NATIONAL HEALTH INVESTORS INC
Form 10-K
February 15, 2012

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, 2011

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 (State or other jurisdiction of incorporation or organization)	62-1470956 (I.R.S. Employer Identification No.)
222 Robert Rose Drive, Murfreesboro, Tennessee (Address of principal executive offices)	37129 (Zip Code)

(615) 890-9100
(Registrant s telephone number, including area code)

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

Title of each Class	Name of each exchange on which registered
Common stock, $.01 par value	New York Stock Exchange

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

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

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

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

Yes [x] No [ ]

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes [x] No [ ]

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405) is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. .

[ ]

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

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

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

The aggregate market value of shares of common stock held by non-affiliates on June 30, 2011 (based on the closing price of these shares on the New York Stock Exchange) was approximately $1,155,024,000. There were 27,781,594 shares of the registrant s common stock outstanding as of February 14, 2012.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant s definitive proxy statement for its 2012 annual meeting of stockholders are incorporated by reference into Part III, Items 10, 11, 12, 13, and 14 of this Form 10-K.

Table of Contents

Table of Contents

Part I

Forward-Looking Statements

References throughout this document to the Company include National Health Investors, Inc. and its wholly-owned subsidiaries. In accordance with the Securities and Exchange Commission s Plain English guidelines, this Annual Report on Form 10-K has been written in the first person. In this document, the words we , our , ours and us refer o to National Health Investors, Inc. and its wholly-owned subsidiaries and not any other person. Unless the context indicates otherwise, references herein to the Company include all of our wholly-owned subsidiaries.

This Annual Report on Form 10-K and other materials we have filed or may file with the Securities and Exchange Commission, as well as information included in oral statements made, or to be made, by our senior management contain certain forward-looking statements as that term is defined by the Private Securities Litigation Reform Act of 1995. All statements regarding our expected future financial position, results of operations, cash flows, funds from operations, continued performance improvements, ability to service and refinance our debt obligations, ability to finance growth opportunities, and similar statements including, without limitations, those containing words such as may , will , believes , anticipates , expects , intends , estimates , plans , and other similar expressions are fo statements.

Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected or contemplated in the forward-looking statements. Such risks and uncertainties include, among other things, the following risks described in more detail under the heading Risk Factors under Item 1A:

*

We depend on the operating success of our customers (facility operators) for collection of our revenues during this time of uncertain economic conditions in the U.S.;

*

We are exposed to the risk that our tenants and borrowers may become subject to bankruptcy or insolvency proceedings;

*

We are exposed to risks related to governmental regulations and payors, principally Medicare and Medicaid, and the effect that lower reimbursement rates will have on our tenants and borrowers business;

*

We are exposed to the risk that the cash flows of our tenants and borrowers will be adversely affected by increased liability claims and general and professional liability insurance costs;

*

We are exposed to risks related to environmental laws and the costs associated with the liability related to hazardous substances;

*

We are exposed to the risk that we may not be indemnified by our lessees and borrowers against future litigation;

*

We depend on the success of future acquisitions and investments;

*

We depend on the ability to reinvest cash in real estate investments in a timely manner and on acceptable terms;

*

We may need to incur more debt in the future, which may not be available on terms acceptable to the Company;

*

We are exposed to the risk that the illiquidity of real estate investments could impede our ability to respond to adverse changes in the performance of our properties;

*

We are exposed to the risk that our assets may be subject to impairment charges;

*

We depend on the ability to continue to qualify as a real estate investment trust;

*

We have ownership limits in our charter with respect to our common stock and other classes of capital stock;

*

We are subject to certain provisions of Maryland law and our charter and bylaws that could hinder, delay or prevent a change in control transaction, even if the transaction involves a premium price for our common stock or our stockholders believe such transaction to be otherwise in their best interests;

Table of Contents

See the notes to the annual consolidated financial statements, and Business and Risk Factors under Item 1 and Item 1A 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 we face. 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 part or all 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 1. BUSINESS.

General

National Health Investors, Inc. (NHI or the Company), a Maryland corporation incorporated in 1991, is a real estate investment trust ("REIT") which invests in income-producing health care properties primarily in the long-term care and senior housing industries. As of December 31, 2011, our portfolio consisted of real estate (excluding corporate office and assets held for sale) and mortgage investments with a carrying value totaling $472,741,000 and other investments in preferred stock and marketable securities of $49,496,000 resulting in total invested assets of $522,237,000. We are a self-managed REIT with our own management reporting directly to our Board of Directors. 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 investing in leased properties and mortgage loans nationwide, primarily in the long-term health care industry. These investments include skilled nursing facilities, assisted living facilities, medical office buildings, independent living facilities, and hospitals, all of which are collectively referred to herein as "Health Care Facilities". We have funded these investments in the past through three sources of capital: (1) current cash flow, including principal prepayments from our borrowers, (2) the sale of equity securities, and (3) debt offerings, including bank lines of credit, the issuance of convertible debt instruments, and the issuance of ordinary debt.

At December 31, 2011, our continuing operations consisted of investments in real estate and mortgage notes receivable in 127 health care facilities located in 24 states consisting of 81 skilled nursing facilities, 36 assisted living facilities, 2 medical office buildings, 4 independent living facilities, and 4 hospitals. These investments consisted of approximately $394,069,000 of net real estate investments in 97 health care facilities with 18 lessees and $78,672,000 aggregate carrying value of mortgage notes receivable from 15 borrowers related to 30 health care facilities.

All of our investments in real estate and mortgage loans are within the United States. We are managed as one reporting unit, rather than multiple reporting units, for internal reporting purposes and for internal decision making. Therefore, we have concluded that we operate as a single segment. Information about revenues from our tenants and borrowers, a measure of our income, and total assets for this segment can be found in Item 8 of this Annual Report.

Types of Health Care Facilities

Skilled nursing facilities. As of December 31, 2011, our portfolio included 55 skilled nursing facilities (SNF) leased to operators and mortgage loans secured by 26 SNFs. SNFs provide some combination of skilled and intermediate nursing and rehabilitative care, including speech, physical and occupational therapy. The operators of the SNFs receive payment from a combination of private pay sources and government programs such as Medicaid and Medicare. SNFs are required to obtain state licenses and are highly regulated at the federal, state and local level. Most SNFs must obtain a Certificate of Need (CON) from the state before opening or expanding such facilities. Some SNFs include assisted living beds.

