NATIONAL HEALTH INVESTORS INC
Form 10-K
March 23, 2007

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2006

OR

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

For the transition period from _____ to _____

Commission File Number 001-10822

National Health Investors, Inc.

(Exact name of registrant as specified in its charter)

MARYLAND	**62-1470956**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
100 Vine Street, Suite 1202, Murfreesboro, Tennessee 37130	**37130**
(Address of principal executive offices)	(Zip Code)

Company s telephone number, including area code: **(615) 890-9100**

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

Title of each Class	Name of each exchange on which registered
Shares of Common Stock	**New York Stock Exchange**
7.30% Notes Due 2007	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act: **Same**

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

Yes: [ ] No: [x]

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

Yes: [ ] No: [x]

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes: [x] No:[ ]

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer (as defined in Rule 12b-2 of the Act). Large accelerated filer [ ] Accelerated filer [x] Non-accelerated filer [ ]

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

Yes: [ ] No : [x]

The aggregate market value of voting stock held by nonaffiliates on June 30, 2006 (based on the closing price of such shares on the New York Stock Exchange) was approximately $561 million. For purposes of the foregoing calculation only, all directors, named executive officers and persons knows to the Registrant to be holders of 5% or more of the Registrant s Common Stock have been deemed affiliates of the Registrant. The number of shares of Common Stock outstanding as of March 22, 2007 was 27,756,091.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant s definitive proxy statement for its 2007 annual meeting of stockholders are incorporated by reference into Part III, Items 10, 11, 12, 13, and 14 of this Form 10-K.

PART I

ITEM 1. BUSINESS.

General

National Health Investors, Inc. (NHI or the Company) is a real estate investment trust ("REIT") which invests in income- producing health care properties primarily in the long-term care industry. As of December 31, 2006, we had ownership interests in real estate, mortgage and notes receivable investments totaling approximately $334,731,000 and other investments in preferred stock and marketable securities of $63,645,000 resulting in total invested assets of $398,376,000. Our mission is to invest in health care real estate which generates current income that will be distributed to stockholders. We have pursued this mission by making mortgage loans and acquiring properties to lease nationwide, primarily in the long-term health care industry. These investments include long-term care facilities, acute care hospitals, medical office buildings, retirement centers and assisted living facilities, all of which are collectively referred to herein as "Health Care Facilities". We have funded these investments through three sources of capital: (1) current cash flow, including principal prepayments from our borrowers, (2) the sale of equity in the form of common and preferred stock, and (3) debt offerings, including bank lines of credit, the issuance of convertible debt instruments, and the issuance of straight debt. At December 31, 2006, we had no outstanding bank lines of credit or convertible debt instruments.

As of December 31, 2006, we had approximately $334,731,000 in real estate, mortgage and notes receivable investments in 139 health care facilities located in 18 states consisting of 97 long-term care facilities, 1 acute care hospital, 4 medical office buildings, 14 assisted living facilities, 6 retirement centers and 17 residential projects for the developmentally disabled. These investments consisted of approximately $99,532,000 aggregate carrying amount of loans to 15 borrowers and $235,199,000 of purchase-leaseback agreements with 17 lessees. Of these 139 facilities, 41 are leased to National HealthCare Corporation (NHC), a publicly-held company and our largest customer. These 41 facilities include 4 centers subleased to and operated by other companies, the lease payments to us being guaranteed by NHC. Of the 139 facilities, 17 were previously acquired through foreclosure and have been sold to third-parties, though we have not met the accounting criteria under Statement of Financial Accounting Standards No. 66 to record the sales for financial statement purposes. Our investment in notes receivable at December 31, 2006 included $8,750,000 from National Health Realty (NHR), a publicly-held real estate investment trust.

We will continue to review our investment opportunities as we generate cash from our operating, investing and financing activities. At December 31, 2006, we were committed, subject to due diligence and financial performance goals, to fund approximately $815,000 in health care real estate projects. The commitments include investments for 3 long-term health care facilities at rates of prime plus 2% (10.25% at December 31, 2006).

Effective November 1, 2004, we assigned our Advisory, Administrative Services and Facilities Agreement (the "Advisory Agreement") with NHC to Management Advisory Source, LLC, (MAS) formed by NHI s President and

Board Chairman W. Andrew Adams. NHI has no ownership in MAS. Pursuant to this Advisory Agreement, services related to investment activities and day-to-day management and operations are provided to NHI by MAS. Accordingly, MAS is subject to the supervision of and policies established by NHI's Board of Directors. Prior to November 1, 2004, NHC had provided advisory services to us since our inception.

Unless the context indicates otherwise, references herein to the Company , we and our include all of our subsidiaries.

Types of Health Care Facilities

Long-term care facilities. As of December 31, 2006, we owned and leased 66 licensed long-term care facilities, 34 of which were operated by NHC. All of the 32 remaining licensed long-term care facilities are leased to other long-term care companies. We also had outstanding first mortgage loans on 31 additional licensed long-term care facilities. All of these facilities provide some combination of skilled and intermediate nursing and rehabilitative care, including speech, physical and occupational therapy. The operators of the long-term care facilities receive payment from a combination of private pay sources and government programs such as Medicaid and Medicare. Long-term care facilities are required to obtain state licenses and are highly regulated at the federal, state and local level. Most long-term care facilities must obtain certificates of need from the state before opening or expanding such facilities.

Acute and long term care hospitals. As of December 31, 2006, we owned and leased 1 acute care hospital. Acute care hospitals provide a wide range of inpatient and outpatient services and are subject to extensive federal, state and local legislation and regulation. Acute and long term care hospitals undergo periodic inspections regarding standards of medical care, equipment and hygiene as a condition of licensure. Services provided by acute and long term care hospitals are generally paid for by a combination of private pay sources and governmental programs.

Medical office buildings. As of December 31, 2006, we owned and leased 4 medical office buildings. Medical office buildings are specifically configured office buildings whose tenants are primarily physicians and other medical practitioners. Medical office buildings differ from conventional office buildings due to the special requirements of the tenants and their patients. Each of our owned medical office buildings is leased to one lessee, and is either physically attached to or located on an acute care hospital campus. The lessee then leases individual office space to the physicians or other medical practitioners. The lessee is responsible to us for the lease obligations of the entire building, regardless of its ability to lease the individual office space.

