NATIONAL HEALTHCARE CORP
Form 10-K
February 15, 2017

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 AND EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2016

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

For the transition period from _____ to _____

Commission File No. 001 13489

(Exact name of registrant as specified in its Corporate Charter)

Delaware	**52 2057472**
(State of Incorporation)	(I.R.S. Employer I.D. No.)

100 Vine Street
Murfreesboro, Tennessee 37130
(Address of principal executive offices)
Telephone Number: **615 890 2020**

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	**NYSE MKT**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S T (§232.405 of this chapter) during the preceding 12 months (or for such 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 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 (as defined in Rule 12b 2 of the Act). Large accelerated filer [ ] Accelerated filer [x] Non accelerated filer [ ] Smaller reporting company [ ]

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 Common Stock held by non affiliates on June 30, 2016 (based on the closing price of such shares on the NYSE MKT) was approximately $505 million. For purposes of the foregoing calculation only, all directors, named executive officers and persons known 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 February 9, 2017 was 15,177,938.

Documents Incorporated by Reference

The following documents are incorporated by reference into Part III, Items 10, 11, 12, 13 and 14 of this Form 10 K: The Registrant s definitive proxy statement for its 2017 shareholder s meeting.

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PART 1

ITEM 1.

BUSINESS

General Development of Business

National HealthCare Corporation, which we also refer to as NHC or the Company, began business in 1971. Our principal business is the operation of skilled nursing facilities, assisted living facilities, independent living facilities and homecare programs. Our business activities include providing sub acute and post acute skilled nursing care, intermediate nursing care, rehabilitative care, memory and Alzheimer s care, senior living services, and home health care services. We have a non controlling ownership interest in a hospice care business that services NHC owned health care centers and others. In addition, we provide management services, accounting and financial services, as well as insurance services to third party operators of health care facilities. We also own the real estate of 13 healthcare properties and lease these properties to third party operators. We operate in 10 states, and our owned and leased properties are located in the Southeastern, Northeastern, and Midwestern parts of the United States.

Narrative Description of the Business

At December 31, 2016, we operated or managed 74 skilled nursing facilities with a total of 9,398 licensed beds. These numbers include 68 facilities with 8,662 beds that we lease or own and six facilities with 736 beds that we manage for others. Of the 68 leased or owned facilities, 39 of the facilities are leased and 29 of the facilities are owned. Of the 39 leased facilities, 35 are leased from National Health Investors, Inc. ("NHI").

Our 21 assisted living facilities (nine leased, eleven owned, and one managed) have 1,015 units (991 units leased or owned and 24 units managed).

Our five independent living facilities (three leased, one owned, and one managed) have 475 retirement apartments (338 apartments leased or owned and 137 apartments managed).

We operated 36 homecare programs licensed in four states (Tennessee, South Carolina, Missouri and Florida) and provided 424,281 homecare patient visits to 19,610 patients in 2016.

We have a partnership agreement and a 75.1% non controlling ownership interest in Caris Healthcare, LP (Caris), a business that specializes in hospice care services in NHC owned health care centers and in other settings. Caris provides hospice care to over 1,000 patients per day in 28 locations in Georgia, Missouri, South Carolina, Tennessee, and Virginia.

We operate specialized care units within certain of our healthcare centers such as Alzheimer's disease care units and sub acute nursing units. Similar specialty units are under consideration at a number of our centers, as well as free standing projects.

Net Patient Revenues. Health care services we provide include a comprehensive range of services. In fiscal 2016, 95.0% of our net operating revenues were derived from such health care services. Highlights of health care services activities during 2016 were as follows:

Skilled Nursing Facilities. The most significant portion of our business and the base for our other health care services is the operation of our skilled nursing facilities. In our facilities, experienced medical professionals provide medical services prescribed by physicians. Registered nurses, licensed practical nurses and certified nursing assistants provide comprehensive, individualized nursing care 24 hours a day. In addition, our facilities provide licensed therapy services, quality nutrition services, social services, activities, and housekeeping and laundry services. We operate 74 skilled nursing facilities as of December 31, 2016. We manage six facilities for third party owners. Revenues from the 68 facilities we own or lease are reported as net patient revenues in our financial statements. Management fee income is recorded as other revenues from the six facilities that we manage. We generally charge 6% to 7% of facility net operating revenues for our management services. Occupancy in skilled nursing facilities we operate was 89.5% during the year ended December 31, 2016.

Rehabilitative Services. We provide therapy services through Professional Health Services, a subsidiary of NHC. Our licensed therapists provide physical, speech, respiratory and occupational therapy for patients recovering from strokes, heart attacks, orthopedic conditions, neurological illnesses, or other illnesses, injuries or disabilities. We maintained a rehabilitation staff of over 1,700 highly trained, professional therapists in 2016. The majority of our rehabilitative services are for patients in our owned and managed skilled nursing facilities. However, we also provide services to over 81 additional health care providers. Our rates for these services are competitive with other market rates.

Medical Specialty Units. All of our skilled nursing facilities participate in the Medicare program, and we have expanded our range of offerings by the creation of center specific medical specialty units such as our memory care units and subacute nursing units. Our trained staff provides care for Alzheimer s patients in early, middle and advanced stages of the disease. We provide specialized care and programs for persons with Alzheimer s or related disorders in dedicated units within many of our skilled nursing facilities. Our specialized rehabilitation programs are designed to shorten or eliminate hospital stays and help to reduce the cost of quality health care. We develop individualized patient care plans to target appropriate medical and functional planning objectives with a primary goal where feasible for a return to home or a similar environment.

