% 0	% 14	% 9	% 7	%
2704 N. Tenaya Way	44,894	0	% 0	% 0	% 0	% 0	% 100	% 0	%
Southern Crescent Center I	41,897	74	% 5	% 0	% 0	% 0	% 21	% 0	%
Auburn Medical Office Building	41,311	19	% 0	% 20	% 0	% 61	% 0	% 0	%
BRB Medical Office Building (b.)	40,733	11	% 12	% 67	% 10	% 0	% 0	% 0	%
Cypresswood Professiona Center - 8101	10,200	100	% 0	% 0	% 0	% 0	% 0	% 0	%
Cypresswood Professional Center - 8111	29,882	28	% 6	% 12	% 0	% 0	% 0	% 54	%
Danbury Medical Plaza (c.)	36,141	24	% 76	% 0	% 0	% 0	% 0	% 0	%
The Sparks Medical Building (b.)	35,127	0	% 16	% 4	% 0	% 20	% 30	% 30	%
Phoenix Children's East Valley Care Center	30,960	0	% 0	% 0	% 0	% 0	% 0	% 100	%
Forney Medical Plaza II	30,507	46	% 0	% 0	% 0	% 0	% 19	% 35	%
Madison Station MOB	30,096	0	% 0	% 0	% 0	% 100	% 0	% 0	%
Apache Junction Medical Plaza (a.)	26,901	9	% 17	% 0	% 34	% 32	% 0	% 8	%
Santa Fe Professional Plaza	24,883	9	% 6	% 10	% 27	% 17	% 31	% 0	%
Professional Bldg at King's Crossing - Bldg A	11,528	100	% 0	% 0	% 0	% 0	% 0	% 0	%
Professional Bldg at King's Crossing - Bldg B (a.)	12,790	0	% 11	% 0	% 0	% 32	% 38	% 19	%
King's Crossing II	20,470	100	% 0	% 0	% 0	% 0	% 0	% 0	%
Emory at Dunwoody Building	20,366	0	% 0	% 0	% 0	% 0	% 0	% 100	%

Edgar Filing: LSI CORP - Form S-8 POS

Piedmont - Roswell Physicians Center	19,927	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %
Piedmont - Vinings Physicians Center	16,790	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %
Ward Eagle Office Village	16,282	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %	0 %	0 %
Haas Medical Office Park	15,850	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %
Health Center at Hamburg	15,400	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %
Northwest Medical Center at Sugar Creek	13,696	0 %	0 %	0 %	0 %	0 %	0 %	21 %	17 %	0 %	0 %	62 %
Family Doctor's MOB	12,050	0 %	0 %	0 %	0 %	100 %	0 %	0 %	0 %	0 %	0 %	0 %
Beaumont Sleep Center	11,556	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %
701 South Tonopah Building	10,747	0 %	0 %	0 %	0 %	100 %	0 %	0 %	0 %	0 %	0 %	0 %
The Children's Clinic at Springdale	9,761	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %	0 %	0 %
5004 Pool Road MOB	4,400	0 %	0 %	0 %	0 %	0 %	0 %	100 %	0 %	0 %	0 %	0 %

Preschool and Childcare Centers:

Chesterbrook Academy - Audubon	8,300	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %
Chesterbrook Academy - Uwchlan	8,163	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %
Chesterbrook Academy - Newtown	8,100	0 %	0 %	0 %	0 %	100 %	0 %	0 %	0 %	0 %	0 %	0 %
Chesterbrook Academy - New Britain	7,998	0 %	0 %	0 %	100 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %

Ambulatory Care Centers:

Hanover Emergency Center	22,000	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %
South Texas ER at Mission	13,578	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %
South Texas ER at Weslaco	13,578	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %
Las Palmas Del Sol Emergency Center-West	9,395	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	100 %
Sub-total Other Investments	2,682,668	18 %	8 %	10 %	13 %	11 %	11 %	11 %	11 %	29 %	29 %	29 %
Total	3,728,504	13 %	10 %	7 %	22 %	8 %	8 %	8 %	8 %	32 %	32 %	32 %

- (a) The estimated market rates related to the 2019 expiring RSF are greater than the lease rates on the expiring leases by an average of approximately 1% to 6%.
- (b) The estimated market rates related to the 2019 expiring RSF are less than the lease rates on the expiring leases by an average of approximately 1% to 3%.
- (c) The estimated market rates related to the 2019 expiring RSF are less than the lease rates on the expiring leases by an average of approximately 9% to 10%.
- (d) The estimated market rates related to the 2019 expiring RSF are less than the lease rates on the expiring leases by an average of approximately 36%.

On a combined basis, based upon the aggregate revenues and square footage for the hospital facilities owned as of December 31, 2018 and 2017, the average effective annual rental per square foot was \$18.28 and \$18.19, respectively. On a combined basis, based upon the aggregate consolidated and unconsolidated revenues and the estimated average occupied square footage for our MOB, FEDs and childcare centers owned as of December 31, 2018 and 2017, the average effective annual rental per square foot was \$29.65 and \$28.40, respectively, excluding an early lease termination fee and hurricane business interruption insurance recovery proceeds during 2018. On a combined basis, based upon the aggregate consolidated and unconsolidated revenues and estimated average occupied square footage for all of our properties owned as of December 31, 2018 and 2017, the average effective annual rental per square foot was \$25.99 and \$25.14, respectively, excluding an early lease termination fee and hurricane business interruption insurance recovery proceeds during 2018. The estimated average occupied square footage for 2018 was calculated by averaging the unavailable rentable square footage on January 1, 2018 and January 1, 2019. The estimated average occupied square footage for 2017 was calculated by averaging the unavailable rentable square footage on January 1, 2017 and January 1, 2018.

None of our properties generated revenues that comprised 10% or more of our consolidated revenues during 2018. Additionally, none of the properties had book values greater than 10% of our consolidated assets as of

December 31, 2018. 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 2018. 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.

Edgar Filing: LSI CORP - Form S-8 POS

The following table sets forth lease expirations for each of the next ten years for our properties as of December 31, 2018.