Assisted Living Facilities. We own 14 assisted living facilities which are leased to individual operators. Assisted living facilities are either free-standing or are attached to long-term care or retirement facilities and provide basic room and board functions for the elderly. Some assisted living projects include licensed long-term care (nursing home) beds. On-site staff personnel are available to assist in minor medical needs on an as needed basis.

Retirement Centers. We own 5 retirement centers, three of which are leased to NHC, one to Sun Healthcare, and one to ElderTrust and have a first mortgage on one other center. Retirement centers offer specially designed residential units for the active and ambulatory elderly and provide various ancillary services for their residents including restaurants, activity rooms and social areas. Charges for services are paid from private sources without assistance from government programs. Retirement centers may be licensed and regulated in some states, but do not require the issuance of a certificate of need such as is required for long-term care facilities.

Residences for the developmentally disabled. As of December 31, 2006, we had outstanding first mortgage notes on 17 residences for the developmentally disabled. Residences for the developmentally disabled are generally small home-like environments which accommodate six to eight mentally and developmentally disabled persons. These persons obtain custodial care which includes food, lodging, education and transportation services. These community based services are replacing the large state institutions which have historically provided care to the developmentally disabled. Services to the developmentally disabled are primarily paid for by state Medicaid programs.

Nature of Investments

Our investments are typically structured as either purchase-leaseback transactions or mortgage loans. We also provide construction loans for facilities for which we have already committed to provide long-term financing or which the operator agrees to enter into a lease with us upon completion of the construction. The lease rates of our leases and the interest rates on the mortgage loans and construction loans have historically ranged between 9% and 12% per annum. We typically charge a commitment fee of 1% based on the purchase price of the property of a purchase-leaseback or the total principal loan amount of a mortgage loan. In instances where construction financing has also been supplied, there is generally an additional 1% commitment fee for the construction financing. We believe our lease terms, mortgage loan and construction loan terms are competitive in the market place. Except for certain properties, as described under Real Estate and Mortgage Write-downs (Recoveries) in Item 7, all of the operating Health Care Facilities are currently performing under their mortgage loans or leases. Typical characteristics

of these transactions are as follows:

Mortgage Loans. In general, the term of our mortgage loans is 10 years with the principal amortized over 20 to 25 years and a balloon payment due at the end of the 10 year term. Substantially all mortgage loans have an additional interest component which is based on the escalation of gross revenues at the project level or fixed rate increases. In certain of our mortgage loans, we have received an equity participation which allows us to share in a portion of any appreciation of the equity value of the underlying property. We do not expect the equity participations to constitute a significant or frequent source of income. In most cases, the owner of the property has committed to make minimum annual capital improvements for the purpose of maintenance or upgrading their respective facilities.

Leases. Our leases generally have an initial leasehold term of 10 to 15 years with one or more five-year renewal options. The leases are "triple net leases" under which the tenant is responsible to pay all taxes, utilities, insurance premium costs, repairs and other charges relating to the ownership and operation of the Health Care Facilities. The tenant is generally obligated at its expense to keep all improvements and fixtures and other components of the Health Care Facilities covered by "all risk" insurance in an amount equal to at least the full replacement costs thereof and to maintain specified minimal personal injury and property damage insurance, protecting us as well as the tenant at such Health Care Facility. The leases also require the tenant to indemnify and hold harmless NHI from all claims resulting from the use and occupancy of each Health Care Facility by the tenant and related activities, as well as to indemnify NHI against all costs related to any release, discovery, clean-up and removal of hazardous substances or materials on, or other environmental responsibility with respect to, each Health Care Facility.

Some of our existing leases contain annual escalators in rent payments. All of the acute care and medical office building properties which we own and lease give the lessee an option to purchase the underlying property at the greater of i) our acquisition costs; ii) the then fair market value as established by independent appraisers or iii) the sum of the land costs, construction costs and any additional capital improvements made to the property by us. In addition, the acute care and medical office building leases contain a right of first refusal for the lessee if we receive an offer to buy the underlying leased property.

Most of the obligations under the leases are guaranteed by the parent corporation of the lessee, if any, or affiliates or individual principals of the lessee. In some leases, the third party operator will also guarantee some portion of the lease obligations, usually for a fixed period such as six months or one year. Some obligations are further backed by other collateral such as machinery, equipment, furnishings and other personal property.

Construction loans. From time to time, although none are currently outstanding, we also provide construction loans that by their terms convert either into purchase leaseback transactions or mortgage loans upon the completion of the construction of the facility. The term of such construction loans are for a period which commences upon the closing of such loan and terminates upon the earlier of (a) the completion of the construction of the applicable facility or (b) a specific date. During the term of the construction loan, funds are usually advanced pursuant to draw requests made by the borrower in accordance with the terms and conditions of the loan. In addition to the security of the lien against the property, we will generally require additional security and collateral in the form of either payment and performance completion bonds or completion guarantees by the borrower's parent, affiliates of the borrower or one or more of the individuals who control the borrower. No such loans are currently outstanding.

Operating Facilities. We owned and operated 17 long-term health care facilities (the Foreclosure Properties) that we acquired through foreclosure or through the acceptance of deeds in lieu of foreclosure and subsequently sold the facilities to an unrelated not-for-profit entity, providing 100% financing. The operating revenues and expenses of these facilities continue to be recorded in the consolidated statements of income until such time as the down payment and continuing investment criteria of Statement of Financial Accounting Standards No. 66, Accounting for Sales of Real Estate (SFAS 66) are met, at which time we will account for the sale under the full accrual method.

Competition and Market Conditions

We compete with real estate partnerships, other REITs and other investors (including, but not limited to, banks, insurance companies, and investment bankers who market securities in mortgage funds) in the acquisition, leasing and financing of health care-related entities, primarily on the basis of price, available capital, knowledge of the industry and flexibility of financing structure.

The operators of the Health Care Facilities compete on a local and regional basis with operators of facilities that provide comparable services. Operators compete for patients and staff based on quality of care, reputation, physical appearance of facilities, services offered, family preference, physicians, staff and price. They compete with independent operators as well as companies managing multiple facilities, some of which are substantially larger and have greater resources than the operators of the Health Care Facilities. Some of these facilities are operated for profit while others are owned by governmental agencies or tax-exempt non-profit organizations.