Assisted Living Facilities. Our assisted living facilities are dedicated to providing personal care services and assistance with general activities of daily living such as dressing, bathing, meal preparation and medication management. We perform resident assessments to determine what services are desired or required and our qualified staff encourages residents to participate in a range of activities. We own or lease 20 assisted living facilities and manage one assisted living facility. Of these 21 centers, fourteen are located within the physical structure of a skilled nursing facility or retirement center and seven are freestanding. In 2016, the rate of occupancy was 86.6%. Certificates of Need are not required to build these projects and we believe overbuilding has occurred in some of our markets.

Independent Living Facilities. Our four owned or leased and one managed independent living facilities offer specially designed residential units for the active and ambulatory elderly and provide various ancillary services for our residents, including restaurants, activity rooms and social areas. Charges for services are paid from private sources without assistance from governmental programs. Independent living centers may be licensed and regulated in some states, but do not require the issuance of a Certificate of Need ("CON") such as is required for skilled nursing facilities. We have, in several cases, developed independent living centers adjacent to our nursing facilities with an initial construction of 40 to 80 units. These units are rented by the month; thus these centers offer an expansion of our continuum of care. We believe these independent living units offer a positive marketing aspect of our skilled nursing facilities.

We have one owned retirement center which is a "continuing care community", where the resident pays a substantial entrance fee and a monthly maintenance fee. The resident then receives a full range of services, including home health nursing, without additional charge.

Homecare Programs. Our home health care programs (we call them homecares) assist those who wish to stay at home or in assisted living residences but still require some degree of medical care or assistance with daily activities. Registered and licensed practical nurses and therapy professionals provide skilled services such as infusion therapy, wound care and physical, occupational and speech therapies. Home health aides may assist with daily activities such as assistance with walking and getting in and out of bed, personal hygiene, medication assistance, light housekeeping and maintaining a safe environment. NHC operates 36 homecare licensed and Medicare certified offices in four states (Tennessee, South Carolina, Missouri and Florida) and some of our homecare patients are previously discharged from our skilled nursing facilities. Medicare reimbursement for homecare services is paid under a prospective payment system. Under this payment system, we receive a prospectively determined amount per patient per 60 day episode as defined by Medicare guidelines. Medicare episodes were 21,623 in 2015 and 20,423 in 2016. We served 19,711 patients in 2015 and 19,610 patients in 2016. Visits provided were 455,551 in 2015 and 424,281 in 2016.

Pharmacy Operations. At December 31, 2016, we operated four regional pharmacy locations (one each in east Tennessee, central Tennessee, South Carolina, and Missouri). These pharmacies

use a central location to supply pharmaceutical services (consulting and medications) and supplies. Regional pharmacies bill Medicare Part D Prescription Drug Plans (PDPs) electronically and directly for inpatients who have selected a PDP. Our regional pharmacies currently serve 58 owned facilities, six managed facilities, and 13 third party entities.

Other Revenues. We generate revenues from management, accounting and financial services to third party operators of healthcare facilities, from insurance services to our managed healthcare facilities, and from rental income. In fiscal 2016, 5.0% of our net operating revenues were derived from such sources. The significant sources of our other revenues are described as follows:

A.

Management, Accounting and Financial Services. We provide management services to skilled nursing facilities, assisted living facilities and independent living facilities operated by third party operators. We typically charge 6% to 7% of the managed centers net operating revenues as a fee for these services. Additionally, we provide accounting and financial services to other healthcare operators. No management services are provided for entities in which we provide accounting and financial services. As of December 31, 2016, we perform management services for eleven healthcare facilities (eight management contracts for third parties and three management contracts where we have an equity method investment) and accounting and financial services for 20 healthcare facilities.

B.

Insurance Services. NHC owns a Tennessee domestic licensed insurance company. The company is licensed in several states and provides workers compensation coverage to substantially all of NHC's operated and managed facilities in addition to other skilled nursing facilities, assisted living and independent living facilities. A second wholly owned insurance subsidiary is licensed in the Cayman Islands and provides general and professional liability coverage in substantially all of NHC s owned and managed centers. This company elects to be taxed as a domestic subsidiary. We also self insure our employees (referred to as "partners") health insurance benefit program at a cost we believe is less than a commercially obtained policy. Finally, we operate a long term care insurance division, which is licensed to sell commercially underwritten long term care policies.

C.

Rental Income. The healthcare properties currently owned and leased to third party operators include nine skilled nursing facilities and four assisted living communities.

Non Operating Income. We generate non operating income from equity in earnings of unconsolidated investments, from dividends and realized gains and losses on marketable securities, interest income, and other miscellaneous non operating income. The significant source of non operating income is described as follows:

Equity in Earnings of Unconsolidated Investments. Earnings from investments in entities in which we lack control but have the ability to exercise significant influence over operating and financial policies are accounted for on the equity method. Our most significant equity method investment is a 75.1% non controlling ownership interest in Caris, a business that specializes in hospice care services in NHC owned health care centers and in other settings. Caris currently has 28 locations serving five states (Georgia, Missouri, South Carolina, Tennessee, and Virginia).

Development and Growth

We are undertaking to expand our post acute and senior health care operations while protecting our existing operations and markets. The following table lists our recent construction and purchase activities.