	Expiring Square Feet	Number of Tenants	Annual Rentals of Expiring Leases(1)	Percentage of Annual Rentals(2)	
Hospital properties					
2019	147,140	2	\$ 1,452,059	2	%
2020	0	0	0	0	%
2021	476,420	3	5,514,290	7	%
2022	0	0	0	0	%
2023	0	0	0	0	%
2024	0	0	0	0	%
2025	0	0	0	0	%
2026	422,276	1	7,161,920	9	%
2027	0	0	0	0	%
2028	0	0	0	0	%
Thereafter	0	0	0	0	%
Subtotal-hospital facilities	1,045,836	6	\$ 14,128,269	18	%
Other consolidated properties					
2019	197,893	70	\$ 5,999,844	8	%
2020	209,332	62	6,685,451	8	%
2021	335,811	61	9,840,603	12	%
2022	248,714	48	7,429,902	9	%
2023	278,464	51	7,700,848	10	%
2024	101,166	15	2,938,364	4	%
2025	143,510	17	4,220,745	5	%
2026	79,538	11	2,294,838	3	%
2027	135,444	8	3,832,330	5	%
2028	29,375	6	945,592	1	%
Thereafter	119,565	7	3,289,201	4	%
Subtotal-other consolidated properties	1,878,812	356	\$ 55,177,718	69	%
Other unconsolidated properties (MOBs)					
2019	5,606	3	\$ 169,800	0	%
2020	63,189	8	1,967,391	2	%
2021	19,619	6	577,613	1	%
2022	34,452	9	1,027,507	1	%
2023	16,542	5	617,829	1	%
2024	34,508	6	1,084,940	1	%
2025	45,610	5	1,309,752	2	%
2026	68,024	8	1,995,285	3	%
2027	12,331	4	526,839	1	%
2028	9,318	2	275,950	1	%
Thereafter	0	0	-	0	%
Subtotal-other unconsolidated properties	309,199	56	\$ 9,552,906	13	%

Edgar Filing: LSI CORP - Form S-8 POS

Total all properties at December 31, 2018 3,233,847 418 \$ 78,858,893 100 %

- (1) The annual rentals of expiring leases reflected above were calculated based upon each property's 2018 average rental rate per occupied square foot applied to each property's scheduled lease expirations (on a square foot basis). These amounts include the data related to the unconsolidated LLCs/LPs in which we hold various non-controlling ownership interests at December 31, 2018 and exclude the bonus rentals earned on the UHS hospital facilities.
- (2) The percentages of annual rentals reflected above were calculated based upon the annual rentals of expiring leases (as reflected above) divided by the total annual rentals of expiring leases (as reflected above).

ITEM 3. Legal Proceedings

None

ITEM 4. Mine Safety Disclosures

Not applicable

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 under the symbol UHT. The high and low closing sales prices for our shares of beneficial interest for each quarter in the years ended December 31, 2018 and 2017 are summarized below:

	2018		2017	
	High	Low	High	Low
	Price	Price	Price	Price
First Quarter	\$73.77	\$53.36	\$66.64	\$60.01
Second Quarter	\$66.76	\$58.05	\$79.68	\$64.20
Third Quarter	\$76.34	\$63.61	\$84.23	\$73.35
Fourth Quarter	\$73.69	\$59.51	\$78.02	\$72.14

Holders

As of January 31, 2019, there were approximately 324 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:

	2018	2017
First Quarter	\$.665	\$.655
Second Quarter	.670	.660
Third Quarter	.670	.660
Fourth Quarter	.675	.665
	\$2.680	\$2.640

Equity Compensation

Refer to Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, of this report for information regarding securities authorized for issuance under our equity compensation plan.

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., Omega Healthcare Investors, Inc., Welltower, Inc. (previously known as Health Care REIT, Inc.), Healthcare Realty Trust, Inc., LTC Properties, Inc., and National Health Investors, Inc.

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 2013.

Company Name / Index	Base	INDEXED RETURNS				
	Period	Years Ending				
	Dec	Dec 14	Dec 15	Dec 16	Dec 17	Dec 18
Universal Health Realty Income Trust	\$ 100	\$127.19	\$139.14	\$190.48	\$226.10	\$192.53
S&P 500 Index	\$ 100	\$113.69	\$115.26	\$129.05	\$157.22	\$150.33
Peer Group	\$ 100	\$136.96	\$129.32	\$129.64	\$127.53	\$146.08

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, 2018. 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)				
	2018	2017	2016	2015	2014
Operating Results:					
Total revenues(1)	\$76,210	\$72,348	\$67,081	\$63,950	\$59,786
Net income(2)	\$24,196	\$45,619	\$17,215	\$23,691	\$51,551
Balance Sheet Data:					
Real estate investments, net of accumulated depreciation(1)					
	\$437,730	\$446,397	\$447,240	\$390,496	\$380,109
Investments in LLCs, net of liabilities(1)(3)	2,760	2,776	33,731	30,492	8,605
Intangible assets, net of accumulated amortization	17,407	20,559	23,815	19,757	23,123
Total assets(1)	483,756	490,008	524,750	458,503	428,490
Total indebtedness, including debt premium(1)(4)	261,281	256,409	315,717	252,306	212,779
Other Data:					
Funds from operations(5)	\$45,034	\$42,228	\$41,559	\$38,349	\$35,937
Cash provided by (used in):					
Operating activities	42,928	46,005	40,733	38,178	32,796
Investing activities	(7,959)	39,461	(74,834)	(44,309)	(4,038)
Financing activities	(33,320)	(86,009)	34,137	6,164	(29,815)
Per Share Data:					
Basic earnings per share:					
Total basic earnings per share(2)	\$1.76	\$3.35	\$1.28	\$1.78	\$3.99
Diluted earnings per share:					
Total diluted earnings per share(2)	\$1.76	\$3.35	\$1.28	\$1.78	\$3.99
Diluted funds from operations per share:					
Total diluted funds from operations per share	\$3.28	\$3.10	\$3.09	\$2.88	\$2.78
Dividends per share	\$2.680	\$2.640	\$2.600	\$2.560	\$2.520
Other Information					
Weighted average number of shares outstanding—basic	13,722	13,625	13,464	13,293	12,927
Weighted average number of shares and share equivalents					
outstanding—diluted	13,722	13,625	13,468	13,301	12,934

(1)As discussed in Note 1 “Summary of Significant Accounting Policies—Investments in Limited Liability Companies”, our consolidated financial statements only include the accounts of our consolidated investments.