The long-term care facilities to which we provide mortgage loans and which we lease to others receive the majority of their revenues from Medicare, Medicaid and other government programs. From time to time, these facilities have experienced Medicare and Medicaid revenue reductions brought about by the enactment of legislation to reduce government costs. Beginning January 1, 2006, CMS (Centers for Medicare and Medicaid Services) implemented major changes to the SNF PPS payment methodology (See Sources of Revenue) that reduced payments to facilities by about 5%. State Medicaid funding is not expected to keep pace with inflation according to industry studies. Additionally, the assisted living industry experienced slower fill up rates on new projects and more competition for their mature projects as overbuilding occurred in certain markets. Any changes in reimbursement methodology that reduces reimbursement to levels that are insufficient to cover the operating costs of our borrowers, lessees and the facilities we operate could adversely impact us.

Operators

The majority of the Health Care Facilities are operated by the owner or lessee. As a percent of total investments, 26.7% of the Health Care Facilities are operated by publicly-owned companies, while 61.8% are operated by regional health care operators and 11.5% are operated by smaller operators. We consider the operator to be an important factor in determining the creditworthiness of the investment, and we generally have the right to approve any changes in operators. Operators who collectively operate more than 3% of our total real estate investments are as follows: NHC, Health Services Management of

Texas, LLC, THI of Baltimore, Inc., Sunrise Senior Living Services, Inc., Health Services Management, Inc., Community Health Systems, Inc., ElderTrust of Florida, RGL Development, LLC, Senior Living Management, American HealthCare, LLC and SeniorTrust of Florida, Inc.

NHC Master Agreement to Lease

On December 27, 2005, under an amendment to the Master Lease, NHC exercised its option to extend the existing lease on 41 properties for the second renewal term. These 41 properties include 38 skilled nursing homes, (four of which are subleased to other parties for whom the lease payments are guaranteed to us by NHC under the Master Lease), and three retirement centers. The 15-year lease extension begins January 1, 2007, and includes three additional five-year renewal options, each at fair market value. Under the terms of the lease, total rent for 2007 will total $33,700,000 (compared to $31,309,000; $33,328,000; and $32,836,000 in 2006, 2005, and 2004, respectively) with rent thereafter escalating by 4% of the increase in facility revenue over a 2007 base year. The master lease was scheduled to expire on December 31, 2006 unless extended by NHC. The terms of the existing lease remained in place for 2006 as discussed below.

Before amendment on December 27, 2005, and before termination of one lease each in 2004 and 2005, the Master Agreement To Lease (the "Master Lease") with NHC covered 40 nursing homes and three retirement centers and contained terms and conditions applicable to all leases entered into by and between NHC and the Company (the "Leases"). The Leases were for an initial term expiring on December 31, 2001 with two five year renewal options at the election of NHC which allow for the renewal of the leases on an omnibus basis only. During 2000, NHC exercised its option to extend the lease term for the first five-year renewal term under the same terms and conditions as the initial term. During 2000, individual facility leases for four centers, all in Florida, were terminated and NHI re-leased the properties to third parties. Although NHC s rent obligations pursuant to the Master Lease are unchanged, NHC receives a credit for rents paid to NHI by the new operators of the four Florida centers.

During the initial term and the first renewal term ending on December 31, 2006 (which renewal term has been exercised by NHC), NHC is obligated to pay three types of rent for the respective Health Care Facilities: (1) base rent, (2) debt service rent, and (3) percentage rent. Base rent (which includes rent on property additions since inception) totaled $19,027,000 in 2006. Debt service rent varies from year to year and is the amount of interest and principal on the mortgages to which the Health Care Facilities were subject when they were transferred to us in 1991. Debt service rent has been adjusted for refinancings from time to time and totaled $7,453,000 in 2006.

In addition to base rent and debt service rent, NHC must pay percentage rent to us equal to 3% of the increase in the gross revenue of each facility. Effective January 1, 2000, we amended our lease agreements with NHC to provide for the calculation of percentage rent based on quarterly revenue increases rather than annual revenue increases. NHC paid $4,829,000 as percentage rent for 2006.

The Master Agreement is a "triple net lease", under which NHC is responsible for all taxes, utilities, insurance premium costs, repairs (including structural portions of the buildings, constituting a part of the Health Care Facilities) and other charges relating to the ownership and operation of the Health Care Facilities. NHC is obligated at its expense to keep all improvements and fixtures and other components of the Health Care Facilities covered by "all risk" insurance in an amount equal to the full replacement costs thereof, insurance against boiler explosion and similar insurance, flood insurance if the land constituting the Health Care Facility is located within a designated flood plain area and to maintain specified property damage insurance, protecting us as well as NHC at such Health Care Facility. NHC is also obligated to indemnify and hold us harmless from all claims resulting from the use and occupancy of each Health Care Facility by NHC or persons claiming under NHC and related activities, as well as to indemnify us against all costs related to any release, discovery, cleanup and removal of hazardous substances or materials on, or other environmental responsibility with respect to, each Health Care Facility leased by NHC.

Commitments

As of December 31, 2006, we have commitments to third parties to make loans to fund projects totaling $815,000 as follows:

		Commitments		
		Less Than	After	
Facility Type	Facilities	One Year	One Year	Total
Long-term Care	3	$ 815,000	$	$ 815,000
Assisted Living				
Totals	3	$ 815,000	$	$ 815,000

Sources of Revenues

General. Our revenues are derived primarily from mortgage interest income, rental income and the operation of the Foreclosure Properties. During 2006, mortgage interest income equaled $14,981,000 of which $217,000 was from NHC. Rental income totaled $46,281,000 of which $31,309,000 was from properties leased by NHC. The interest and rental payments are primarily derived from the operations of the Health Care Facilities. The source and amount of revenues from such operations are determined by (i) the licensed bed or other capacity of the Health Care Facilities, (ii) the occupancy rate of the Health Care Facilities, (iii) the extent to which the services provided at each Health Care Facility are utilized by the patients, (iv) the mix of private pay, Medicare and Medicaid patients at the Health Care Facilities, and (v) the rates paid by private paying patients and by the Medicare and Medicaid programs. Facility operating revenues are derived from the operations of the Foreclosure Properties and are determined by similar factors.

Governmental and other concerns regarding health care costs have and may continue to result in significant reductions in payments to health care facilities, and there can be no assurance that future payment rates for either governmental or private health care plans will be sufficient to cover cost increases in providing services to patients. Any changes in reimbursement policies which reduce reimbursement to levels that are insufficient to cover the cost of providing patient care have and could continue to adversely affect revenues of our health-related lessees and borrowers and thereby adversely affect those lessees' and borrowers' abilities to make their lease or debt payments to us. Failure of the lessees or borrowers to make their lease or debt payments would have a direct and material adverse impact on us.