Type of Operation	Description	Size	Location	Placed in Service
SNF/ALF	Leased	120 beds / 52 units	Independence, MO	March, 2014
SNF	Leased	70 beds	Independence, MO	March, 2014
SNF/ALF	Leased	130 beds / 52 units	St. Peters, MO	March, 2014
ALF	Partnership	83 units	Augusta, GA	June, 2014
Psychiatric Hospital	Partnership	14 beds	Osage Beach, MO	June, 2014
SNF	New Facility	52 beds	Kingsport, TN	December, 2014
SNF/ALF	New Facility	92 beds/60 units	Gallatin, TN	April, 2015
Memory Care	Partnership	60 beds	St. Peters, MO	November, 2015
SNF	Bed Addition	44 beds	Charleston, SC	May, 2016
SNF/ALF	New Facility	90 beds / 80 units	Nashville, TN	June, 2016
SNF	Bed Addition	8 beds	Kingsport, TN	September, 2016
SNF	New Facility	112 beds	Columbia, TN	January, 2017
ALF	New Facility	78 units	Bluffton, SC	Under construction
ALF	New Facility	80 units	Garden City, SC	Under construction
SNF	Bed Addition	30 beds	Springfield, MO	Under construction
Memory Care	Bed Addition	23 units	Murfreesboro, TN	Under construction

For the projects under construction at December 31, 2016, the two assisted living facilities are expected to begin operations in the first quarter of 2017. For the skilled nursing facility bed addition and memory care bed addition, these two projects are expected to begin operations during the third quarter of 2017.

During 2017, we plan to apply for Certificates of Need for additional beds in certain of our markets. We also will evaluate the feasibility of expansion into new markets by building Medicare and private pay health care centers or private pay assisted living communities.

Skilled Nursing Facilities

The skilled nursing facilities operated by our subsidiaries provide in patient skilled and intermediate nursing care services and in patient and out patient rehabilitation services. Skilled nursing care consists of 24 hour nursing service by registered or licensed practical nurses and related medical services prescribed by the patient's physician. Intermediate nursing care consists of similar services on a less intensive basis principally provided by non licensed personnel. These distinctions are generally found in the health care industry although for Medicaid reimbursement purposes, some states in which we operate have additional classifications, while in other states the Medicaid rate is the same regardless of patient classification. Rehabilitative services consist of physical, speech, respiratory, and

occupational therapies, which are designed to aid the patient's recovery and enable the patient to resume normal activities.

Each health care facility has a licensed administrator responsible for supervising daily activities, and larger facilities have assistant administrators. All have medical directors, a director of nurses and full time registered nurse coverage. All centers provide physical therapy and most have other rehabilitative programs, such as occupational or speech therapy. Each facility is located near at least one hospital and is qualified to accept patients discharged from such hospitals. Each facility has a full dining room, kitchen, treatment and examining room, emergency lighting system, and sprinkler system where required. Management believes that all facilities are in compliance with the existing fire and life safety codes.

We provide centralized management and support services to NHC operated healthcare facilities. The management and support services include operational support through the use of regional vice presidents and regional nurses, accounting and financial services, cash management, data processing, legal, consulting and services in the area of rehabilitative care. Our personnel are employed by our administrative services affiliate, National Health Corporation ("National"), which is also responsible for overall services in the area of personnel, loss control, health insurance, education and training. We reimburse the administrative services contractor by paying all the costs of personnel employed for our benefit as well as a fee. National is wholly owned by the National Health Corporation Employee Stock Ownership Plan and provides its services only to us.

We provide management services to centers operated under management contracts and offsite accounting and financial services to other third party owners, all pursuant to separate contracts. The term of each contract and the amount of the management fee or accounting and financial services fee is determined on a case by case basis. Typically, we charge 6% to 7% of net operating revenues of the managed centers for our management contracts and

specific item fees for our accounting and financial service agreements. The initial terms of the contracts range from two years to ten years. In certain contracts, we maintain a right of first refusal should the owner desire to sell a managed center.

Skilled Nursing Facility Occupancy Rates

The following table shows certain information relating to occupancy rates for our owned and leased skilled nursing facilities:

	Year Ended December 31,		
	2016	2015	2014
Overall census	89.5%	90.0%	88.9%

Occupancy rates are calculated by dividing the total number of days of patient care provided by the number of patient days available (which is determined by multiplying the number of licensed beds by 365 or 366).

Customers and Sources of Revenues

No individual customer, or related group of customers, accounts for a significant portion of our revenues. We do not expect the loss of a single customer or group of related customers would have a material adverse effect.

Certain groups of patients receive funds to pay the cost of their care from a common source. The following table sets forth sources of net patient revenues for the periods indicated:

	Year Ended December 31,		
Source	2016	2015	2014
Medicare	37%	40%	39%
Medicaid	26%	25%	26%
Private Pay and Other	25%	24%	24%
Managed Care	12%	11%	11%
Total	100%	100%	100%

The source and amount of the revenues are further dependent upon (i) the licensed bed capacity of our health care facilities, (ii) the occupancy rate of the facilities, (iii) the extent to which the rehabilitative and other skilled ancillary services provided at each facility are utilized by the patients in the centers, (iv) the mix of private pay, Medicare,

Managed Care and Medicaid patients, and (v) the rates paid by our various payor sources.

We attempt to attract an increased percentage of private, managed care and Medicare patients by providing rehabilitative and other post acute care services. These services are designed to speed the patient's recovery and allow the patient to return home as soon as it is practical.

Medicare is a health insurance program for the aged and certain other chronically disabled individuals operated by the federal government. Medicare covers nursing home services for beneficiaries who require nursing care and/or rehabilitation services following a hospitalization of at least three consecutive days. For each eligible day a Medicare beneficiary is in a skilled nursing facility, Medicare pays the facility a daily payment, subject to adjustment for certain factors such as wage index in the particular geographic area. The payment covers all services provided by the skilled nursing facility for the beneficiary that day, including room and board, nursing, therapy and drugs, as well as an estimate of capital related costs to deliver those services.