(2)Net income and earnings per share during 2018 includes (i) \$4.5 million of hurricane recovery proceeds in excess of damaged property write-downs; (ii) \$1.2 million of hurricane-related business interruption insurance recovery proceeds (approximately \$500,000 of which related to 2017), and; (iii) \$1.7 million of revenue related to a lease termination agreement. Net income and earnings per share during 2017 includes: (i) \$2.0 million of hurricane recovery proceeds received in excess of damaged property write-downs, and; (ii) a \$27.2 million net gain (net of related transaction costs) recorded in connection with the Arlington transaction, as discussed in Note 3 “New Construction, Acquisitions, Dispositions and Property Exchange Transaction”. Net income and earnings per share

during 2016 includes \$528,000 of transactions costs related to various transactions during 2016. Net income and earnings per share during 2015 includes: (i) an \$8.7 million gain recorded in connection with a property exchange transaction, and; (ii) \$243,000 of transaction costs related to various transactions during 2015. Net income and earnings per share during 2014 includes: (i) a \$25.4 million gain recorded in connection with our purchase of third-party minority ownership interests in eight LLCs (January and August, 2014) in which we formerly held non-controlling majority ownership interests (we own 100% of each of these entities since the effective dates); (ii) a \$13.0 million gain on the divestiture of real property (the Bridgeway), and; (iii) \$427,000 of transaction costs related to the 2014 acquisition and divestiture activity previously mentioned.

(3) In March, 2017, as discussed in Note 3 “New Construction, Acquisitions, Dispositions and Property Exchange Transaction”, Arlington Medical Properties, LLC a formerly jointly-owned LLC in which we held an 85% noncontrolling ownership interest, sold the real estate assets of St. Mary’s Professional Office Building which generated \$57.3 million of net cash proceeds to us. Investments in LLCs at December 31, 2014 reflect the consolidation of various LLCs, as mentioned in note 2 above. Investments in LLCs at December 31, 2015 and 2016 includes a member loan issued to St. Mary’s Professional Office Building,

amounting to \$22.7 million and \$21.6 million, respectively, which was repaid to us in 2017 when the real estate assets were sold.

- (4) Excludes third-party debt that is non-recourse to us, incurred by unconsolidated LLCs in which we hold various non-controlling equity interests as follows: \$27.3 million as of December 31, 2018, \$27.8 million as of December 31, 2017, \$28.4 million as of December 31, 2016, \$28.9 million as of December 31, 2015 and \$52.7 million as of December 31, 2014 (See Note 8 to the consolidated financial statements).
- (5) Our funds from operations (“FFO”) during 2017, 2016, 2015 and 2014 are net of reductions for transaction costs of \$107,000, \$528,000, \$243,000, \$427,000 and \$203,000, respectively. There were no transaction costs during 2018 that impacted FFO. On January 1, 2017, we adopted ASU 2017-01 “Business Combinations (Topic 805) – Clarifying the Definition of a Business”, which permits the capitalization of acquisition costs to the underlying assets since acquisitions are now generally considered asset acquisitions versus business combinations.

Funds from operations (“FFO”) is a widely recognized measure of performance for Real Estate Investment Trusts (“REITs”). We believe that FFO and FFO per diluted share, which are non-GAAP financial measures, are helpful to our investors as measures of our operating performance. We compute FFO, as reflected on the attached Supplemental Schedules, in accordance with standards established by the National Association of Real Estate Investment Trusts (“NAREIT”), which may not be comparable to FFO reported by other REITs that do not compute FFO in accordance with the NAREIT definition, or that interpret the NAREIT definition differently than we interpret the definition. FFO adjusts for the effects of gains, such as gains on transactions and hurricane recovery proceeds in excess of damaged property write-downs during the periods presented. We adjusted for hurricane insurance recovery proceeds in excess of damaged property write-downs since we believe that this gain is similar in nature and has the same characteristics as an adjustment for gains/losses resulting from the sale of depreciable property, which are required to be excluded from FFO under NAREIT’s definition. FFO does not represent cash generated from operating activities in accordance with GAAP and should not be considered to be an alternative to net income determined in accordance with GAAP. In addition, FFO should not be used as: (i) an indication of our financial performance determined in accordance with GAAP; (ii) an alternative to cash flow from operating activities determined in accordance with GAAP; (iii) a measure of our liquidity, or; (iv) an indicator of funds available for our cash needs, including our ability to make cash distributions to shareholders.

A reconciliation of our reported net income to FFO for each of the last five years is shown below:

	(000s)				
	2018	2017	2016	2015	2014
Net income	\$24,196	\$45,619	\$17,215	\$23,691	\$51,551
Depreciation and amortization expense on real property/intangibles:					
Consolidated investments	24,337	24,598	22,493	21,710	20,548
Unconsolidated affiliates	1,036	1,240	1,851	1,690	2,290
Less gains:					
Gain on property exchange	—	—	—	(8,742)	—
Gains on fair value recognition resulting from the purchase of minority interests in majority-owned LLCs, net	—	—	—	—	(25,409)
Gain on divestiture of real property	—	—	—	—	(13,043)
Gain on Arlington transaction	—	(27,196)	—	—	—
Hurricane insurance recovery proceeds in excess of damaged property write-downs	(4,535)	(2,033)	—	—	—

Edgar Filing: LSI CORP - Form S-8 POS

Funds From Operations	\$45,034	\$42,228	\$41,559	\$38,349	\$35,937
Weighted average number of shares and equivalents outstanding					
- Diluted	13,722	13,625	13,468	13,301	12,934
Funds From Operations per diluted share	\$3.28	\$3.10	\$3.09	\$2.88	\$2.78

ITEM 7. Management's Discussion and Analysis of Financial Condition and Results of Operations Overview

We are a real estate investment trust ("REIT") that commenced operations in 1986. We invest in healthcare and human service related facilities currently including acute care hospitals, rehabilitation hospitals, sub-acute facilities, surgery centers, free-standing emergency departments, childcare centers and medical/office buildings. As of February 27, 2019, we have sixty-nine real estate investments or commitments in twenty states consisting of:

- six hospital facilities including three acute care, one rehabilitation and two sub-acute;
- four free-standing emergency departments ("FEDs");
- fifty-five medical/office buildings ("MOBs"), including four owned by unconsolidated LLCs/LPs, and;
- four preschool and childcare centers.