Assisted living facilities. As of December 31, 2011, our portfolio included 33 assisted living facilities (ALF) leased to operators and mortgage loans secured by 3 ALFs. ALFs are either free-standing or are attached to skilled nursing or retirement facilities and provide basic room and board functions for elderly residents. They may also provide assistance to elderly residents with activities of daily living such as bathing, grooming and administering medication. Some assisted living projects include licensed skilled nursing beds. On-site staff personnel are available to assist in minor medical needs on an as-needed basis. Operators of ALFs are typically paid from private sources without assistance from government programs.

Medical office buildings. As of December 31, 2011, our portfolio included 2 medical office buildings (MOB) leased to operators. MOBs are specifically configured office buildings whose tenants are primarily physicians and other medical practitioners. MOBs differ from conventional office buildings due to the special requirements of the tenants. Each of our MOBs is leased to one lessee, and is either physically attached to or located on an acute care hospital campus. The lessee then

Table of Contents

sub-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 sub-lease the individual office space.

Independent living facilities. As of December 31, 2011, our portfolio included 4 independent living facilities (ILF) leased to two operators. ILFs 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. Services provided by ILF operators are generally paid from private sources without assistance from government programs. ILFs may be licensed and regulated in some states, but do not require the issuance of a CON as required for SNFs.

Hospitals. As of December 31, 2011, our portfolio included 4 hospitals (HOSP); 2 of which are leased to operators, 1 leased property currently under development and 1 mortgage loan with a purchase option. Hospitals provide a wide range of inpatient and outpatient services, including acute psychiatric and rehabilitation services, and are subject to extensive federal, state and local legislation and regulation. Hospitals undergo periodic inspections regarding standards of medical care, equipment and hygiene as a condition of licensure. Services provided by hospitals are generally paid for by a combination of private pay sources and government programs.

Nature of Investments

Our investments are typically structured as acquisitions of properties through purchase-leaseback transactions, acquisitions of real estate operations with in-place leases, or as mortgage loans. We have also provided construction loans for facilities for which we were already committed to provide long-term financing or for which the operator agreed to enter into a lease with us upon completion of the construction. The lease rates on our leases and the interest rates on our mortgage and construction loans have typically ranged between 8% and 12% per annum. We normally charge a commitment fee of 1% based on the purchase price of the property in a purchase-leaseback transaction or the total principal amount of a mortgage or construction loan. We believe our lease and loan terms are competitive within our peer group. Typical characteristics of these transactions are as follows:

Leases. Our leases generally have an initial leasehold term of 10 to 15 years with one or more 5-year renewal options. The leases are "triple net leases" under which the tenant is responsible for the payment of all taxes, utilities, insurance premium costs, repairs and other charges relating to the ownership and operation of the Health Care Facilities, including required levels of capital expenditure each year. The tenant is obligated at its expense to keep all improvements, fixtures and other components of the Health Care Facilities covered by "all risk" insurance in an amount equal to at least the full replacement cost thereof and to maintain specified minimal personal injury and

property damage insurance. Our leases require the tenant to name us as an additional insured party on the tenant s insurance policy. The leases also require the tenant to indemnify and hold us harmless from all claims resulting from the use and occupancy of each Health Care Facility by the tenant and related activities, and to indemnify us 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.

Most of our existing leases contain annual escalators in rent payments. For financial statement purposes, rental income is recognized on a straight-line basis over the term of the lease. The acute care and MOB properties (excluding acute psychiatric) 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 MOB leases (excluding acute psychiatric) contain a right of first refusal for the lessee if we receive an offer to buy the underlying leased property.

Some 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. Some obligations are backed further by other collateral such as machinery, equipment, furnishings and other personal property.

Construction loans. From time to time, we also provide construction loans that by their terms convert to mortgage loans upon the completion of the construction of the facility. We may also obtain a purchase option to acquire the facility at a future date and lease the facility back to the operator. The terms of such construction loans are for a period which commences upon the closing of such loans and terminate 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

Table of Contents

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.

Mortgage Loans. In general, our mortgage loans have a maturity of at least 10 years with the principal amortized over 20 to 25 years and a balloon payment due at maturity. Most of the loans are at a fixed interest rate; however, some interest rates increase based on scheduled fixed rate increases. In most cases, the owner of the facility is committed to make minimum annual capital expenditures for the purpose of maintaining or upgrading their respective facility. Additionally, most of our loans are collateralized by first mortgage liens and corporate or personal guarantees.

We have made mortgage loans to borrowers secured by a second deed-of-trust where there is a process in place for the borrower to obtain long-term financing, primarily with a U.S. government agency, and where the historical financial performance of the underlying health care facility meets our loan underwriting criteria. The interest rate on our second mortgage loans are currently 12% to 14.5% per annum.

Investment in preferred stock and marketable securities of other REITs. We have invested a portion of our funds in the preferred and common shares of other publicly-held REITs to ensure the substantial portion of our assets are invested for real estate purposes. Refer to Notes 5 and 6 of our consolidated financial statements included herein for further information.

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 banks who market securities in mortgage funds) in the acquisition, leasing and financing of health care-related properties primarily on the basis of price 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 residents and/or 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 our Health Care Facilities. Some of these facilities are operated for profit while others are owned by governmental agencies or tax exempt not-for-profit organizations.

The SNFs which either secure our mortgage loans or we lease to operators 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. In particular, the establishment of a Medicare prospective payment system (PPS) for SNF services to replace the cost-based reimbursement system significantly reduced Medicare reimbursement to SNF providers. While Congress subsequently took steps to mitigate the impact of the prospective payment system on SNFs, other federal legislative policies have been adopted and continue to be proposed that would reduce Medicare and/or Medicaid payments to SNFs. State Medicaid funding is not expected to keep pace with inflation according to industry studies. Any changes in government reimbursement methodology that reduces reimbursement to levels that are insufficient to cover the operating costs of our borrowers and lessees could adversely impact us. The ALF industry generally relies on private-pay residents who may be negatively impacted in an economic downturn. The success of these facilities is often impacted by the existence of comparable, competing facilities in a local market.

Operator Diversification

The majority of our Health Care Facilities are operated by the owner or lessee. For the year ended December 31, 2011, 56% of our portfolio revenue was from publicly-owned companies, 35% was from regional operators, and 9% was from smaller operators. As a percent of total investments at net book value, approximately 19% of the Health Care Facilities are operated by publicly-owned companies, 68% are operated by regional health care companies and 13% are operated by smaller companies. 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.