Medicaid is a medical assistance program for the indigent, operated by individual states with the financial participation of the federal government. The states in which we operate currently use prospective cost based reimbursement systems. Under cost based reimbursement systems, the skilled nursing facility is reimbursed for the reasonable direct and indirect allowable costs it incurred in a base year in providing routine resident care services as defined by the program.

Private pay, managed care, and other payment sources include commercial insurance, individual patient funds, managed care plans and the Veterans Administration. Although payment rates vary among these sources, market forces and costs largely determine these rates. Private paying patients, private insurance carriers and the Veterans Administration generally pay on the basis of the center's charges or specifically negotiated contracts.

We contract with over 60 managed care organizations ("MCO's") and insurance carriers for the provision of subacute and other medical specialty services by our owned and managed facilities.

Regulation and Licenses

Health care is an area of extensive regulatory oversight and frequent regulatory change. The federal government and the states in which we operate regulate various aspects of our business. These regulatory bodies, among other things, require us annually to license our skilled nursing facilities, assisted living facilities in some states and other health care businesses, including home health. In particular, to operate nursing facilities and provide health care services we must comply with federal, state and local laws relating to the delivery and adequacy of medical care, distribution of pharmaceuticals, equipment, personnel, operating policies, fire prevention, rate setting, building codes and environmental protection.

Governmental and other authorities periodically inspect our skilled nursing facilities and home health agencies to assure that we continue to comply with their various standards. We must pass these inspections to continue our licensing under state law, to obtain certification under the Medicare and Medicaid programs, and to continue our participation in the Veterans Administration program. We can only participate in other third party programs if our facilities pass these inspections. In addition, these authorities inspect our record keeping and inventory control.

From time to time, we, like others in the health care industry, may receive notices from federal and state regulatory agencies alleging that we failed to comply with applicable standards. These notices may require us to take corrective action, and may impose civil money penalties and/or other operating restrictions. If our skilled nursing facilities and home health agencies fail to comply with these directives or otherwise fail to comply substantially with licensure and certification laws, rules and regulations, we could lose our certification as a Medicare and Medicaid provider and/or lose our licenses.

Local and state health and social service agencies and other regulatory authorities specific to their location regulate, to varying degrees, our assisted living facilities. Although regulations and licensing requirements vary significantly from state to state, they typically address, among other things, personnel education, training and records; facility services, including administration of medication, assistance with supervision of medication management and limited nursing services; physical plant specifications; furnishing of resident units; food and housekeeping services; emergency evacuation plans; and resident rights and responsibilities. If assisted living facilities fail to comply with licensing requirements, these facilities could lose their licenses. Most states also subject assisted living facilities to state or local building codes, fire codes and food service licensure or certification requirements. In addition, the manner and extent to which the assisted living industry is regulated at federal and state levels are evolving.

Changes in the laws or new interpretations of existing laws as applied to the skilled nursing facilities, the assisted living facilities or other components of our health care businesses, may have a significant impact on our operations.

In all states in which we operate, before a skilled nursing facility can make a capital expenditure exceeding certain specified amounts or construct any new skilled health care beds, approval of the state health care regulatory agency or agencies must be obtained and a Certificate of Need issued. The appropriate state health planning agency must review the Certificate of Need according to state specific guidelines before a Certificate of Need can be issued. A Certificate of Need is generally issued for a specific maximum amount of expenditure and the project must be completed within a specific time period. There is no advance assurance that we will be able to obtain a Certificate of Need in any particular instance. In some states, approval is also necessary in order to purchase existing health care beds, although the purchaser is normally permitted to avoid a full scale Certificate of Need application procedure by giving advance written notice of the acquisition and giving written assurance to the state regulatory agency that the change of ownership will not result in a change in the number of beds, services offered and, in some cases, reimbursement rates at the facility.

While there are currently no significant legislative proposals to eliminate Certificates of Need pertaining to skilled nursing care in the states in which we do business, deregulation in the Certificate of Need area would likely result in increased competition and could adversely affect occupancy rates and the supply of licensed and certified personnel.

Medicare and Medicaid Participation

All health care centers, owned, leased or managed by us are certified to participate in Medicare. Health care centers participating in Medicare are known as SNFs ("Skilled Nursing Facilities"). All but seven of our

affiliated nursing centers participate in Medicaid. All of our homecares (Home health agencies) participate in Medicare, which comprises the majority of their revenue. Homecares also participate in Medicaid.

During the fiscal years, we received payments from Medicare and, if participating, from Medicaid. We record as receivables the amounts we ultimately expect to receive under the Medicare and Medicaid programs and record into profit or loss any differences in amounts actually received at the time of interim or final settlements. Adjustments have not had a material adverse effect within the last three years.

Certifications and Participation Requirements; Efforts to Impose Reduced Payments

Changes in certification and participation requirements of the Medicare and Medicaid programs have restricted, and are likely to continue to restrict further, eligibility for reimbursement under those programs. Failure to obtain and maintain Medicare and Medicaid certification at our nursing centers would result in denial of Medicare and Medicaid payments which would likely result in a significant loss of revenue. In addition, private payors, including managed care payors, increasingly are demanding that providers accept discounted payments resulting in lost revenue for specific patients. Efforts to impose reduced payments, greater discounts and more stringent cost controls by government and other payors are expected to continue. Any reforms that significantly limit rates of reimbursement under the Medicare and Medicaid programs could have a material adverse effect on our profitability and cash flows. We are unable to predict what reform proposals or reimbursement limitations will be adopted in the future or the effect such changes will have on our operations. No assurance can be given that such reforms will not have a material adverse effect on us.