Forward Looking Statements

This report contains "forward-looking statements" that reflect our current estimates, expectations and projections about our future results, performance, prospects and opportunities. Forward-looking statements include, among other things, information concerning our possible future results of operations, business and growth strategies, financing plans, expectations that regulatory developments or other matters will not have a material adverse effect on our business or financial condition, our competitive position and the effects of competition, the projected growth of the industry in which we operate, and the benefits and synergies to be obtained from our completed and any future acquisitions, and statements of our goals and objectives, and other similar expressions concerning matters that are not historical facts. Words such as "may," "will," "should," "could," "would," "predicts," "potential," "continue," "expects," "anticipates," "future," "plans," "believes," "estimates," "appears," "projects" and similar expressions, as well as statements in future tense, identify forward-looking statements.

Forward-looking statements should not be read as a guarantee of future performance or results, and will not necessarily be accurate indications of the times at, or by which, such performance or results will be achieved. Forward-looking information is based on information available at the time and/or our good faith belief with respect to future events, and is subject to risks and uncertainties that could cause actual performance or results to differ materially from those expressed in the statements. Such factors include, among other things, the following:

- a substantial portion of our revenues are dependent upon one operator, Universal Health Services, Inc. ("UHS"), which comprised approximately 30%, 32% and 33% of our consolidated revenues for the years ended December 31, 2018, 2017 and 2016, respectively. We cannot assure you that subsidiaries of UHS will renew the leases on our three acute care hospitals (two of which are scheduled to expire in December, 2021 and one of which is scheduled to expire in December, 2026) and two FEDs at existing lease rates or fair market value lease rates. In addition, if subsidiaries of UHS exercise their options to purchase the respective leased hospital facilities and FEDs upon expiration of the lease terms, our future revenues and results of operations could decrease if we were unable to earn a favorable rate of return on the sale proceeds received, as compared to the rental revenue currently earned pursuant to these leases;
- in certain of our markets, the general real estate market has been unfavorably impacted by increased competition/capacity and decreases in occupancy and rental rates which may adversely impact our operating results and the underlying value of our properties;
- a number of legislative initiatives have recently been passed into law that may result in major changes in the health care delivery system on a national or state level to the operators of our facilities, including UHS. No assurances can be given that the implementation of these new laws will not have a material adverse effect on the business, financial condition or results of operations of our operators;
- the potential indirect impact of the Tax Cuts and Jobs Act of 2017 (the "2017 Tax Act"), signed into law on December 22, 2017, which makes significant changes to corporate and individual tax rates and calculation of taxes, which could potentially impact our tenants and jurisdictions, both positively and negatively, in which we do business, as well as

the overall investment thesis for REITs;

• a subsidiary of UHS is our Advisor and our officers are all employees of a wholly-owned subsidiary of UHS, which may create the potential for conflicts of interest;

• lost revenues resulting from the exercise of purchase options, lease expirations and renewals and other restructuring;

- our ability to continue to obtain capital on acceptable terms, including borrowed funds, to fund future growth of our business;
- the outcome and effects of known and unknown litigation, government investigations, and liabilities and other claims asserted against us, UHS or the other operators of our facilities. UHS and its subsidiaries are subject to pending legal actions, purported shareholder class actions and shareholder derivative cases, governmental investigations and regulatory actions and the effects of adverse publicity relating to such matters. Since UHS comprised approximately 30% of our consolidated revenues during the year ended December 31, 2018, and since a subsidiary of UHS is our Advisor, you are encouraged to obtain and review the disclosures contained in the Legal Proceedings section of Universal Health Services, Inc.'s Forms 10-Q and 10-K, as publicly filed with the Securities and Exchange Commission. Those filings are the sole responsibility of UHS and are not incorporated by reference herein;
- failure of UHS or the other operators of our hospital facilities to comply with governmental regulations related to the Medicare and Medicaid licensing and certification requirements could have a material adverse impact on our future revenues and the underlying value of the property;
- the potential unfavorable impact on our business of deterioration in national, regional and local economic and business conditions, including a worsening of credit and/or capital market conditions, which may adversely affect our ability to obtain capital which may be required to fund the future growth of our business and refinance existing debt with near term maturities;
- a deterioration in general economic conditions which could result in increases in the number of people unemployed and/or insured and likely increase the number of individuals without health insurance; as a result, the operators of our facilities may experience decreases in patient volumes which could result in decreased occupancy rates at our medical office buildings;
- a worsening of the economic and employment conditions in the United States could materially affect the business of our operators, including UHS, which may 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;
- real estate market factors, including without limitation, 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;
- the impact of property values and results of operations of severe weather conditions, including the effects of Hurricane Harvey on several of our properties in Texas;
- government regulations, including changes in the reimbursement levels under the Medicare and Medicaid programs;
- the issues facing the health care industry that affect the operators of our facilities, including UHS, such as: changes in, or the ability to comply with, existing laws and government regulations; unfavorable changes in the levels and terms of reimbursement by third party payors or government programs, including Medicare (including, but not limited to, the potential unfavorable impact of future reductions to Medicare reimbursements resulting from the Budget Control Act of 2011, as discussed below) and Medicaid (most states have reported significant budget deficits that have, in the past, resulted in the reduction of Medicaid funding to the operators of our facilities, including UHS); demographic changes; the ability to enter into managed care provider agreements on acceptable terms; an increase in uninsured and self-pay patients which unfavorably impacts the collectability of patient accounts; decreasing in-patient admission trends; technological and pharmaceutical improvements that may increase the cost of providing, or reduce the demand for, health care, and; the ability to attract and retain qualified medical personnel, including physicians;
 - in August, 2011, the Budget Control Act of 2011 (the "2011 Act") was enacted into law. The 2011 Act imposed annual spending limits for most federal agencies and programs aimed at reducing budget deficits by \$917 billion between 2012 and 2021, according to a report released by the Congressional Budget Office. The 2011 Act provides for new spending on program integrity initiatives intended to reduce fraud and abuse under the Medicare program. Among its other provisions, the law established a bipartisan Congressional committee, known as the Joint Select Committee on Deficit Reduction (the "Joint Committee"), which was tasked with making recommendations aimed at reducing future federal