Medicare and Medicaid. A significant portion of the revenue of our Foreclosure Properties and our lessees and borrowers is derived from governmental-funded reimbursement programs, such as Medicare and Medicaid.

Medicare is uniform nationwide and reimburses nursing centers under a fixed payment methodology named the Prospective Payment System (SNF PPS). PPS was instituted as mandated by the Balanced Budget Act of 1997. PPS became effective July 1, 1998. PPS is an acuity based classification system that uses nursing and therapy indexes adjusted by geographical wage indexes to calculate per diem rates for each Medicare patient. Payment rates are updated annually and are generally increased each October when the federal fiscal year begins. The acuity classification system is named Resource Utilization Groups III (RUGs). SNF PPS as implemented had an adverse impact on the healthcare industry and our lessees and borrowers business by decreasing payments materially, which has adversely impacted our business. Refinements in the form of temporary add-ons provided some relief until October 1, 2002. Annual market basket (inflationary) increases have continued to improve payments.

On July 28, 2005, the Centers for Medicare and Medicaid Services (CMS) issued a final rule updating SNF PPS and consolidated billing provisions. The rule updates the per diem payment rates under the SNF PPS for federal fiscal year (FY) 2006.

Effective October 1, 2006, PPS rates were increased by a 3.1% annual inflation update factor. Payments to facilities for the fourth quarter of 2006 reflect the continuation of the temporary add-on payments.

Including inflation, total projected payments to providers in FY 2006 were the same as total payments made to providers in FY 2005. However, the final rule caused a redistribution of payments among providers. This was accomplished by expanding the RUGs from 44 RUG groups to 53 RUG groups, and eliminating temporary rate add-ons. The elimination of temporary add-ons has always been tied to the long awaited RUG refinement. RUG refinement modifies case mix weights and indexes. This is a permanent change in the PPS methodology. Excluding the 3.1% annual inflation update factor, RUG refinement reduced Medicare payment rates beginning January 1, 2006 by 5%, thereby reducing 2006 revenues for operators of long-term care facilities.

Medicaid is a joint federal and state program designed to provide medical assistance to medically indigent persons . These programs are operated by state agencies that adopt their own medical reimbursement methodology and standards. Payment rates and covered services vary from state to state. In many instances, revenues from Medicaid programs are insufficient to cover the actual costs incurred in providing care to those patients. State Medicaid plans subject to budget constraints are of particular concern to us given the repeal of the Boren Amendment by the Balance Budget Act of 1997. The Boren Amendment provided fair reimbursement protection to nursing facilities. Changes in federal funding and pressure on certain provider taxes coupled with state budget problems have produced an uncertain environment. Industry studies predict the Medicaid crisis will continue with states required contribution to Medicare Part D and anticipated budget deficits. States will more than likely be unable to keep pace with nursing center inflation. States are under pressure to pursue other alternatives to long term care such as community and home based services. Furthermore, several of the states in which we have investments have actively sought to reduce or slow the increase of Medicaid spending for nursing home care.

Medicare and Medicaid programs are highly regulated and subject to frequent and substantial changes resulting from legislation, adoption of rules and regulations, and administrative and judicial interpretations of existing law. Moreover, as health care facilities have experienced increasing pressure from private payors attempting to control health care costs, reimbursement from private payors has in many cases effectively been reduced to levels approaching those of government payors.

Licensure and Certification. The health care industry is highly regulated by federal, state and local law, and is directly affected by state and local licensing requirements, facility inspections, state and federal reimbursement policies, regulations concerning capital and other expenditures, certification requirements and other such laws, regulations and rules. Sanctions for failure to comply with these regulations and laws include (but are not limited to) loss of licensure, fines and loss of certification to participate in the Medicare and Medicaid programs, as well as potential criminal penalties. The failure of any lessee or borrower to comply with such laws, requirements and regulations could affect its ability to operate the facility or facilities and could adversely affect such lessee's or borrower's ability to make lease or debt payments to us.

In the past several years, due to rising health care costs, there has been an increased emphasis on detecting and eliminating fraud and abuse in the Medicare and Medicaid programs. Payment of any consideration in exchange for referral of Medicare and Medicaid patients is generally prohibited by federal statute, which subjects violators to severe penalties, including exclusion from the Medicare and Medicaid programs, fines and even prison sentences. In recent years, both federal and state governments have significantly increased investigation and enforcement activity to detect and punish wrongdoers. In addition, legislation has been adopted at both state and federal levels which severely restricts the ability of physicians to refer patients to entities in which they have a financial interest.

It is anticipated that the trend toward increased investigation and enforcement activity in the area of fraud and abuse, as well as self-referral, will continue in future years. Certain of our investments are with lessees or borrowers which are partially or wholly owned by physicians. In the event that any lessee or borrower were to be found in violation of laws regarding fraud and abuse or self-referral, that lessee's or borrower's ability to operate the facility as a health care facility could be jeopardized, which could adversely affect the lessee's or borrower's ability to make lease or debt payments to us and thereby adversely affect us.

Certificates of Need. Certain Health Care Facilities in which we invest are also generally subject to state statutes which may require regulatory approval in the form of a certificate of need ("CON") prior to the addition or construction of new beds, the addition of services or certain capital expenditures. CON requirements are not uniform throughout the United States and are subject to change. We cannot predict the impact of regulatory changes with respect to CON's on the operations of our lessees and mortgagees; however, in our primary market areas, a significant reduction in new construction of long term care beds has occurred.

Investment Policies

Our investment objectives are (i) to provide current income for distribution to our stockholders through investments primarily in health care related facilities, (ii) to provide the opportunity to realize capital growth resulting from appreciation, if any, in the residual value of our portfolio properties, and (iii) to preserve and protect stockholders' capital. There can be no assurance that these objectives will be realized.

We anticipate making new investments in 2007. In making new investments, we would consider such factors as (i) the geographic area and type of property, (ii) the location, construction quality, condition and design of the property, (iii) the current and anticipated cash flow and its adequacy to meet operational needs and lease or mortgage obligations and to provide a competitive market return on equity to our investors, (iv) the growth, tax and regulatory environments of the communities in which the properties are located, (v) occupancy and demand for similar health care facilities in the same or nearby communities, (vi) the quality, experience and creditworthiness of the management operating the facilities located on the property; and (vii) the

mix of private and government sponsored patients. There can be no assurances that investments containing these attributes will be found or closed.