Medicare Legislation and Regulations

Federal Health Care Reform

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("PPACA" or, commonly, ACA) and the Health Care and Education Reconciliation Act of 2010 ("HCERA"), which represents significant changes to the current U.S. health care system (collectively the "Acts"). The primary goals of the Acts are to: (1) expand coverage to Americans without health insurance, (2) reform the delivery system to improve quality and drive efficiency, (3) and to lower the overall costs of providing health care. The timeline of the enacted provisions span over several years some of the provisions were effective immediately in 2010 and others will be phased in through 2020.

Since a significant goal of federal health care reform is to transform the delivery of health care by holding providers accountable for the cost and quality of care provided, Medicare and many commercial third party payors are implementing Accountable Care Organization ("ACO") models in which groups of providers share in the benefit and

risk of providing care to an assigned group of individuals. Other reimbursement methodology reforms in which we are participating or expect to participate in include value based purchasing, in which a portion of provider reimbursement is redistributed based on relative performance on designated economic, clinical quality, and patient satisfaction metrics. Also, CMS is implementing demonstration programs to bundle acute care and post acute care reimbursement to hold providers accountable for costs across a broader continuum of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in public and commercial health plans. In 2015, CMS announced its goal by 2018 to have 50% of Medicare payments through alternative payment models such as ACOs or bundled payments. CMS also intends to tie 85% of fee-for-service Medicare reimbursements to quality or value by the end of 2017. Providers who respond successfully to these trends and are able to deliver quality care at lower costs are likely to benefit financially.

Skilled Nursing Facilities (SNFs)

SNF PPS Medicare is uniform nationwide and reimburses nursing centers under a fixed payment methodology named the Skilled Nursing Facility Prospective Payment System ("SNF PPS"). SNF 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 or decreased each October when the federal fiscal year begins. The acuity classification system is named RUGs (Resource Utilization Groups IV). There are currently 66 classifications of RUG groups.

In July 2016, CMS released its final rule outlining the fiscal year 2017 Medicare payments and policy changes for skilled nursing facilities. The 2017 final rule provided for an approximate 2.4% rate update, which began October 1, 2016. This increase consisted of a 2.7% market basket increase reduced by 0.3% for a multifactor productivity adjustment required by the ACA. CMS estimates the update will increase overall payments to skilled nursing facilities in fiscal year 2017 by $920 million compared to fiscal year 2016 levels. The policy changes in the

2017 final rule continue to shift skilled nursing facility Medicare payments from volume to value. The final rule makes changes to the SNF Quality Reporting Program and Value Based Purchasing Program with some of these changes effective for the fiscal year beginning October 1, 2017.

Homecares (HHAs)

HH PPS Medicare is uniform nationwide and reimburses homecares under a fixed payment methodology named the Home Health Prospective Payment System ("HH PPS"). Generally, Medicare makes payments under the HH PPS on the basis of a national standardized 60 day episode payment, adjusted for case mix and geographical wage index. Payment rates are updated at the beginning of each calendar year. The acuity classification system is named HHRGs (Home Health Resource Groups).

In October 2016 and effective January 1, 2017, CMS released its final rule for 2017 home health prospective payment system rates. CMS estimated the net impact of the PPS rule resulted in a 0.7% decrease ($130 million) in Medicare payments for agencies in 2017. The estimated decrease reflects the effects of a 2.5% home health payment update; rebasing adjustments to the national standardized 60-day episode payment rate, the national per-visit payment rate, and the non-routine medical supplies conversion factor (expected impact of -2.3%), and the effects of an adjustment to the national standardized 60-day episode payment rate to account for nominal case-mix growth (expected impact of -0.9%). However, the freestanding home health agencies are expected to have an overall reduction of 0.8%, and agencies in eight states including the states of South Carolina and Florida are expected to average a reimbursement decrease of 1.9%. NHC estimates the overall effect on its agencies will be a reduction of approximately 1.0%.

In October 2015 and effective January 1, 2016, CMS released its final rule for 2016 home health prospective payment system rates. CMS estimated the net impact of the PPS rule resulted in a 1.5% decrease ($260 million) in Medicare payments for agencies in 2016. The payment decrease reflected the impact of a 1.9% inflation update offset by a 0.97% decrease to account for up coding of claims, a 2.4% decrease required by the third year of the four year phase in of the rebasing adjustments, and a decrease resulting from a change in the conversion factor for non routine medical supplies. The final rule also established a value based purchasing model that began January 1, 2016 for Medicare certified agencies in nine states, including Tennessee and Florida.

Medicaid Legislation and Regulations

Skilled Nursing Facilities (SNF)

State Medicaid plans subject to budget constraints are of particular concern to us. Changes in federal funding coupled with state budget problems and Medicaid expansion under the Affordable Care Act have produced an uncertain environment. States will more likely than not be unable to keep pace with post-acute healthcare inflation. States are

under pressure to pursue other alternatives to skilled nursing care such as community and home based services.

Effective July 1, 2016 and for the fiscal year 2017, the state of Tennessee implemented specific individual nursing facility rate increases. We estimate the resulting increase in revenue beginning July 1, 2016 will be approximately $1,700,000 annually, or $425,000 per quarter.

Effective October 1, 2016 and for the fiscal year 2017, South Carolina implemented specific individual nursing facility rate changes. We estimate the resulting increase in revenue beginning October 1, 2016 will be approximately $1,000,000 annually, or $250,000 per quarter.