budget deficits by an additional \$1.5 trillion over 10 years. The Joint Committee was unable to reach an agreement by the November 23, 2011 deadline and, as a result, across-the-board cuts to discretionary, national defense and Medicare spending were implemented on March 1, 2013 resulting in Medicare payment reductions of up to 2% per fiscal year with a uniform percentage reduction across all Medicare programs. The Bipartisan Budget Act of 2015, enacted on November 2, 2015, continued the 2% reductions to Medicare reimbursement imposed under the 2011 Act. We cannot predict whether Congress will restructure the implemented Medicare payment reductions or what federal other deficit reduction initiatives

may be proposed by Congress going forward. We also cannot predict the effect these enactments will have on operators (including UHS), and, thus, our business;

• in March, 2010, the Health Care and Education Reconciliation Act of 2010 and the Patient Protection and Affordable Care Act (the “ACA”) 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. Initiatives to repeal the ACA, in whole or in part, to delay elements of implementation or funding, and to offer amendments or supplements to modify its provisions, have been persistent. The ultimate outcomes of legislative attempts to repeal or amend the ACA and legal challenges to the ACA are unknown. Recent Congressional and Presidential election results created a political environment in which there have been repeated attempts to repeal or replace substantial portions of the ACA;

• an increasing number of legislative initiatives have been passed into law that may result in major changes in the health care delivery system on a national or state level. Legislation has already been enacted that has eliminated the penalty for failing to maintain health coverage that was part of the original Legislation. President Trump has already taken executive actions: (i) requiring all federal agencies with authorities and responsibilities under the Legislation to “exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay” parts of the Legislation that place “unwarranted economic and regulatory burdens” on states, individuals or health care providers; (ii) the issuance of a final rule in June, 2018 by the Department of Labor to enable the formation of association health plans that would be exempt from certain Legislation requirements such as the provision of essential health benefits; (iii) the issuance of a final rule in August, 2018 by the Department of Labor, Treasury, and Health and Human Services to expand the availability of short-term, limited duration health insurance, (iv) eliminating cost-sharing reduction payments to insurers that would otherwise offset deductibles and other out-of-pocket expenses for health plan enrollees at or below 250 percent of the federal poverty level; (v) relaxing requirements for state innovation waivers that could reduce enrollment in the individual and small group markets and lead to additional enrollment in short-term, limited duration insurance and association health plans; and (vi) the issuance of a proposed rule by the Department of Labor, Treasury, and Health and Human Services that would be incentivize the use of health reimbursement accounts by employers to permit employees to purchase health insurance in the individual market. The uncertainty resulting from these Executive Branch policies has led to reduced Exchange enrollment in 2018 and 2019 and is expected to further worsen the individual and small group market risk pools in future years. It is also anticipated that these and future policies may create additional cost and reimbursement pressures on hospitals. In addition, while attempts to repeal the entirety of the Affordable Care Act (“ACA”) have not been successful to date, a key provision of the ACA was repealed as part of the Tax Cuts and Jobs Act and on December 14, 2018, a federal U.S. District Court Judge in Texas ruled the entire ACA is unconstitutional. While that ruling is stayed and has been appealed, it has caused greater uncertainty regarding the future status of the ACA. If all or any parts of the ACA are found to be unconstitutional, it could have a material adverse effect on the business, financial condition and results of operations of the operators of our properties, and, thus, our business;

• there can be no assurance that if any of the announced or proposed changes described above are implemented there will not be negative financial impact on the operators of our hospitals, which material effects may include a potential decrease in the market for health care services or a decrease in the ability of the operators of our hospitals to receive reimbursement for health care services provided which could result in a material adverse effect on the financial condition or results of operations of the operators of our properties, and, thus, our business;

• competition for our operators from other REITs;

• the operators of our facilities face competition from other health care providers, including physician owned facilities and other competing facilities, including certain facilities operated by UHS but the real property of which is not owned by us. Such competition is experienced in markets including, but not limited to, McAllen, Texas, the site of our McAllen Medical Center, a 370-bed acute care hospital, and Riverside County, California, the site of our Southwest Healthcare System-Inland Valley Campus, a 130-bed acute care hospital;

•

changes in, or inadvertent violations of, tax laws and regulations and other factors than can affect REITs and our status as a REIT;

• 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;

• our ownership interest in four LLCs/LPs in which we hold non-controlling equity interests. In addition, pursuant to the operating and/or partnership agreements of the four LLCs/LPs in which we continue to hold non-controlling ownership

interests, the third-party member and the Trust, at any time, potentially subject to certain conditions, 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 to 90 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 to 90 days of the acceptance by the Non-Offering Member; fluctuations in the value of our common stock, and; other factors referenced herein or in our other filings with the Securities and Exchange Commission.

Given these uncertainties, risks and assumptions, you are cautioned not to place undue reliance on such forward-looking statements. Our actual results and financial condition, including the operating results of our lessees and the facilities leased to subsidiaries of UHS, could differ materially from those expressed in, or implied by, the forward-looking statements.

Forward-looking statements speak only as of the date the statements are made. We assume no obligation to publicly update any forward-looking statements to reflect actual results, changes in assumptions or changes in other factors affecting forward-looking information, except as may be required by law. All forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by this cautionary statement.

Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes.