We will not, without the approval of a majority of the Board of Directors, enter into any joint venture relationships with or acquire from or sell to any director, officer, or employee of NHC or NHI, or any affiliate thereof, as the case may be, any of our assets or other property.

The Board of Directors, without the approval of the stockholders, may alter our investment policies if they determine that such a change is in our best interests and our stockholders best interests. The methods of implementing our investment policies may vary as new investment and financing techniques are developed or for other reasons.

We may incur additional indebtedness in the future to make investments in health care related facilities or business when it is advisable in the opinion of the Board of Directors. We may negotiate other lines of credit, or arrange for other short or long-term borrowings from banks, NHC or otherwise. We have and may arrange for long term borrowings from institutional investors or through public offerings. We have invested and may in the future invest in properties subject to existing loans or secured by mortgages, deeds of trust or similar liens with favorable terms or REMIC investments.

Advisory Agreement

Management Advisory Source, LLC - Effective November 1, 2004, we assigned our Advisory Agreement with NHC to a new company, Management Advisory Source, LLC (MAS), formed by NHI s President and Board Chairman, W. Andrew Adams. NHI has no ownership in MAS. Pursuant to this agreement, services related to investment activities and day-to-day management and operations are provided to NHI by MAS. Accordingly, MAS is subject to the supervision of and policies established by NHI's Board of Directors. In 2006, the expense recorded under the Advisory Agreement was $3,499,000. We believe it to be in the best interest of NHI to accentuate its independence from NHC, its largest tenant. Therefore, Mr. Adams, through his company MAS, assumed the responsibilities of the Advisory Agreement. To assure independence from NHC, Mr. Adams resigned as CEO of NHC and terminated his managerial responsibilities with NHC in 2004. From November 1, 2004 to October 1, 2006, Mr. Adams outsourced non-managerial functions of the Advisory Agreement such as payroll processing, accounting, financing and the like to NHC. Effective October 1, 2006, MAS began to provide these services. Mr. Adams has remained as NHC Board Chairman, focusing on strategic planning, but has no management involvement with NHC.

NHC - We entered into the Advisory Agreement on October 17, 1991 with NHC as "Advisor" under which NHC provided management and advisory services to us through November 1, 2004. Under the Advisory Agreement, we engaged NHC to use its best efforts (a) to present to us a continuing and suitable investment program consistent with our investment policies adopted by the Board of Directors from time to time; (b) to manage our day-to-day affairs and operations; and (c) to provide administrative services and facilities appropriate for such management. In performing its obligations under the Advisory Agreement, NHC was subject to the supervision of and policies established by our

Board of Directors.

The Advisory Agreement was initially for a stated term which expired December 31, 1997. Since then, the Agreement was on a year-to-year term, but terminable on 90 days notice, and terminable for cause at any time. For 1993 and later years, the Advisor was entitled to annual compensation which was calculated on a formula related to the increase in funds from operations per common share (as defined in the Advisory Agreement).

Pursuant to the Advisory Agreement, the advisor managed all of our day-to-day affairs and provided all such services through its personnel or contractual agreements. The Advisory Agreement provided that without regard to the amount of compensation received by the Advisor under the Advisory Agreement, the Advisor pay all expenses in performing its obligations including the employment expenses of the personnel providing services to us. The Advisory Agreement further provided that NHI pay the expenses incurred with respect to and allocable to the prudent operation and business of NHI including any fees, salaries, and other employment costs, taxes and expenses paid to our directors, officers and employees who are not also employees of the Advisor.

Investor Information

We maintain a worldwide web site at www.nhinvestors.com. We publish to this web site our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and press releases. We do not necessarily have these filed the same day as they are filed with the SEC or released to the public, but rather have a policy of placing these on the web site within two (2) business days of public release or SEC filing.

We also maintain the following documents on the web site:

*

The NHI Code of Ethics and Standards of Conduct. This has been adopted for all employees of our Administrative Services Contractor, officers and directors of the Company. The website will also disclose whether there have been any amendments or waivers to the Code of Ethics and Standards of Conduct. To date there have been none.

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Information on our NHI Valuesline , which allows our staff and investors unrestricted access to our Corporate Compliance Officer, executive officers and directors. The toll free number is 800-526-4064 and the communications may be made anonymously, if desired.

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The NHI Restated Audit Committee Charter.

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The NHI Compensation Committee Charter.

*

The NHI Nomination and Corporate Governance Committee Charter

We will furnish, free of charge, a copy of any of the above documents to any interested investor upon receipt of a written request.

ITEM 1A. RISK FACTORS.

We depend on the operating success of our tenants, who operate in the skilled nursing and assisted living industry for collection of our rent revenues. Our skilled nursing, hospital and projects for the developmentally disabled facility operators revenues are primarily driven by occupancy, Medicare and Medicaid reimbursement and private pay rates. Our assisted living facility operators revenues are primarily driven by occupancy and private pay rates. Expenses for these facility types are driven by the costs of labor, food, utilities, taxes, insurance and rent or debt service. Revenues from government reimbursement have, and may continue, to come under pressure due to reimbursement cuts and from federal and state budget shortfalls. Liability insurance and staffing costs continue to increase for our operators. To the extent that any decrease in revenues and/or any increase in operating expenses result in a facility not generating enough cash to make payments to us, the credit of our operator and the value of other collateral would have to be relied upon.

We are exposed to the risk that our operators may not be able to meet the rent, principal and interest or other payments due us, which may result in an operator bankruptcy or insolvency, or that an operator might become subject to bankruptcy or insolvency proceedings for other reasons. Although our operating lease agreements provide us the right to evict an operator, demand immediate payment of rent and exercise other remedies, and our mortgage loans provide us the right to terminate any funding obligations, demand immediate repayment of principal and unpaid interest, foreclose on the collateral and exercise 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 limit or delay our ability to collect unpaid rent in the case of a lease or to receive unpaid principal and/or interest in the case of a mortgage loan, and to exercise other rights and remedies.

We may be required to fund certain expenses (e.g., real estate taxes, maintenance and capital improvements) to preserve the value of a facility, avoid the imposition of liens on a facility and/or transition a facility to a new operator. In some instances, we have terminated our lease with an operator and released the facility to another operator. In some of those situations, we provided working capital loans to and limited indemnification of the new operator. If we cannot transition a leased facility to a new operator, we may take possession of that facility, which may expose us to certain successor liabilities. Should such events occur, our revenue and operating cash flow may be adversely affected.