For the year ended December 31, 2011, operators of facilities which provided more than 3% of our total revenues were (in alphabetical order): Bickford Senior Living; Community Health Systems, Inc.; Emeritus Senior Living; Health Services Management, Inc.; Legend Healthcare, LLC; National HealthCare Corporation; Senior Living Management Corporation, LLC; and Suite Living Senior Specialty Services.

Table of Contents

Major Customer - NHC

National HealthCare Corporation (NHC), is a publicly-held company and our largest customer. We lease 41 health care facilities to NHC. On December 27, 2005, under an amendment to the Master Agreement (originally dated October 17, 1991), NHC exercised its option to extend the existing lease on the 41 facilities for the second renewal term. These 41 properties include 38 SNFs (4 of which are subleased to other parties for whom the lease payments are guaranteed to us by NHC under the Master Agreement) and 3 ILFs. The 15-year lease extension began January 1, 2007, and includes 3 additional 5-year renewal options, each at fair rental value of such leased property as negotiated between the parties and determined without including the value attributable to any improvements to the leased property voluntarily made by the tenant at its expense. Under the terms of the lease, rent escalates by 4% of the increase, if any, in each facility s revenue over a 2007 base year. We refer to this additional rent component as percentage rent .

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) 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.

Our rental income from continuing operations in 2011 was $76,050,000 ($35,996,000 or 47% from NHC); in 2010 was $71,289,000 ($35,212,000 or 49% from NHC); and in 2009 was $53,648,000 ($34,782,000 or 65% from NHC).

Beginning with our inception in 1991, NHC provided advisory services to us under an Advisory, Administrative Services and Facilities Agreement (the "Advisory Agreement"). Effective November 1, 2004, we assigned the Advisory Agreement with NHC to Management Advisory Source, LLC (MAS), formed by our Board Chairman and then Chief Executive Officer W. Andrew Adams. On December 3, 2007, we elected to become a self-managed REIT, with our own management reporting directly to the Board of Directors, and we terminated the Advisory Agreement with MAS on March 31, 2008. Under a consulting agreement with our Board of Directors, Mr. Adams served as Chief Executive Officer until March of 2011. Mr. Adams remains the Chairman of the Board of Directors.

Commitments and Contingencies

As described in Note 9 to the consolidated financial statements, as of December 31, 2011, we have future conditional funding commitments totaling $2,050,000 to two borrowers, a commitment of $146,000 to a lessee for certain capital improvements and operating equipment, and a construction commitment of $16,547,000. We have $9,478,000 in future conditional payments to be made in connection with three purchase/leaseback transactions we completed between 2009 and 2011. Funding of the commitments described above results in a higher basis from which we will charge agreed-upon lease or borrowing rates.

As described in Note 3 and 9 to our consolidated financial statements, we have agreed to sell six (five remaining) SNFs to our current lessee, affiliates of Fundamental Long Term Care Holdings, LLC. We are committed to finance a portion of the purchase price, not to exceed $8,000,000, with individual loans for each facility to be repaid over a term of five years with interest of 11.5% per annum plus annual increases.

Sources of Revenues

General. Our revenues are derived primarily from rental income and mortgage interest income. During 2011, rental income was $76,050,000 (92%) and mortgage interest income was $6,652,000 (8%) of total revenue from continuing operations of $82,702,000. Our revenues depend on the operating success of our facility operators whose source and amount of revenues are determined by (i) the licensed beds 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.

Table of Contents

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 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 SNF lessees and borrowers is derived from government funded reimbursement programs, such as Medicare and Medicaid. Reimbursement under these programs is subject to periodic pre- and post-payment review and other audits by federal and state authorities. Medicare is uniform nationwide and reimburses skilled nursing centers under a prospective payment system (PPS) which is based on a predetermined, fixed amount. 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 adjusted each October when the federal fiscal year begins. The current acuity classification system is named Resource Utilization Groups IV (RUGs IV) and was effective October 1, 2010. PPS as implemented in 1998 had an adverse impact on the healthcare industry and our lessees and borrowers business by decreasing payments materially, which adversely impacted our business. Refinements in the form of temporary add-ons provided some relief until October 1, 2002. Since then, annual market basket (inflationary) increases have continued to improve payments; however, other federal legislative policies have been adopted and continue to be proposed that could reduce Medicare and/or Medicaid payments to nursing facilities.

RUGs IV incorporates changes to PPS that will significantly alter how SNFs are paid for rendering care. Operators of our SNFs who are not well versed in the new regulations will be at risk for reductions in revenue. Some examples are as follows:

A shift to 66 payment categories from 53 payment categories;

Changes related to assessment reference dates and qualifiers that will significantly reduce utilization of rehabilitation and extensive service categories;

Modification to therapy services related to estimating treatments and utilization of concurrent therapy that will likely result in RUG classifications at much lower levels of therapy than previous results; and

Adjustments related to assistance with activities of daily living (ADLs) and an increased emphasis on ADL scores in the nursing case mix indices and related RUG payment rates.

Medicaid is a joint federal and state program designed to provide medical assistance to eligible needy persons. Medicaid 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 Balanced Budget Act of 1997. The Boren Amendment provided fair reimbursement protection to nursing facilities. Changes in federal funding 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. Healthcare reimbursement will likely continue to be of significant importance to federal and state authorities. We cannot make any assessment as to the ultimate timing or the effect that any future legislative reforms may have on our lessees and borrowers costs of doing business and on the amount of reimbursement by government and other third-party payors. There can be no assurance that future payment rates for either government or private payors 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 could adversely affect the operating revenues of our SNF and hospital lessees and borrowers, and thereby adversely affect their ability to make their lease or debt payments to us. Failure of

Table of Contents

our lessees and borrowers to make their scheduled lease and loan payments to us would have a direct and material adverse impact on us.

Government Regulation

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 restrict 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. The SNFs and hospitals in which we invest are also generally subject to state statutes which may require regulatory approval in the form of a CON prior to the construction or expansion of facilities to accommodate new beds (or addition of new beds to existing facilities), 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 CONs on the operations of our lessees and borrowers; 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. Our investment policies include making investments in real estate and mortgage notes receivable and securities of other publicly-held REITs.