We consider our critical accounting policies to be those that require us to make significant judgments and estimates when we prepare our financial statements, including the following:

Purchase Accounting for Acquisition of Investments in Real Estate: Purchase accounting is applied to the assets and liabilities related to all real estate investments acquired from third parties. In accordance with current accounting guidance, we account for our property acquisitions as acquisitions of assets, which requires the capitalization of acquisition costs to the underlying assets. The fair value of the real estate acquired is allocated to the acquired tangible assets, consisting primarily of land, building and tenant improvements, and identified intangible assets and liabilities, consisting of the value of above-market and below-market leases, and acquired ground leases, based in each case on their fair values. Loan premiums, in the case of above market rate assumed loans, or loan discounts, in the case of below market assumed loans, are recorded based on the fair value of any loans assumed in connection with acquiring the real estate.

The fair values of the tangible assets of an acquired property are determined based on comparable land sales for land and replacement costs adjusted for physical and market obsolescence for the improvements. The fair values of the tangible assets of an acquired property are also determined by valuing the property as if it were vacant, and the “as-if-vacant” value is then allocated to land, building and tenant improvements based on management’s determination of the relative fair values of these assets. Management determines the as-if-vacant fair value of a property based on assumptions that a market participant would use, which is similar to methods used by independent appraisers. In addition, there is intangible value related to having tenants leasing space in the purchased property, which is referred to as in-place lease value. Such value results primarily from the buyer of a leased property avoiding the costs

associated with leasing the property and also avoiding rent losses and unreimbursed operating expenses during the hypothetical lease-up period. Factors considered by management in performing these analyses include an estimate of carrying costs during the expected lease-up periods considering current market conditions and costs to execute similar leases. In estimating carrying costs, management includes real estate taxes, insurance and other operating expenses and estimates of lost rental revenue during the expected lease-up periods based on current market demand. Management also estimates costs to execute similar leases including leasing commissions, tenant improvements, legal and other related costs. The value of in-place leases are amortized to expense over the remaining initial terms of the respective leases.

In allocating the fair value of the identified intangible assets and liabilities of an acquired property, above-market and below-market in-place lease values are recorded based on the present value (using an interest rate which reflects the risks associated with the leases acquired) of the difference between (i) the contractual amounts to be paid pursuant to the in-place leases and (ii) estimated fair market lease rates from the perspective of a market participant for the corresponding in-place leases, measured, for above-market leases, over a period equal to the remaining non-cancelable term of the lease and, for below-market leases, over a period equal to the

initial term plus any below market fixed rate renewal periods. The capitalized above-market lease values are amortized as a reduction of rental income over the remaining non-cancelable terms of the respective leases. The capitalized below-market lease values, also referred to as acquired lease obligations, are amortized as an increase to rental income over the initial terms of the respective leases.

Asset Impairment: We review each of our properties for indicators that its carrying amount may not be recoverable. Examples of such indicators may include a significant decrease in the market price of the property, a change in the expected holding period for the property, a significant adverse change in how the property is being used or expected to be used based on the underwriting at the time of acquisition, an accumulation of costs significantly in excess of the amount originally expected for the acquisition or development of the property, or a history of operating or cash flow losses of the property. When such impairment indicators exist, we review an estimate of the future undiscounted net cash flows (excluding interest charges) expected to result from the real estate investment's use and eventual disposition and compare that estimate to the carrying value of the property. We consider factors such as future operating income, trends and prospects, as well as the effects of leasing demand, competition and other factors. If our future undiscounted net cash flow evaluation indicates that we are unable to recover the carrying value of a real estate investment, an impairment loss is recorded to the extent that the carrying value exceeds the estimated fair value of the property. The evaluation of anticipated cash flows is highly subjective and is based in part on assumptions regarding future occupancy, rental rates and capital requirements that could differ materially from actual results in future periods. Since cash flows on properties considered to be long-lived assets to be held and used are considered on an undiscounted basis to determine whether the carrying value of a property is recoverable, our strategy of holding properties over the long-term directly decreases the likelihood of their carrying values not being recoverable and therefore requiring the recording of an impairment loss. If our strategy changes or market conditions otherwise dictate an earlier sale date, an impairment loss may be recognized and such loss could be material. If we determine that the asset fails the recoverability test, the affected assets must be reduced to their fair value.

We generally estimate the fair value of rental properties utilizing a discounted cash flow analysis that includes projections of future revenues, expenses and capital improvement costs that a market participant would use based on the highest and best use of the asset, which is similar to the income approach that is commonly utilized by appraisers. In certain cases, we may supplement this analysis by obtaining outside broker opinions of value or third party appraisals.

In considering whether to classify a property as held for sale, we consider factors such as whether management has committed to a plan to sell the property, the property is available for immediate sale in its present condition for a price that is reasonable in relation to its current value, the sale of the property is probable, and actions required for management to complete the plan indicate that it is unlikely that any significant changes will be made to the plan. If all the criteria are met, we classify the property as held for sale. Upon being classified as held for sale, depreciation and amortization related to the property ceases and it is recorded at the lower of its carrying amount or fair value less cost to sell. The assets and related liabilities of the property are classified separately on the consolidated balance sheets for the most recent reporting period. Only those assets held for sale that constitute a strategic shift or that will have a major effect on our operations are classified as discontinued operations.

An other than temporary impairment of an investment in an unconsolidated LLC is recognized when the carrying value of the investment is not considered recoverable based on evaluation of the severity and duration of the decline in value, including projected declines in cash flow. To the extent impairment has occurred, the excess carrying value of the asset over its estimated fair value is charged to income.

Federal Income Taxes: No provision has been made for federal income tax purposes since we qualify as a REIT under Sections 856 to 860 of the Internal Revenue Code of 1986, and intend to continue to remain so qualified. To qualify as a REIT, we must meet certain organizational and operational requirements, including a requirement to distribute at least 90% of our annual REIT taxable income to shareholders. As a REIT, we generally will not be subject to federal, state or local income tax on income that we distribute as dividends to our shareholders. We have historically distributed, and intend to continue to distribute, 100% of our annual REIT taxable income to our shareholders.

We are subject to a federal excise tax computed on a calendar year basis. The excise tax equals 4% of the amount by which 85% of our ordinary income plus 95% of any capital gain income for the calendar year exceeds cash distributions during the calendar year, as defined. No provision for excise tax has been reflected in the financial statements as no tax was due.