Effective July 1, 2016 and for the fiscal year 2017, the state of Missouri approved a Medicaid rate increase of $2.83 per patient day to Missouri skilled nursing providers. We estimate the resulting increase in revenue beginning July 1, 2016 will be approximately $800,000 annually, or $200,000 per quarter.

Competition

In most of the communities in which we operate health care centers, there are other health care centers with which we compete. We own, lease or manage (through subsidiaries) 74 skilled nursing facilities located in nine states. Each of these states is a certificate of need states which generally requires the state to approve the opening of any new skilled nursing facilities. There are hundreds of operators of skilled nursing facilities in each of these states and no single operator, including us, dominates any of these state s skilled nursing care markets, except for some small rural markets which might have only one skilled nursing facility. In competing for patients and staff with these facilities, we depend upon referrals from acute care hospitals, physicians, residential care facilities, church

groups and other community service organizations. The reputation in the community and the physical appearance of our facilities are important in obtaining patients, since members of the patient s family generally participate to a greater extent in selecting skilled nursing facilities than in selecting an acute care hospital. We believe that by providing and emphasizing rehabilitative as well as skilled care services at our facilities, we are able to broaden our patient base and to differentiate our facilities from competing skilled nursing facilities.

As we expand into the assisted living market, we monitor proposed or existing competing assisted living centers. Our development goal is to link our skilled nursing facilities with our assisted living centers, thereby obtaining a competitive advantage for both.

Our homecares compete with other home health agencies (HHA s) in most communities we serve. Competition occurs for patients and employees. Our homecares depend on hospital and physician referrals and reputation in order to maintain a healthy census.

We experience competition in employing and retaining nurses, technicians, aides and other high quality professional and non professional employees. In order to enhance our competitive position, we have an educational tuition loan program, an American Dietetic Association approved internship program, a specially designed nurse's aide training class, and we make financial scholarship aid available to physical therapy vocational programs. We support the Foundation for Geriatric Education. We also conduct an "Administrator in Training" course, 24 months in duration, for the professional training of administrators. Presently, we have nine full time individuals in this program. Two of our four regional senior vice presidents, our three regional administrators, and 52 of our 74 health care center administrators are graduates of this program.

We experience competition in providing management and accounting services to other long term health care providers. Those services are provided primarily to owners with whom we have had previous involvement through ownership or leasing arrangements. Our insurance services are provided primarily to centers for which we also provide management and/or accounting services.

Our employee benefit package offers a tuition reimbursement program. The goal of the program is to insure a well trained qualified work force to meet future demands. While the program is offered to all disciplines, special emphasis has been placed on supporting students in nursing and physical therapy programs. Students are reimbursed at the end of each semester after presenting tuition receipts and grades to management. The program has been successful in providing a means for many bright students to pursue a formal education.

Employees

As of December 31, 2016, our Administrative Services Contractor (National Health Corporation) had approximately 14,450 full and part time employees, who we call "Partners". No employees are represented by a bargaining unit. We believe our current relations with our employees are good.

Investor Information

We are subject to the reporting requirements under the Exchange Act. Consequently, we are required to file reports and information with the Securities and Exchange Commission (SEC), including reports on the following forms: annual report on Form 10 K, quarterly reports on Form 10 Q, current reports on Form 8 K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act. These reports and other information concerning our company may be accessed through the SEC's website at http://www.sec.gov.

You may also find on our website at http://www.nhccare.com electronic copies of our annual report on Form 10 K, quarterly reports on Form 10 Q, current reports on Form 8 K and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act, as well as all 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. All such filings are available free of charge. Information contained in our website is not deemed to be a part of this Annual Report.

We also maintain the following documents on the website:

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The NHC Code of Ethics. This Code 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 Business Conduct that amended, restated, and replaced the prior Code of Ethics.

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Information on our "NHC 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 incognito, if desired.

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The NHC Restated Audit Committee Charter.

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The NHC Compensation Committee Charter Restated 2013.

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The NHC Nominating 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

You should carefully consider the risk factors set forth below, as well as the other information contained in this Annual Report on Form 10 K. These risk factors should be considered in connection with evaluating the forward looking statements contained in this Annual Report on Form 10 K, because these factors could cause the actual results and conditions to differ materially from those projected in forward looking statements. The risks described below are not the only risks facing us. Additional risks and uncertainties that are not currently known to us or that we currently deem to be immaterial may also materially and adversely affect our business operations. Any of the following risks could materially adversely affect our business, financial condition or results of operations and cash flows.

Risks Relating to Our Company

We depend on reimbursement from Medicare, Medicaid and other third party payors and reimbursement rates from such payors may be reduced. We derive a substantial portion of our revenue from third party payors, including the Medicare and Medicaid programs. Third party payor programs are highly regulated and are subject to frequent and substantial changes. Changes in the reimbursement rate or methods of payment from third party payors, including the Medicare and Medicaid programs, or the implementation of other measures to reduce reimbursements for our services has in the past, and could in the future, result in a substantial reduction in our revenues and operating margins. Additionally, net revenue realizable under third party payor agreements can change after examination and retroactive adjustment by payors during the claims settlement processes or as a result of post payment audits. Payors may disallow requests for reimbursement based on determinations that certain costs are not reimbursable or reasonable because additional documentation is necessary or because certain services were not covered or were not reasonable and medically necessary. There also continue to be new legislative and regulatory proposals that could impose further limitations on government and private payments to health care providers. In some cases, states have enacted or are considering enacting measures designed to reduce their Medicaid expenditures and to make changes to private health care insurance. We cannot assure you that adequate reimbursement levels will continue to be available for the services provided by us, which are currently being reimbursed by Medicare, Medicaid or private third party payors. Further limits on the scope of services reimbursed and on reimbursement rates could have a material adverse effect on our liquidity, financial condition and results of operations. It is possible that the effects of further refinements to PPS that result in lower payments to us or cuts in state Medicaid funding could have a material adverse effect on our results of operations. See Item 1, "Business Regulation and Licenses" and "Medicare Legislation and Regulations" and "Medicaid Legislation and Regulations".