As described in Notes 3 and 4 to the consolidated financial statements, we funded or made commitments to fund new investments in real estate and mortgage assets during 2011 totaling $100,378,000, and we anticipate making additional investments in 2012 that meet our underwriting criteria. In making new investments, we 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 income return 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 meeting our standards regarding 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 NHI, or any affiliate thereof, as the case may be, any of our assets or other property.

Table of Contents

The Board of Directors, without the approval of the stockholders, may alter our investment policies if it determines 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.

Future investments in health care related facilities or businesses may utilize borrowed funds when it is advisable in the opinion of the Board of Directors. We may negotiate lines of credit or arrange for other short or long-term borrowings from lenders. We may arrange for long-term borrowings from institutional investors or through public offerings. We have previously 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 in mortgage investment pools.

Executive Officers of the Company

The table below sets forth the name, position and age of each of our executive officers. Each executive officer is appointed by the Board of Directors, serves at its pleasure and holds office for a term of one year. There is no family relationship among any of the named executive officers or with any director. All information is given as of February 14, 2012:

Name	Position	Age
J. Justin Hutchens	President and Chief Executive Officer	37
Roger R. Hopkins	Chief Accounting Officer	50
Kristin S. Gaines	Chief Credit Officer	40

J. Justin Hutchens was appointed Chief Executive Officer and President of National Health Investors (NYSE: NHI) in March 2011. Mr. Hutchens joined NHI as the President, Chief Operating Officer in February 2009. Prior to joining NHI, he had 15 years of field operations background in the senior housing and long-term care industry including national operating experience as the Senior Vice-President & COO of Summerville Senior Living in 2003 until the Summerville merger with Emeritus Senior Living (NYSE: ESC) in 2007 at which time he was appointed the Executive Vice-President & COO of Emeritus. He holds a Master of Science in Management from Regis University and a Bachelor of Science in Human Services from the University of Northern Colorado. He completed an Executive Management Program studying Measurement and Control of Organizational Performance at the University of Michigan.

Roger R. Hopkins joined NHI in 2006 and was named Chief Accounting Officer in December 2006. He has nearly 30 years of public accounting and financial management experience. Until 2006, he was a partner in the Tennessee regional accounting firm of Rodefer Moss & Co, PLLC. He was previously a senior manager in the Nashville, Tennessee office of Deloitte & Touche. Mr. Hopkins received his B.S. degree in accounting from Tennessee Technological University in 1982 and is a Certified Public Accountant.

Kristin S. Gaines was appointed NHI s Chief Credit Officer in February 2010. She joined NHI in 1998 as a Credit Analyst. During her tenure with NHI, Ms. Gaines has had a progressive career in the areas of finance and operations. Her experience has culminated in a breadth of expertise in underwriting, portfolio oversight and real estate finance. Ms. Gaines holds an MBA and she received her BBA in Accounting both from Middle Tennessee State University.

We have a staff of 9, all serving in our corporate office in Murfreesboro, TN. Essential services such as internal auditing, tax compliance, information technology, legal services, and investor relations are outsourced to third-party professional firms.

Investor Information

We maintain a web site at www.nhireit.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 have a policy of publishing these on the web site within two (2) business days after public release or filing with the SEC.

Table of Contents

We also maintain the following documents on our web site:

*

The NHI Code of Ethics and Standards of Conduct. This has been adopted for all employees, 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.

*

Information on our NHI Valuesline which allows our employees and stockholders unrestricted access to our Internal Auditor, executive officers and directors. The toll free number is 877-880-2974 and the communications may be made anonymously, if desired.

*

The NHI Restated Audit Committee Charter.

*

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.

Our transfer agent is Computershare. Computershare will assist registered owners with the NHI Dividend Reinvestment plan, change of address, transfer of ownership, payment of dividends, replacement of lost checks or stock certificates. Computershare s contact information is: Computershare Trust Company, N.A., P.O. Box 43078, Providence, RI 02940-3078. The toll free number is 800-942-5909 and the website is www.computershare.com.

The Annual Stockholders meeting will be held at 4:00 p.m. local time on May 4, 2012 at our corporate office at 222 Robert Rose Drive, Murfreesboro, TN.

ITEM 1A. RISK FACTORS.

We depend on the operating success of our customers (facility operators) for collection of our revenues during this time of uncertain economic conditions in the U.S.

Revenues to operators of our Health Care Facilities are primarily driven by occupancy, Medicare and Medicaid reimbursement and private pay rates. Revenues from government reimbursement have, and may continue to, come under pressure due to reimbursement cuts and from widely-publicized federal and state budget shortfalls and constraints. Overall weak economic conditions in the U.S. which affect housing sales, investment returns and personal incomes may adversely affect occupancy rates of ALFs that generally rely on private pay residents. Expenses for the Health Care Facilities are driven by the costs of labor, food, utilities, taxes, insurance and rent or debt service. Liability insurance and staffing costs continue to increase for our operators. To the extent any decrease in revenues and/or any increase in operating expenses results in a facility not generating enough cash to make scheduled payments to us, our revenues, net income and funds from operations would be adversely affected. Such events and circumstances would cause us to evaluate whether there was an impairment of the real estate or mortgage loan that should be charged to earnings. Such impairment would be measured as the amount by which the carrying amount of the asset exceeded its fair value. Consequently, we might be unable to maintain or increase our current dividend and the market price of our stock may decline.

We are exposed to the risk that our tenants and borrowers 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 leased the facility to another operator. In some of those situations, we provided working capital loans to, and limited indemnification of, the new

Table of Contents

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 governmental regulations and payors, principally Medicare and Medicaid, and the effect that lower reimbursement rates will have on our tenants and borrowers business.

Our operators businesses are affected by government reimbursement and private payor rates. To the extent that any of our Health Care Facilities receive 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 interruption or delays in payments due to any ongoing governmental investigations and audits at such facilities. In recent years, governmental payors have frozen or reduced payments to health care providers due to budgetary pressures. On July 29, 2011, the Centers for Medicare and Medicaid Services (CMS) announced the Skilled Nursing Facilities Prospective Payment System final rule for fiscal year 2012 that cuts Medicare payments to SNF operators by a net 11.1% beginning October 1, 2011. Such reductions in Medicare reimbursement will have an adverse effect on the financial operations of our borrowers and lessees who operate SNFs. 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 borrowers will be adversely affected by increased liability claims and general and professional liability insurance costs.