We are exposed to risks related to government regulations and the effect they have on our operators business. Our operators businesses are affected by government reimbursement and private payor rates. To the extent that any skilled nursing, hospital or project for the developmentally disabled facility receives a significant portion of its revenues from governmental payors, primarily Medicare and Medicaid, such revenues may be subject to statutory and regulatory changes, retroactive rate adjustments, recovery of program overpayments or set-offs, administrative rulings, policy interpretations, payment or other delays by fiscal intermediaries, government funding restrictions (at a program level or with respect to specific facilities) and

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interruption or delays in payments due to any ongoing governmental investigations and audits at such facility. In recent years, governmental payors have frozen or reduced payments to health care providers due to budgetary pressures. Changes in health care reimbursement will likely continue to be of paramount importance to federal and state authorities. We cannot make any assessment as to the ultimate timing or effect any future legislative reforms may have on the financial condition of the health care industry. There can be no assurance that adequate reimbursement levels will continue to be available for services provided by any facility operator, whether the facility receives reimbursement from Medicare, Medicaid or private payors. Significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material adverse effect on an operator s liquidity, financial condition and results of operations, which could adversely affect the ability of an operator to meet its obligations to us. In addition, the replacement of an operator that has defaulted on its lease or loan could be delayed by the approval process of any federal, state or local agency necessary for the transfer of the facility or the replacement of the operator licensed to manage the facility.

We are exposed to the risk that the cash flows of our tenants and mortgages will be affected by increased liability claims and increased general and professional liability insurance costs. Long-term care facility operators (assisted living and skilled nursing facilities) have experienced substantial increases in both the number and size of patient care liability claims in recent years, particularly in the states of Texas and Florida. As a result, general and professional liability costs have increased and may continue to increase. Nationwide, long-term care liability insurance rates are increasing because of large jury awards in states like Texas and Florida. In 2004 and 2005, both Texas and Florida adopted skilled nursing facility liability laws that modify or limit tort damages. Despite some of these reforms, the long-term care industry overall continues to experience very high general and professional liability costs. Insurance companies have responded to this claims crisis by severely restricting their capacity to write long-term care general and professional liability policies. No assurance can be given that the climate for long-term care general and professional liability insurance will improve in any of the foregoing states or any other states where the facility operators conduct business. Insurance companies may continue to reduce or stop writing general and professional liability policies for assisted living and skilled nursing facilities. Thus, general and professional liability insurance coverage may be restricted, very costly or not available, which may adversely affect the facility operators future operations, cash flows and financial condition, and may have a material adverse effect on the facility operators ability to meet their obligations to us.

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

We are exposed to risks related to environmental laws and the costs associated with the liability related to hazardous substances. Under various federal and state laws, owners or operators of real property may be required to respond to the release of hazardous substances on the property and may be held liable for property damage, personal injuries or penalties that result from environmental contamination. These laws also expose us to the possibility that we may become liable to reimburse the government for damages and costs it incurs in connection with the contamination. Generally, such liability attaches to a person based on the person s relationship to the property. Our

tenants or borrowers are primarily responsible for the condition of the property and since we are a passive landlord, we do not participate in the management of any property in which we have an interest. Moreover, we review environmental site assessment of the properties that we own or encumber prior to taking an interest in them. Those assessments are designed to meet the all appropriate inquiry standard, which qualifies us for the innocent purchaser defense if environmental liabilities arise. Based upon such assessments, we do not believe that any of our properties are subject to material environmental contamination. However, environmental liabilities, including mold, may be present in our properties and we may incur costs to remediate contamination, which could have a material adverse effect on our business or financial condition.

We depend on the ability to reinvest cash from our operating, investing and financing activities in a timely manner and on acceptable terms. From time to time, we will have cash available from (1) the proceeds of sales of our securities, (2) principal payments on our loans receivable, and (3) the sale of properties, including non-elective dispositions, under the terms of master leases or similar financial support arrangements. We must re-invest these proceeds, on a timely basis, in health care investments or in qualified short-term investments. We compete for real estate investments with a broad variety of potential investors. This competition for attractive investments may negatively affect our ability to make timely investments on terms acceptable to us. Delays in acquiring properties may negatively impact revenues and perhaps our ability to make distributions to stockholders.

We depend on the ability to continue to qualify as a REIT. We intend to operate as a REIT under the Internal Revenue Code and believe we have and will continue to operate in such a manner. Since REIT qualification requires us to meet a number of complex requirements, it is possible that we may fail to fulfill them, and if we do, our earnings will be reduced by the amount of

federal taxes owed. A reduction in our earnings would affect the amount we could distribute to our stockholders. Also, if we were not a REIT, we would not be required to make distributions to stockholders since a non-REIT is not required to pay dividends to stockholders amounting to at least 90% of its annual taxable income.

We are dependent upon Management Advisory Source, LLC (MAS) for services related to investment activities and day-to-day management to include accounting, monitoring of investments, finance activities, etc. MAS, which was formed by our President and Board Chairman W. Andrew Adams, outsourced most functions of the Advisory Agreement such as accounting, monitoring of investments, finance activities, etc. to NHC from November 1, 2004 to October 1, 2006. Our advisory agreement with MAS may be cancelled upon 90 days notice or upon demand in some circumstances. The cancellation of this agreement could, at least temporarily, have a material adverse impact on our business and upon our ability to comply with government regulations.

See the notes to the annual financial statements, and Business under Item 1 herein for a discussion of various governmental regulations and other operating factors relating to the health care industry and the risk factors inherent in them. You should carefully consider these risks before making any investment decisions in the Company. These risks and uncertainties are not the only ones facing the Company. There may be additional risks that we do not presently know of or that we currently deem immaterial. If any of the risks actually occur, our business, financial condition or results of operations could be materially adversely affected. In that case, the trading price of our shares of stock could decline, and you may lose all or part of your investment. Given these risks and uncertainties, we can give no assurance that these forward-looking statements will, in fact, occur and, therefore, caution investors not to place undue reliance on them.

ITEM 1B. UNRESOLVED STAFF COMMENTS.

None

ITEM 2. PROPERITIES.