Earnings and profits, which determine the taxability of dividends to shareholders, will differ from net income reported for financial reporting purposes due to the differences for federal tax purposes in the cost basis of assets and in the estimated useful lives used to compute depreciation and the recording of provision for investment losses.

Results of Operations

Year ended December 31, 2018 as compared to the year ended December 31, 2017:

For the year ended December 31, 2018, net income was \$24.2 million as compared to \$45.6 million during 2017. The \$21.4 million decrease was primarily attributable to:

- a \$27.2 million decrease due to the gain recorded during the first quarter of 2017 in connection with our purchase of the minority interest in, and subsequent divestiture of, the St. Mary's Professional Office Building ("Arlington transaction");
- a \$2.5 million increase resulting from the increase in hurricane insurance recoveries in excess of property damage write-downs recorded during 2018 as compared to 2017;
- a \$1.7 million increase in connection with a lease termination agreement entered into during 2018;
- a \$1.2 million increase resulting from hurricane-related business interruption insurance recovery proceeds recorded during 2018 (approximately \$500,000 of which related to 2017);
- a \$645,000 decrease in equity in income of LLCs, due primarily to the March, 2017 divestiture of St. Mary's Professional Office Building;
- a decrease of approximately \$400,000 resulting from non-recurring repairs and remediation expenses incurred during 2018 at one of our medical office buildings, and;
- other combined net increases of approximately \$1.4 million due to the increased net income generated at various properties, including the properties acquired during 2018 and 2017.

Total revenues increased \$3.9 million, or 5.3%, during 2018 as compared to 2017 due primarily to the revenues generated at MOB's acquired during 2018 and 2017, as well as net increases at various other properties.

Included in our other operating expenses are expenses related to the consolidated medical office buildings, which totaled \$18.6 million and \$17.4 million for the years ended December 31, 2018 and 2017, respectively. The increase in operating expenses during 2018 as compared to 2017 is partially due to: (i) the newly constructed medical office building which opened in April, 2017, and; (ii) approximately \$400,000 of non-recurring repairs and remediation expenses incurred at one of our medical office buildings. A large portion of the expenses associated with our consolidated medical office buildings is passed on directly to the tenants either directly as tenant reimbursements of common area maintenance expenses or included in base rental amounts. Tenant reimbursements for operating expenses are accrued as revenue in the same period the related expenses are incurred and are included as tenant reimbursement revenue in our condensed consolidated statements of income.

During 2018, we had a total of 34 new or renewed leases related to the medical office buildings as indicated in Item 2. Properties, in which we have significant investments, some of which are accounted for by the equity method. These leases comprised approximately 17% of the aggregate rentable square feet of these properties (14% related to renewed leases and 3% related to new leases). During 2017, we had a total of 38 new or renewed leases related to the medical office buildings, in which we have significant investments, some of which are accounted for by the equity method. These leases comprised approximately 10% of the aggregate rentable square feet of these properties (7% related to renewed leases and 3% related to new leases).

Rental rates, tenant improvement costs and rental concessions vary from property to property based upon factors such as, but not limited to, the current occupancy and age of our buildings, local overall economic conditions, proximity to hospital campuses and the vacancy rates, rental rates and capacity of our competitors in the market. The weighted-average tenant improvement costs associated with new or renewed leases was approximately \$10 per square foot during each of 2018 and 2017. The weighted-average leasing commissions on the new and renewed leases commencing during each year was approximately 4% of base rental revenue over the term of the leases during 2018 and 2% of base rental revenue over the term of the leases during 2017. The average aggregate value of the tenant

concessions, generally consisting of rent abatements, provided in connection with new and renewed leases commencing during each year was approximately 0.5% of the future aggregate base rental revenue over the lease terms during 2018 and approximately 2% of the future aggregate base rental revenue over the lease terms during 2017. Rent abatements were, or will be, recognized in our results of operations under the straight-line method over the lease term regardless of when payments are due. In connection with lease renewals executed during each year, the weighted-average rental rates, as compared to rental rates on the expired leases, decreased by approximately 3% during each of 2018 and 2017.

Funds from operations (“FFO”) is a widely recognized measure of performance for Real Estate Investment Trusts (“REITs”). We believe that FFO and FFO per diluted share, which are non-GAAP financial measures, are helpful to our investors as measures of our operating performance. We compute FFO, as reflected on the attached Supplemental Schedules, in accordance with standards established by the National Association of Real Estate Investment Trusts (“NAREIT”), which may not be comparable to FFO reported by other REITs that do not compute FFO in accordance with the NAREIT definition, or that interpret the NAREIT definition differently than we interpret the definition. FFO adjusts for the effects of gains, such as gains on transactions and hurricane recovery proceeds in excess of

damaged property write-downs during the periods presented. We adjusted for hurricane insurance recovery proceeds in excess of damaged property write-downs since we believe that this gain is similar in nature and has the same characteristics as an adjustment for gains/losses resulting from the sale of depreciable property, which are required to be excluded from FFO under NAREIT's definition. FFO does not represent cash generated from operating activities in accordance with GAAP and should not be considered to be an alternative to net income determined in accordance with GAAP. In addition, FFO should not be used as: (i) an indication of our financial performance determined in accordance with GAAP; (ii) an alternative to cash flow from operating activities determined in accordance with GAAP; (iii) a measure of our liquidity, or; (iv) an indicator of funds available for our cash needs, including our ability to make cash distributions to shareholders.

Below is a reconciliation of our reported net income to FFO for 2018 and 2017 (in thousands):

	2018	2017
Net income	\$24,196	\$45,619
Depreciation and amortization expense on consolidated investments	24,337	24,598
Depreciation and amortization expense on unconsolidated affiliates	1,036	1,240
Hurricane insurance recovery proceeds in excess of damaged property write-downs	(4,535)	(2,033)
Gain on Arlington transaction	—	(27,196)
Funds From Operations	\$45,034	\$42,228
Weighted average number of shares outstanding - Diluted	13,722	13,625
Funds From Operations per diluted share	\$3.28	\$3.10

Our FFO increased \$2.8 million, or \$.18 per diluted share, during 2018 as compared to 2017 due primarily to: (i) an increase of approximately \$1.7 million, or \$.12 per diluted share, resulting from a lease termination agreement entered into during 2018 on a single-tenant medical office building located in Texas (this agreement terminated a lease that was scheduled to expire in July, 2020); (ii) an increase of approximately \$500,000, or \$.04 per diluted share, resulting from business interruption insurance recovery proceeds recorded during 2018 that related to the period of August through December of 2018; (iii) a decrease of approximately \$400,000, or \$.03 per diluted share, consisting of non-recurring repairs and remediation expenses incurred during 2018 at one of our medical office buildings, and; (iv) other combined net increase of approximately \$1.0 million due to the increased net income generated at various properties, including the properties acquired during 2018 and 2017.