Long-term care facility operators (ALFs and SNFs) 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. Both Texas and Florida

have now adopted SNF 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 ALFs and SNFs. 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 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.

Table of Contents

We are exposed to the risk that we may not be indemnified by our lessees and borrowers against future litigation.

Our leases require that the lessee name us as an additional insured party on the tenant s insurance policy in regard to claims made for professional liability or personal injury. The leases also require the tenant to indemnify and hold us harmless for all claims resulting from the occupancy and use of each Health Care Facility. We cannot give any assurance that these protective measures will completely eliminate any risk to us related to future litigation, the costs of which could have a material adverse impact on us.

We depend on the success of future acquisitions and investments.

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 existing 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 depend on the ability to reinvest cash in real estate investments 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 reinvest 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 the amount of distributions to stockholders.

We may need to incur more debt in the future, which may not be available on terms acceptable to the Company.

We operate with a policy of incurring debt when, in the opinion of our Board of Directors, it is advisable. Currently, we believe that our low debt levels, availability under our unsecured credit facility and current liquidity will enable us to meet our obligations and continue to make investments in healthcare real estate. While we currently have a very low debt ratio, in the future, we may increase our borrowings. We may incur additional debt by borrowing under our unsecured credit facility, mortgaging properties we own and/or issuing debt securities in a public offering or in a private transaction. We believe we will be able to raise additional debt and equity capital at reasonable costs to refinance our credit facility at or prior to its maturity. Our ability to raise reasonably priced capital is not guaranteed; we may be unable to raise reasonably priced capital because of reasons related to our business or for reasons beyond our control, such as market conditions. If our access to capital becomes limited, it could have an impact on our ability to refinance our debt obligations, fund dividend payments, acquire properties and fund acquisition activities.

We are exposed to the risk that the illiquidity of real estate investments could impede our ability to respond to adverse changes in the performance of our properties.

Real estate investments are relatively illiquid and, therefore, our ability to quickly sell or exchange any of our properties in response to changes in economic and other conditions may be limited. All of our properties are "special purpose" properties that cannot be readily converted to general residential, retail or office use. Health Care Facilities that participate in Medicare or Medicaid must meet extensive program requirements, including physical plant and operational requirements, which are revised from time to time. Transfers of operations of Health Care Facilities are subject to regulatory approvals not required for transfers of other types of commercial operations and other types of real estate. Thus, if the operation of any of our properties becomes unprofitable due to competition, age of improvements or other factors such that our lessee or borrower becomes unable to meet its obligations on the lease or mortgage loan, the liquidation value of the property may be less than the net book value or the amount owed on any related mortgage loan, because the property may not be readily adaptable to other uses. The sale of the property or the replacement of an operator that has defaulted on its lease or loan could also be delayed by the approval process of any federal, state or local agency necessary for the transfer of the property or the replacement of the operator with a new operator licensed to manage the facility. No assurances can be given that we will recognize full value for any property that we are required to sell for liquidity reasons. Should such events occur, our income and cash flows from operations could be adversely affected.

Table of Contents

We are exposed to the risk that our assets may be subject to impairment charges.

We periodically, but not less than quarterly, evaluate our real estate investments and other assets for impairment indicators. The judgment regarding the existence of impairment indicators is based on factors such as market conditions, operator performance and legal structure. If we determine that a significant impairment has occurred, we would be required to make an adjustment to the net carrying value of the asset, which could have a material adverse affect on our reported results of operations in the period in which the impairment charge occurs.

We depend on the ability to continue to qualify as a REIT.

We intend to operate as a REIT under the Internal Revenue Code of 1986, as amended (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.

We have ownership limits in our charter with respect to our common stock and other classes of capital stock.

Our charter, subject to certain exceptions, contains restrictions on the ownership and transfer of our common stock and preferred stock that are intended to assist us in preserving our qualification as a REIT. Our charter, provides that any transfer that would cause NHI to be beneficially owned by fewer than 100 persons or would cause NHI to be closely held under Internal Revenue Code would be void, which, subject to certain exceptions, results in no person or entity being allowed to own, actually or constructively, more than 9.9% of the outstanding shares of our stock. Our Board of Directors, in its sole discretion, may exempt a proposed transferee from the ownership limit and such an exemption has been granted through Excepted Holder Agreements to members of the Carl E. Adams family. Based on the Excepted Holder Agreements currently outstanding, the individual ownership limit for all other stockholders is approximately 7.5%. Our charter gives our Board of Directors broad powers to prohibit and rescind any attempted transfer in violation of the ownership limits. These ownership limits may delay, defer or prevent a transaction or a change of control that might involve a premium price for our common stock or might otherwise be in the best interests of our stockholders.

We are subject to certain provisions of Maryland law and our charter and bylaws that could hinder, delay or prevent a change in control transaction, even if the transaction involves a premium price for our common stock or our stockholders believe such transaction to be otherwise in their best interests.

Certain provisions of Maryland law, our charter and our bylaws have the effect of discouraging, delaying or preventing transactions that involve an actual or threatened change in control, even if these transactions involve a premium price for our common stock or our stockholders believe such transaction to be otherwise in their best interests. The Maryland Business Combination Act provides that, unless exempted, a Maryland corporation may not engage in business combinations, including mergers, dispositions of 10% or more of its assets, issuances of shares of stock and other specified transactions with an "interested stockholder" or an affiliate of an interested stockholder for five years after the most recent date on which the interested stockholder became an interested stockholder, and thereafter, unless specified criteria are met. An interested stockholder is generally a person owning or controlling, directly or indirectly, 10% or more of the voting power of the outstanding stock of a Maryland corporation. Unless our Board of Directors takes action to exempt us, generally or with respect to certain transactions, from this statute in the future, the Maryland Business Combination Act will be applicable to business combinations between us and other persons. The Company s Charter and Bylaws also contain certain provisions that could have the effect of making it more difficult for a third party to acquire, or discouraging a third party from attempting to acquire, control of the Company. Such provisions could limit the price that certain investors might be willing to pay in the future for the common stock. These provisions include a staggered board of directors, blank check preferred stock, and the application of Maryland corporate law provisions on business combinations and control shares. The foregoing matters may, together or separately, have the effect of discouraging or making more difficult an acquisition or change of control of the Company.