The Affordable Care Act and its implementation could impact our business. The Affordable Care Act may continue to alter the existing U.S. health care system for the delivery and financing of health care. A significant goal of Federal health care reform is to transform the delivery of health care by changing reimbursement for health care services to hold providers accountable for the cost and quality of care provided. Medicare and many commercial third party payors are implementing ACO models in which groups of providers share in the benefit and risk of providing care to an assigned group of individuals at lower cost. Other reimbursement methodology reforms include value-based purchasing, in which a portion of provider reimbursement is redistributed based on relative performance on designated economic, clinical quality, and patient satisfaction metrics. In addition, CMS is implementing programs to bundle acute care and post-acute care reimbursement to hold providers accountable for costs across a broader continuum of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in public and commercial health plans. Providers who respond successfully to these trends and are able to deliver quality care at lower cost are likely to benefit financially. The Affordable Care Act and the programs implemented by the law may reduce reimbursements for our services and may impact the demand

for the Company s products. In addition, various healthcare programs and regulations may be ultimately implemented at the federal or state level. Failure to respond successfully to these trends could negatively impact our business, results of operations and/or financial condition.

We cannot predict the effect that further healthcare reform, the possible repeal and replacement of the Affordable Care Act, and other changes in government programs may have on our business, financial condition or results of operations. Since the adoption of the Affordable Care Act in 2010, the law has been challenged before the U.S. Supreme Court, and several bills have been and continue to be introduced in Congress to delay, defund or repeal implementation of or amend significant provisions of the Affordable Care Act. In addition, there continues to be ongoing litigation over the interpretation and implementation of certain provisions of the law. Furthermore, on January 20, 2017, newly-inaugurated President Trump issued an executive order that, among other things, stated that it was the intent of his administration to repeal the Affordable Care Act and, pending that repeal, instructed the executive branch of the federal government to defer or delay the implementation of any provision or requirement of the Affordable Care Act that would impose a fiscal burden on any state or a cost, fee, tax or penalty on any individual, family, health care provider, or health insurer.

We cannot predict whether the Affordable Care Act will be repealed, replaced, or modified or the impact that the President s executive order will have on the implementation and enforcement of the provisions of the Affordable Care Act. In addition, if the Affordable Care Act is replaced or modified, we cannot predict what the replacement plan or modifications would be, when the replacement plan or modifications would become effective, or whether any of the existing provisions of the Affordable Care Act would remain in place.

The net effect of the Affordable Care Act on our business is subject to numerous variables, including the law s complexity, lack of complete implementing regulations and interpretive guidance, and the gradual implementation of the numerous programs designed to improve access and quality. As a result, we are unable to predict the effect on our business, financial condition or results of operations, the reductions in government healthcare reimbursement spending, and numerous other provisions potentially impacted by the possible repeal, replacement or modification of the Affordable Care Act.

We conduct business in a heavily regulated industry, and changes in, or violations of regulations may result in increased costs or sanctions that reduce our revenue and profitability. In the ordinary course of our business, we are regularly subject to inquiries, investigations and audits by federal and state agencies to determine whether we are in compliance with regulations governing the operation of, and reimbursement for, skilled nursing, assisted living and independent living facilities, hospice, home health agencies and our other operating areas. These regulations include those relating to licensure, conduct of operations, ownership of facilities, construction of new and additions to existing facilities, allowable costs, services and prices for services. In particular, various laws, including federal and state anti kickback and anti fraud statutes, prohibit certain business practices and relationships that might affect the provision and cost of health care services reimbursable under federal and/or state health care programs such as Medicare and Medicaid, including the payment or receipt of remuneration for the referral of patients whose care will be paid by federal governmental programs. Sanctions for violating the anti kickback and anti fraud statutes include criminal penalties and civil sanctions, including fines and possible exclusion from governmental programs such as Medicare and Medicaid.

In addition, the Stark Law broadly defines the scope of prohibited physician referrals under federal health care programs to providers with which they have ownership or other financial arrangements. Many states have adopted, or are considering, legislative proposals similar to these laws, some of which extend beyond federal health care programs, to prohibit the payment or receipt of remuneration for the referral of patients and physician referrals regardless of the source of the payment for the care. These laws and regulations are complex and limited judicial or regulatory interpretation exists. We cannot assure you that governmental officials charged with responsibility for enforcing the provisions of these laws and regulations will not assert that one or more of our arrangements are in violation of the provisions of such laws and regulations.