Impact of Hurricane Harvey

In late August, 2017, five of our medical office buildings located in the Houston, Texas area incurred extensive water damage as a result of Hurricane Harvey. Until various times during the second quarter of 2018, these properties were temporarily closed and non-operational as we continued to reconstruct and restore them to operational condition. During the second quarter of 2018, reconstruction on all of the occupied space in these properties had been completed and operations were resumed.

During the first quarter of 2018, pursuant to the terms of a global settlement with our commercial property insurance carrier, we received \$5.5 million of additional insurance recovery proceeds bringing the aggregate hurricane-related insurance recoveries to \$12.5 million. The aggregate insurance recovery proceeds, which are net of applicable deductibles, covered substantially all of the costs incurred related to the remediation, repair and reconstruction of each of these properties as well business interruption recoveries for the lost income related to each of these properties during the period they were non-operational.

Included in our financial results for the year ended December 31, 2018 are hurricane insurance recoveries of approximately \$4.5 million consisting of recovery proceeds in excess of the damaged property write-downs. Additionally, during 2018, we recorded approximately \$1.2 million of hurricane business interruption insurance recoveries in connection with the damage sustained from Hurricane Harvey. Included in this amount, which covered the period of late August, 2017 through the second quarter of 2018 (after satisfaction of the applicable deductibles), was approximately \$500,000 related to 2017.

Included in our financial results for the year ended December 31, 2017 are hurricane related expenses of approximately \$5.0 million consisting of \$3.6 million related to property damage and \$1.4 million related to remediation and demolition expenses. Also included in our financial results for the twelve-month period ended December 31, 2017 are aggregate hurricane related insurance recoveries of approximately \$7.0 million, consisting of \$5.0 million related to recovery of hurricane related expenses and \$2.0 million related to recovery proceeds in excess of the damaged property write-downs.

Year ended December 31, 2017 as compared to the year ended December 31, 2016:

For the year ended December 31, 2017, net income was \$45.6 million as compared to \$17.2 million during 2016. The \$28.4 million increase was primarily attributable to:

- a \$27.2 million increase due to the gain recorded during the first quarter of 2017 in connection with the Arlington transaction, as discussed herein;
- a \$2.0 million increase resulting from the hurricane recovery proceeds in excess of damaged property write-downs recorded during 2017;
- a \$708,000 decrease due to increased interest expense resulting primarily from an increase in our average cost of funds under our revolving credit agreement, offset by the repayment of four third-party mortgages (during the second, third and fourth quarters of 2017) utilizing funds borrowed under our revolving credit agreement which bear interest at a comparatively lower interest rate;
- a \$421,000 increase due to a decrease in transaction cost expense, and;
- \$538,000 of other combined net decreases primarily attributable to the unfavorable impact resulting from the temporary closure of the properties damaged by Hurricane Harvey, as discussed below.

Total revenues increased \$5.3 million, or 7.9%, during the year ended December 31, 2017, as compared to 2016, due primarily to the revenues generated at MOB's acquired during 2017 and 2016, as well as net increases at various other properties.

Included in our other operating expenses are expenses related to the consolidated medical office buildings, which totaled \$17.4 million and \$16.4 million for the years ended December 31, 2017 and 2016, respectively. The increase in operating expenses during 2017, as compared to 2016, is partially due to new acquisitions during 2017 and 2016. A large portion of the expenses associated with our consolidated medical office buildings is passed on directly to the tenants either directly as tenant reimbursements of common area maintenance expenses or included in base rental amounts. Tenant reimbursements for operating expenses are accrued as revenue in the same period the related expenses are incurred and are included as tenant reimbursement revenue in our consolidated statements of income.

During 2016, we had a total of 32 new or renewed leases related to the medical office buildings in which we have significant investments, some of which are accounted for by the equity method. These leases comprised approximately 10% of the aggregate rentable square feet of these properties (7% related to renewed leases and 3% related to new leases). Rental rates, tenant improvement costs and rental concessions vary from property to property based upon factors such as, but not limited to, the current occupancy and age of our buildings, local overall economic conditions, proximity to hospital campuses and the vacancy rates, rental rates and capacity of our competitors in the market. The weighted-average tenant improvement costs associated with these new or renewed leases was approximately \$12 per square foot during 2016. The weighted-average leasing commissions on the new and renewed leases commencing during 2016 was approximately 2% of base rental revenue over the term of the leases. The average aggregate value of the tenant concessions, generally consisting of rent abatements, provided in connection with new and renewed leases commencing during 2016 was approximately 2% of the future aggregate base rental revenue over the lease terms. Rent abatements were, or will be, recognized in our results of operations under the straight-line method over the lease term regardless of when payments are due. In connection with lease renewals executed during 2016, the weighted-average rental rates, as compared to rental rates on the expired leases, decreased by approximately 3%.

Below is a reconciliation of our reported net income to FFO for 2017 and 2016 (in thousands):

	2017	2016
Net income	\$45,619	\$17,215
Depreciation and amortization expense on consolidated investments	24,598	22,493
Depreciation and amortization expense on unconsolidated affiliates	1,240	1,851

Edgar Filing: LSI CORP - Form S-8 POS

Hurricane insurance recovery proceeds in excess of damaged property write-downs	(2,033)	—
Gain on Arlington transaction	(27,196)	—
Funds From Operations	\$42,228	\$41,559
Weighted average number of shares and equivalents outstanding - Diluted	13,625	13,468
Funds From Operations per diluted share	\$3.10	