Other risks.

See the notes to the consolidated financial statements, Business under Item 1 and Legal Proceedings under Item 3 herein for a discussion of various governmental regulations and operating factors relating to the health care industry and other factors and the risks inherent in them. You should carefully consider each of the foregoing risks before making any investment decisions in the Company. These risks and uncertainties are not the only ones facing us. 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

Table of Contents

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.

Table of Contents

ITEM 2. PROPERTIES OWNED OR ASSOCIATED WITH MORTGAGE LOAN INVESTMENTS

AS OF DECEMBER 31, 2011

SKILLED NURSING		Lease (L)/	Licensed
Center	City	Mortgage (M)	Beds
ALABAMA			
NHC HealthCare, Anniston	Anniston	L	151
NHC HealthCare, Moulton	Moulton	L	136
ARIZONA			
Sunbridge Estrella Care & Rehabilitation	Avondale	L	161
FLORIDA			
Ayers Health & Rehabilitation Center	Trenton	L	120
Bayonet Point Health & Rehabilitation Center	Hudson	L	180
Bear Creek Nursing Center	Hudson	L	120
Brooksville Healthcare Center	Brooksville	L	180
Cypress Cove Care Center	Crystal River	L	120
Heather Hill Healthcare Center	New Port Richey	L	120
Parkway Health & Rehabilitation Center	Stuart	L	177
Royal Oak Nursing Center	Dade City	L	120
The Health Center of Merritt Island	Merritt Island	L	180
The Health Center of Plant City	Plant City	L	180
GEORGIA			
Ashton Woods Rehabilitation Center	Atlanta	M	157
NHC HealthCare, Rossville	Rossville	L	112
The Place at Deans Bridge	Augusta	M	100
The Place at Martinez	Augusta	M	100
The Place at Pooler	Pooler	M	122
IDAHO			
Grangeville Health and Rehabilitation Center	Grangeville	L	60
KANSAS			
Chanute HealthCare Center	Chanute	M	77
Council Grove HealthCare Center	Council Grove	M	80
Haysville HealthCare Center	Haysville	M	119
Larned HealthCare Center	Larned	M	83
Sedgwick HealthCare Center	Sedgwick	M	62

KENTUCKY			
NHC HealthCare, Glasgow	Glasgow	L	206
NHC HealthCare, Madisonville	Madisonville	L	94
MASSACHUSETTS			
Buckley HealthCare Center	Greenfield	M	120
Holyoke Health Care Center	Holyoke	M	102
John Adams HealthCare Center	Quincy	M	71
Longmeadow of Taunton	Taunton	M	100
MISSOURI			
Charlevoix HealthCare Center	St. Charles	M	142
Columbia HealthCare Center	Columbia	M	97
Joplin HealthCare Center	Joplin	M	92
NHC Healthcare, Desloge	Desloge	L	120
NHC Healthcare, Joplin	Joplin	L	126
NHC Healthcare, Kennett	Kennett	L	170

Table of Contents

SKILLED NURSING (continued)		Lease (L)/	Licensed
Center	City	Mortgage (M)	Beds
NHC Healthcare, Maryland Heights	Maryland Heights	L	220
NHC HealthCare, St. Charles	St. Charles	L	120
NEW HAMPSHIRE			
Epsom HealthCare Center	Epsom	M	108
Maple Leaf HealthCare Center	Manchester	M	114
Villa Crest HealthCare Center	Manchester	M	165
SOUTH CAROLINA			
NHC Healthcare, Anderson	Anderson	L	290
NHC Healthcare, Greenwood	Greenwood	L	152
NHC HealthCare, Laurens	Laurens	L	176
UniHealth Post-Acute Care-Orangeburg	Orangeburg	L	88
TENNESSEE			
NHC Healthcare, Athens	Athens	L	98
NHC Healthcare, Chattanooga	Chattanooga	L	207
NHC HealthCare, Columbia	Columbia	L	106
NHC HealthCare, Dickson	Dickson	L	211
NHC HealthCare, Franklin	Franklin	L	80
NHC Healthcare, Hendersonville	Hendersonville	L	122
NHC Healthcare, Hillview	Columbia	L	92
NHC Healthcare, Johnson City	Johnson City	L	160
NHC Healthcare, Knoxville	Knoxville	L	139
NHC Healthcare, Lewisburg	Lewisburg	L	102
NHC HealthCare, McMinnville	McMinnville	L	150
NHC HealthCare, Milan	Milan	L	122
NHC Healthcare, Oakwood	Lewisburg	L	60
NHC HealthCare, Pulaski	Pulaski	L	102
NHC Healthcare, Scott	Lawrenceburg	L	62
NHC HealthCare, Sequatchie	Dunlap	L	120
NHC HealthCare, Smithville	Smithville	L	120
NHC Healthcare, Somerville	Somerville	L	84
NHC Healthcare, Sparta	Sparta	L	120
NHC HealthCare, Springfield	Springfield	L	107
TEXAS			
Heritage Manor of Canton*	Canton	L	110
Heritage Oaks*	Arlington	L	204
Heritage Place*	Mesquite	L	149
Legend Healthcare & Rehabilitation	Paris	L	120

Legend Oaks Healthcare and Rehabilitation Center *(East)*	Houston	L	125
Legend Oaks Healthcare and Rehabilitation Center *(Northwest)*	Houston	L	125
Legend Oaks Healthcare and Rehabilitation Center	San Antonio	L	125
Legend Oaks Healthcare and Rehabilitation Center - Ennis	Ennis	L	124
Legend Healthcare & Rehabilitation	Greenville	L	125
Legend Oaks Healthcare and Rehabilitation Center	Houston	L	124
Legend Oaks Healthcare and Rehabilitation Center	Houston	L	125
Park Place Care Center	Georgetown	M	164
The Village at Richardson*	Richardson	L	280
Winterhaven Healthcare Center*	Houston	L	160