NHI PROPERTIES

LONG TERM CARE		Licensed
Center	City	Beds
ALABAMA		
NHC HealthCare, Anniston	Anniston	151
NHC HealthCare, Moulton	Moulton	136
ARIZONA		

Sunbridge Estrella Care and Rehabilitation	Avondale	161
FLORIDA		
Ayers Health and Rehabilitation Center	Trenton	120
Bayonet Point Health & Rehabilitation Center	Hudson	180
Bear Creek Nursing Center	Hudson	120
Brooksville Healthcare Center	Brooksville	180
Cypress Cove Care Center	Crystal River	120
Heather Hill HealthCare Center	New Port Richey	120
Osceola Health Care Center	St. Cloud	120
Parkway Health and Rehabilitation Center	Stuart	177
Lake Bennett Health and Rehabilitation Center	Ocoee	120
Royal Oak Nursing Center	Dade City	120
The Health Center of Merritt Island	Merritt Island	180
The Health Center of Plant City	Plant City	180

LONG TERM CARE (continued)		Licensed
Center	City	Beds
FLORIDA (continued)		
Savannah Cove of Maitland*	Maitland	39
Savannah Cove of the Palm Beaches*	West Palm Beach	30
GEORGIA		
Ashton Woods Rehabilitation Center	Rossville	157
The Place at Martinez	Augusta	100
The Place at Deans Bridge	Augusta	100
The Place at Pooler	Pooler	122
NHC HealthCare, Rossville	Rossville	112
The Place at Augusta	Augusta	100
IDAHO		
Grangeville Health and Rehabilitation Center	Grangeville	60
Sunbridge Retirement and Rehabilitation for Nampa*	Nampa	46
KANSAS		
Chanute HealthCare Center	Chanute	77
Council Grove HealthCare Center	Council Grove	80
Emporia Rehabilitation Center	Emporia	79
Haysville HealthCare Center	Haysville	119
Cheyenne Meadows Living Center	Hoisington	56
Larned HealthCare Center	Larned	73
Sedgwick HealthCare Center	Sedgwick	62
KENTUCKY		
NHC HealthCare, Glasgow*	Glasgow	194
NHC HealthCare, Madisonville	Madisonville	94
MASSACHUSETTS		
John Adams HealthCare Center	Quincy	71
Buckley HealthCare Center	Greenfield	120
Holyoke HealthCare Center	Holyoke	102
Longmeadow of Taunton	Taunton	100
MISSOURI		
Charleviox HealthCare Center	St. Charles	142

Columbia HealthCare Center	Columbia	97
Joplin HealthCare Center	Joplin	92
NHC HealthCare, Desloge	Desloge	120
NHC HealthCare, Joplin	Joplin	126
NHC HealthCare, Kennett	Kennett	170
NHC HealthCare, Maryland Heights	Maryland Heights	220
NHC HealthCare, St. Charles	St. Charles	120
NEW HAMPSHIRE		
Epsom HealthCare Center	Epsom	108
Maple Leaf HealthCare Center	Manchester	114
Villa Crest HealthCare Center	Manchester	165
NEW JERSEY		
Brighton Gardens of Edison*	Edison	30

LONG TERM CARE (continued)		Licensed
Center	City	Beds
SOUTH CAROLINA		
NHC HealthCare, Anderson	Anderson	290
NHC HealthCare, Greenwood	Greenwood	152
NHC HealthCare, Laurens	Laurens	176
TENNESSEE		
NHC HealthCare, Athens	Athens	98
NHC HealthCare, Chattanooga	Chattanooga	207
NHC HealthCare, Columbia	Columbia	106
NHC HealthCare, Dickson*	Dickson	191
NHC HealthCare, Franklin	Franklin	80
NHC HealthCare, Hendersonville	Hendersonville	122
NHC HealthCare, Hillview	Columbia	92
NHC HealthCare, Knoxville	Knoxville	139
NHC HealthCare, Lewisburg	Lewisburg	102
NHC HealthCare, McMinnville	McMinnville	150
NHC HealthCare, Milan	Milan	122
NHC HealthCare, Oakwood	Lewisburg	60
NHC HealthCare, Pulaski	Pulaski	102
NHC HealthCare, Scott	Lawrenceburg	62
NHC HealthCare, Sequatchie	Dunlap	120
NHC HealthCare, Smithville*	Smithville	114
NHC HealthCare, Somerville*	Somerville	72
NHC HealthCare, Sparta	Sparta	120
NHC HealthCare, Springfield	Springfield	107
TEXAS		
Beaumont Health Care Center	Beaumont	82
Cleveland Health Care Center	Cleveland	148
College Street Health Care Center	Beaumont	50
Columbus Nursing and Rehabilitation	Columbus	129
Conroe Health Care Center	Conroe	108
Friendswood Health Care Center	Friendswood	102
Forest Lane Healthcare Center	Dallas	120
Heritage Manor - Canton	Canton	110
Heritage Place	Dallas	149
Heritage Oaks	Arlington	204

Hill Country Care Center	Dripping Springs	60
Huntsville Health Care Center	Huntsville	92
Lawrence Street Health Care Center	Tomball	150
Liberty Health Care Center	Liberty	118
Pecan Tree Manor	Gainesville	122
Richmond Health Care Center	Richmond	92
Sugar Land Health Care Center	Sugarland	150
The Village at Richardson	Dallas	280
West Janisch Health Care Center	Houston	116
Winterhaven Healthcare Center	Houston	160
VIRGINIA		
NHC HealthCare, Bristol	Bristol	120
Heritage Hall- Charlottesville	Charlottesville	120
Heritage Hall- Brookneal	Brookneal	60

LONG TERM CARE (continued)	City	Licensed Beds
VIRGINIA (continued)		
Heritage Hall- Lexington	Lexington	60
Heritage Hall- Virginia Beach	Virginia Beach	90
Heritage Hall- Front Royal	Front Royal	60
Heritage Hall- Grundy	Grundy	120
Heritage Hall- Laurel Meadows	Laurel Fork	60
WISCONSIN		
Milwaukee South HealthCare Center	Milwaukee	191

ACUTE CARE PROPERTIES		
KENTUCKY		
Kentucky River Hospital	Jackson	55

MEDICAL OFFICE BUILDINGS		
		Sq. Ft.
FLORIDA		
North Okaloosa	Crestview	27,017
ILLINOIS		
Crossroads	Mt. Vernon	12,910
TEXAS		
Hill Regional	Hillsboro	23,000
Pasadena	Pasadena	61,500

RETIREMENT CENTERS		Licensed Beds
IDAHO		
Sunbridge Retirement and Rehab for Nampa*	Nampa	117
NEW HAMPSHIRE		
Heartland Place	Epsom	78
TENNESSEE		
Colonial Hill Retirement Center	Johnson City	63

Parkwood Retirement Apartments	Chattanooga	30
TEXAS		
Tomball Retirement Center	Tomball	60
ASSISTED LIVING AND DEVELOPMENTALLY DISABLED		Licensed Beds
ARIZONA		
The Place at Gilbert	Gilbert	59
The Place at Glendale	Glendale	40
The Place at Tanque Verde	Tucson	42
The Place at Tucson	Tucson	60
FLORIDA		
19th Street Group Home	Gainesville	6
107th Place Group Home	Belleview	6

LONG TERM CARE (continued)	City	Licensed Beds
FLORIDA (continued)		
Bessent Road Group Home	Starke	6
Claudia Drive Group Home	Jacksonville	6
Coletta Drive Group Home	Orlando	6
Frederick Avenue Group Home	Daytona Beach	6
High Desert Court Group Home	Jacksonville	6
Plaza Oval Group Home	Casselberry	6
Rosewood Group Home	Ormond Beach	6
Second Street Group Home	Ocala	6
Spring Street Group Home	Lake City	6
Suffridge Drive Group Home	Bonita Springs	6
Savannah Court of Maitland*	Maitland	112
The Place at Daytona Beach	Daytona Beach	60
The Place at Maitland	Maitland	116
Savannah Court of Palm Beaches*	West Palm Beach	114
Tunis Street Group Home	Jacksonville	6
Walnut Street Group Home	Starke	6
IDAHO		
Sunbridge Retirement and Rehab for Nampa*	Nampa	20
KENTUCKY		
NHC HealthCare, Glasgow	Glasgow	12
NEW JERSEY		
Brighton Gardens of Edison*	Edison	118
PENNSYLVANIA		
Heritage Hill Senior Community	Weatherly	142
SOUTH CAROLINA		
The Place at Conway	Conway	52
TENNESSEE		
717 Cheatam Street	Springfield	8
305 West Hillcrest Drive	Springfield	8
307 West Hillcrest Drive	Springfield	8

NHC HealthCare, Dickson*	Dickson	20
NHC HealthCare, Somerville*	Somerville	9
NHC HealthCare, Smithville*	Smithville	6
The Place at Gallatin	Gallatin	49
The Place at Kingsport	Kingsport	49
The Place at Tullahoma	Tullahoma	49

*These facilities are listed in multiple categories (numbers of beds are not duplicated elsewhere in this table).

ITEM 3. LEGAL PROCEEDINGS.

One of our owned nursing home properties, leased to a subsidiary of NHC and located in Nashville, Tennessee, was damaged by a tragic fire on September 25, 2003 which resulted in the loss of life or critical injury to a number of patients. The lease requires NHC to indemnify and hold harmless NHI from any and all demands and claims arising from its use of the property. Although NHI had been named as a defendant in 32 lawsuits, all of these lawsuits have been settled at no cost to NHI.

A provision of the lease allowed that if substantial damage occurs during the lease term, NHC may terminate the lease with respect to the damaged property. During October 2004, NHC exercised its right to terminate the lease on the Nashville facility. As a result, NHI was entitled to receive all property insurance proceeds paid as a result of the fire. NHI retained the right to the bed license following lease termination. Prior to the fire, NHI received annualized rent of $250,000 per year on the Nashville facility. NHI received $2,654,000 in insurance proceeds which was included in non-operating income for the year ended December 31, 2005. NHI sold the Nashville facility in May 2005 (See Note 3 to the financial statements).

On October 13, 2006, a lawsuit was filed in Chancery Court for the State of Tennessee, Rutherford County, against us and the individual directors serving on the Special Committee alleging breach of fiduciary duty and improper action in connection with the offer by Mr. Adams as described under Acquisition Offer in Item 7. We filed a motion to dismiss the complaint and on January 26, 2007 an amended lawsuit was filed against NHI and the members of the Special Committee. We intend to vigorously defend the allegations in the complaint. NHI has previously indemnified all members of the Board of Directors for all actions related to NHI, including serving on the Special Committee. NHI expects that indemnification to cover the expenses incurred by the directors in the defense of this action.

The Health Care Facilities are subject to claims and suits in the ordinary course of business. Our lessees and mortgagees have indemnified and will continue to indemnify us against all liabilities arising from the operation of the Health Care Facilities, and will indemnify us against environmental or title problems affecting the real estate underlying such facilities. While there are lawsuits pending against certain of the owners and/or lessees of the Health Care Facilities, management believes that the ultimate resolution of all pending proceedings will have no material adverse effect on our financial position, operations and cash flows.

Through the operation of our 17 foreclosure properties, we are subject to general and professional liability litigation for the provision of patient care. The entire long-term care industry has seen a dramatic increase in personal injury/wrongful death claims based on alleged negligence by nursing homes and their employees in providing care to residents. We have maintained or caused the majority of our lessees or mortgagees to maintain insurance coverage for this type of litigation. In Florida, however, coverage is limited. We are subject to certain claims, none of which, in management s opinion, would be material to our financial position or results of operations.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

The Annual Meeting of the Shareholders was held on May 2, 2006, the results of which were included in the March 31, 2006, Form 10-Q filed with the SEC on May 4, 2006.

PART II

ITEM 5. MARKET FOR REGISTRANT S COMMON EQUITY, RELATED SHAREHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.

On October 16, 1996, the NHI Board of Directors, pursuant to powers granted by NHI's charter, changed the limit on the percentage of ownership which any person may have in the outstanding common stock of NHI from a limit of 7.0% (as passed on October 17, 1995) to a limit of 9.9%. The limit on ownership of any other class of stock (including issues convertible into common stock) remains at 9.9% of the outstanding stock.

In order to qualify for the beneficial tax treatment accorded to a REIT, we must make quarterly distributions to holders of our Common Stock equal on an annual basis to at least 90% of our REIT taxable income (excluding net capital gains), as defined in the Internal Revenue Code. Cash available for distribution to our stockholders is primarily derived from interest payments received on our mortgages and from rental payments received under our leases. All distributions will be made by us at the discretion of the Board of Directors and will depend on our cash flow and earnings, our financial condition, bank covenants contained in our financing documents and such other factors as the Board of Directors deems relevant. Our REIT taxable income is calculated without reference to our cash flow. Therefore, under certain circu