Table of Contents

SKILLED NURSING (continued)			
Center	City	Lease (L)/ Mortgage (M)	Licensed Beds
VIRGINIA			
Heritage Hall - Brookneal	Brookneal	M	60
Heritage Hall - Grundy	Grundy	M	120
Heritage Hall - Laurel Meadows	Laurel Fork	M	60
Heritage Hall - Virginia Beach	Virginia Beach	M	90
Heritage Hall - Front Royal	Front Royal	M	60
Heritage Hall - Lexington	East Lexington	M	60
NHC HealthCare, Bristol	Bristol	L	120
ASSISTED LIVING			
ARIZONA			
The Place at Gilbert	Gilbert	L	40
The Place at Glendale	Glendale	L	38
The Place at Tanque Verde	Tucson	L	42
The Place at Tucson	Tucson	L	60
FLORIDA			
Brentwood at Fore Ranch	Ocala	M	120
Indigo Palms at Maitland	Maitland	L	116
Savannah Court of Maitland	Maitland	L	151
Savannah Court of Palm Beaches	W. Palm Beach	L	144
Savannah Court of Bartow	Bartow	L	30
Savannah Court of St. Cloud	St. Cloud	L	30
Savannah Court of Lakeland	Lakeland	L	30
GEORGIA			
Savannah Court at Lake Oconee	Greensboro	L	64
ILLINOIS			
Bickford of Peoria	Peoria	L	32
INDIANA			
Bickford of Lafayette	LaFayette	L	28
IOWA			
Bickford of Clinton	Clinton	L	37
Bickford of Iowa City	Iowa City	L	37
LOUISIANA			
West Monroe Arbors	West Monroe	L	59
Bossier Arbors	Bossier City	L	60

Bastrop Arbors	Bastrop	L	38
Minden Arbors	Minden	L	26
MICHIGAN			
Bickford of Battle Creek	Battle Creek	L	46
Bickford of Lansing	Lansing	L	46
Bickford of Midland	Midland	L	46
Bickford of Saginaw	Saginaw	L	46
MINNESOTA			
Traditions	Owatonna	M	70
Suite Living of Champlin	Champlin	L	30
Suite Living of Hugo	Hugo	L	24
Suite Living of Maplewood	Maplewood	L	42
Suite Living of North Branch	North Branch	L	30

Table of Contents

ASSISTED LIVING (continued)			
Center	City	Lease (L)/ Mortgage (M)	Licensed Beds
NEW JERSEY			
Brighton Gardens of Edison	Edison	L	148
OREGON			
East Cascade Retirement Community	Madras	M	76
PENNSYLVANIA			
Heritage Hill Senior Community	Weatherly	L	143
SOUTH CAROLINA			
The Place at Conway	Conway	L	52
TENNESSEE			
The Place at Gallatin	Gallatin	L	49
The Place at Kingsport	Kingsport	L	49
The Place at Tullahoma	Tullahoma	L	49
HOSPITALS			
ARIZONA			
Santé Mesa	Mesa	M	70
CALIFORNIA			
Alvarado Parkway Institute	La Mesa	L	66
KENTUCKY			
Kentucky River Hospital	Jackson	L	55
TENNESSEE			
Polaris**	Murfreesboro	L	60
INDEPENDENT LIVING CENTERS			
IDAHO			
Sunbridge Retirement & Rehab for Nampa	Nampa	L	183
MISSOURI			
Lake St. Charles Retirement Center	St. Charles	L	180
TENNESSEE			
Colonial Hill Retirement Center	Johnson City	L	63
Parkwood Retirement Apartments	Chattanooga	L	30

MEDICAL OFFICE BUILDINGS			Sq. Ft.
FLORIDA			
North Okaloosa	Crestview	L	27,017
TEXAS			
Pasadena Bayshore	Pasadena	L	61,500
CORPORATE OFFICE			
TENNESSEE	Murfreesboro	N/A	7,000

*Facility was classified as held for sale at December 31, 2011 in the consolidated financial statements
**Under construction

Table of Contents

10-YEAR LEASE EXPIRATIONS

The following table provides additional information on our leases which are scheduled to expire based on the maturity date contained in the most recent lease agreement or extension. Leases associated with facilities held for sale at December 31, 2011 are not considered below. We expect that, prior to maturity, we will negotiate new terms of a lease to either the current tenant or another qualified operator.

Year	Leases Expiring	Rentable Square Feet*	Number of Beds	Annualized Gross Rent** (in thousands)	Percentage of Annualized Gross Rent
2012	2	27,017	115	$ 3,561	4.4%
2013	1	-	148	1,372	1.7%
2014	1	-	780	6,444	7.9%
2015	-	-	-	-	-
2016	1	-	449	3,707	4.6%
2017	1	-	116	593	0.7%
2018	2	61,500	88	1,080	1.3%
2019	1	-	143	403	0.5%
2020	-	-	-	-	-
2021	1	-	344	1,692	2.1%
Thereafter	8	-	7,672	62,524	76.8%

*Rentable Square Feet represents total square footage in two MOB investments.

**Annualized Gross Rent refers to the amount of lease revenue that our portfolio would generate if all leases were in effect for the twelve-month calendar year, regardless of the commencement date, maturity date, or renewals.

ITEM 3. LEGAL PROCEEDINGS.

The Health Care Facilities are subject to claims and suits in the ordinary course of business. Our lessees and borrowers have indemnified and are obligated to continue to indemnify us against all liabilities arising from the operation of the Health Care Facilities, and are further obligated to indemnify us against environmental or title problems affecting the real estate underlying such facilities. While there may be lawsuits pending against certain of

the owners and/or lessees of the Health Care Facilities, management believes that the ultimate resolution of all such pending proceedings will have no material adverse effect on our financial condition, results of operations or cash flows.

As previously disclosed, in November 2008, the Company was served with a Civil Investigative Demand by the Office of the Tennessee Attorney General (OTAG), which indicated that the OTAG was investigating transactions between the Company and three Tennessee nonprofit corporations. NHI has provided the OTAG with requested information and documents and has been working with the OTAG with respect to this investigation. The investigation has been resolved with respect to one of the nonprofit corporations. Although the transaction is subject to the approval of the OTAG, NHI has entered into agreements to purchase and lease to a third party the facilities owned by the second nonprofit. While NHI has not received any indication that the OTAG will object to the transaction, NHI can give no assurance that the transaction will be approved by the OTAG. A receiver was recently appointed for the third nonprofit. Other than as described above, NHI does not know whether the OTAG will commence any legal proceedings with respect to either of these nonprofit corporations or, if so, what relief will be sought.

As previously disclosed, in 2009, Burt Shearer Trustee, as trustee of the Shearer Family Living Trust, filed a shareholder derivative complaint naming as defendants NHI directors W. Andrew Adams, Robert A. McCabe, Jr., Robert T. Webb, and Ted H. Welch and as a nominal defendant NHI. On September 21, 2010, the Court granted a motion to dismiss the complaint, entered a judgment, and dismissed the action with prejudice. Despite that ruling, the Company s Board received a new demand letter from Mr. Shearer dated October 11, 2010 that again asserted that certain NHI directors and officers breached their fiduciary duties to NHI in connection with its transaction with Care Foundation of America, Inc. (CFA). In response, the Company s Board appointed a special committee that on December 6, 2010 made its report and recommendation to the Board. The Board considered the demand and unanimously accepted the special committee s recommendation to reject the demand on the basis that pursuing the proposed claims, in whole or in part, would not be in the best interests of the Company. Mr. Shearer was notified of the Board s determination by letter dated December 13, 2010. On February 3, 2011, Mr. Shearer filed a new derivative shareholder lawsuit (M.D. Tenn. Case No. 3:11-99), making the same claim and allegations as in the action that was dismissed with prejudice. The Company has responded to the new lawsuit by filing a motion to dismiss, in which the Company contends that Mr. Shearer lacks standing to bring the action given the Board s acceptance of the special committee s

Table of Contents

recommendation. The individual defendants have filed a separate motion to dismiss, in which they contend that the judgment in the first action precludes a subsequent action. Both motions have been fully briefed and are pending before the Court.

ITEM 4. MINE AND SAFETY DISCLOSURES.

Not applicable.

PART II

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

The Company s charter contains certain provisions which are designed to ensure that the Company s status as a REIT is protected for federal income tax purposes. One of these provisions provides that any transfer that would cause NHI to be beneficially owned by fewer than 100 persons or would cause NHI to be closely held under the IRS Code would be void, which, subject to certain exceptions, results in no stockholder being allowed to own, either directly or indirectly pursuant to certain tax attribution rules, more than 9.9% of the Company s stock. In 1991, the Board created an exception to this ownership limitation for Dr. Carl E. Adams, his spouse, Jennie Mae Adams, and their lineal descendants. Effective May 12, 2008, we entered into Excepted Holder Agreements with W. Andrew Adams and certain members of his family. These written agreements are intended to restate and replace the parties prior verbal agreement. Based on the Excepted Holder Agreements currently outstanding, the individual ownership limit for all other stockholders is approximately 7.5%. Our charter gives our Board of Directors broad powers to prohibit and rescind any attempted transfer in violation of the ownership limits. These agreements were entered into in connection with the Company s announcement in 2008 of a stock purchase program pursuant to which the Company subsequently purchased 194,100 shares of its common stock in the public market from its stockholders.

A separate agreement was entered into with each of the spouse and children of Dr. Carl E. Adams and others within Mr. W. Andrew Adams family. We needed to enter into such an agreement with each family member because of the

complicated ownership attribution rules under the Internal Revenue Code. The Agreement permits the Excepted Holders to own stock in excess of 9.9% up to the limit specifically provided in the individual agreement and not lose rights with respect to such shares. However, if the stockholder s stock ownership exceeds the limit, then such shares in excess of the limit become Excess Stock and lose voting rights and entitlement to receive dividends. The Excess Stock classification remains in place until the stockholder no longer exceeds the threshold limit specified in the Agreement. The purpose of these agreements is to ensure that the Company does not violate the prohibition against a REIT being closely held.

W. Andrew Adams Excess Holder Agreement also provides that he will not own shares of stock in any tenant of the Company if such ownership would cause the Company to constructively own more than a 9.9% interest in such tenant. Again, this prohibition is designed to protect the Company s status as a REIT for tax purposes.

In order to qualify for the beneficial tax treatment accorded to a REIT, we must make 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 circumstances, we may not have received cash sufficient to pay our required distributions.

Table of Contents

Common Stock Market Prices and Dividends

Our common stock is traded on the New York Stock Exchange under the symbol NHI . As of February 14, 2012, there were 896 holders of record of shares and 18,164 beneficial owners of the shares.

High and low stock prices of our common stock on the New York Stock Exchange and dividends declared for the last two years were:

	2011			2010		
	Sales Price		**Cash Dividends**	Sales Price		Cash Dividends
Quarter Ended	**High**	**Low**	**Declared**	High	Low	Declared
March 31	**$48.48**	**$44.55**	**$.615**	$38.79	$32.03	$.575
June 30	**49.55**	**42.52**	**.615**	42.73	37.27	.575
September 30	**48.03**	**37.90**	**.615**	46.06	36.66	.605
December 31	**46.16**	**39.81**	**.87**[(1)]	48.31	42.61	.605

(1) Includes a special dividend of $0.22 per share

The closing price of our stock on February 14, 2012 was $48.98.

We currently maintain two equity compensation plans: the NHI 1997 Stock Option Plan (the 1997 Plan) and the 2005 Stock Option, Restricted Stock and Stock Appreciation Rights Plan (the 2005 Plan). Each of these plans has been approved by our stockholders. The following table provides information as of December 31, 2011 about our common stock that may be issued upon grants of restricted stock and the exercise of options under our existing equity compensation plans.

	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in the first column)
Equity compensation plans approved by security holders	509,422	$42.03	360,635(a)

(a) These shares remain available for grant under the 2005 Plan.

Table of Contents

The following graph demonstrates the performance of the cumulative total return to the stockholders of our common stock during the previous five years in comparison to the cumulative total return on the FTSE NAREIT All REITs Index and the Standard & Poor s 500 Stock Index. The FTSE NAREIT All REITs Index is comprised of all tax-qualified REITs that are listed on the New York Stock Exchange, the American Stock Exchange or the NASDAQ National Market List. The FTSE NAREIT All REITs Index is not free float adjusted, and constituents are not required to meet minimum size and liquidity criteria.

ITEM 6. SELECTED FINANCIAL DATA.

The following table represents our financial information for the five years ended December 31, 2011. This financial information has been derived from our historical financial statements including those for the most recent three years included elsewhere in this Annual Report on Form 10-K and should be read in conjunction with those consolidated financial statements, accompanying footnotes and Management s Discussion and Analysis of Financial Condition and Results of Operations in Item 7.

Table of Contents

NATIONAL HEALTH INVESTORS, INC.

SELECTED FINANCIAL DATA

(dollars in thousands, except share and per share amounts)