The regulatory environment surrounding the post acute and long term care industry has intensified, particularly for larger for profit, multi facility providers like us. The federal government has imposed extensive enforcement policies resulting in a significant increase in the number of inspections, citations of regulatory deficiencies and other regulatory sanctions, including terminations from the Medicare and Medicaid programs, denials of payment for new Medicare and Medicaid admissions and civil monetary penalties. If we fail to comply, or are perceived as failing to comply, with the extensive laws and regulations applicable to our business, we could become ineligible to receive government program reimbursement, be required to refund amounts received from Medicare, Medicaid or private payors, suffer civil or criminal penalties, suffer damage to our reputation in various markets or be required to make significant changes to our operations. We are also subject to federal and state laws that govern financial and other arrangements between health care providers. These laws often prohibit certain direct

and indirect payments or fee splitting arrangements between health care providers that are designed to induce the referral of patients to a particular provider for medical products and services. Possible sanctions for violation of any of these restrictions or prohibitions include loss of eligibility to participate in reimbursement programs and/or civil and criminal penalties. Furthermore, some states restrict certain business relationships between physicians and other providers of health care services. Many states prohibit business corporations from providing, or holding themselves out as a provider of, medical care. From time to time, we may seek guidance as to the interpretation of these laws; however, there can be no assurance that such laws will ultimately be interpreted in a manner consistent with our practices. In addition, we could be forced to expend considerable resources responding to an investigation or other enforcement action under these laws or regulations. Furthermore, should we lose licenses or certifications for a number of our facilities as a result of regulatory action or otherwise, we could be deemed in default under some of our agreements, including agreements governing outstanding indebtedness. We also are subject to potential lawsuits under a federal whistle blower statute designed to combat fraud and abuse in the health care industry, known as the federal False Claims Act. These lawsuits can involve significant monetary awards to private plaintiffs who successfully bring these suits. When a private party brings a qui tam action under the False Claims Act, it files the complaint with the court under seal, and the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation. Even if, in the course of an investigation, the court partially unseals a complaint to allow the government and a defendant to work toward a resolution of the complaint's allegations, the defendant is prohibited from revealing to anyone the existence of the compliant or that the partial unsealing has occurred.

We have established policies and procedures that we believe are sufficient to ensure that our facilities will operate in substantial compliance with these anti fraud and abuse requirements. While we believe that our business practices are consistent with Medicare and Medicaid criteria, those criteria are often vague and subject to change and interpretation. Aggressive anti fraud actions, however, have had and could have an adverse effect on our financial position, results of operations and cash flows. See Item 1, "Business Regulation and Licenses".

We are unable to predict the future course of federal, state and local regulation or legislation, including Medicare and Medicaid statutes and regulations, or the intensity of federal and state enforcement actions. Our failure to obtain or renew required regulatory approvals or licenses or to comply with applicable regulatory requirements, the suspension or revocation of our licenses or our disqualification from participation in certain federal and state reimbursement programs, or the imposition of other harsh enforcement sanctions could have a material adverse effect upon our operations and financial condition.

We are required to comply with laws governing the transmission and privacy of health information. The Health Insurance Portability and Accountability Act of 1996, or HIPAA, requires us to comply with standards for the exchange of health information within our Company and with third parties, such as payors, business associates and patients. These include standards for common health care transactions, such as claims information, plan eligibility, payment information and the use of electronic signatures, unique identifiers for providers, employers, health plans and individuals, and security, privacy and enforcement. If we are found to be in violation of the privacy or security rules under HIPAA or other federal or state laws protecting the confidentiality of patient health information, we could be subject to criminal penalties and civil sanctions, which could increase our liabilities, harm our reputation and have a material adverse effect on our business, financial position, results of operations and liquidity.

We are defendants in significant legal actions, which are commonplace in our industry, and which could subject us to increased operating costs and substantial uninsured liabilities, which would materially and adversely affect our liquidity and financial condition. As is typical in the health care industry, we are subject to claims that our services have resulted in resident injury or other adverse effects. We, like our industry peers, have experienced an increasing trend in the frequency and severity of professional liability and workers compensation claims and litigation asserted against us. In some states in which we have significant operations, insurance coverage for the risk of punitive damages arising from professional liability claims and/or litigation may not, in certain cases, be available due to state law prohibitions or limitations of availability. We cannot assure you that we will not be liable for punitive damage awards that are either not covered or are in excess of our insurance policy limits. We also believe that there have been, and will continue to be, governmental investigations of long term care providers, particularly in the area of Medicare/Medicaid false claims, as well as an increase in enforcement actions resulting from these investigations. Insurance is not available to cover such losses. Any adverse determination in a legal proceeding or governmental investigation, whether currently asserted or arising in the future, could have a material adverse effect on our financial condition.

Due to the rising cost and limited availability of professional liability and workers compensation insurance, we are largely self insured on all of these programs and as a result, there is no limit on the maximum number of claims or amount for which we or our insurance subsidiaries can be liable in any policy period. Although

we base our loss estimates on independent actuarial analyses using the information we have to date, the amount of the losses could exceed our estimates. In the event our actual liability exceeds our estimates for any given period, our results of operations and financial condition could be materially adversely impacted. In addition, our insurance coverage might not cover all claims made against us. If we are unable to maintain our current insurance coverage, if judgments are obtained in excess of the coverage we maintain, if we are required to pay uninsured punitive damages, or if the number of claims settled within the self insured retention currently in place significantly increases, we could be exposed to substantial additional liabilities. We cannot assure you that the claims we pay under our self insurance programs will not exceed the reserves we have set aside to pay claims. The number of claims within the self insured retention may increase.

Failure to maintain effective internal controls in accordance with Section 404 of the Sarbanes Oxley Act could result in a restatement of our financial statements, cause investors to lose confidence in our financial statements and our company and have a material adverse effect on our business and stock price. We produce our consolidated financial statements in accordance with the requirements of U.S. GAAP. Effective internal controls are necessary for us to provide reliable financial reports to help mitigate the risk of fraud and to operate successfully as a publicly traded company. As a public company, we are required to document and test our internal control procedures in order to satisfy the requirements of Section 404 of the Sarbanes Oxley Act of 2002, or Section 404, which requires annual management assessments of the effectiveness of our internal controls over financial reporting.

Testing and maintaining internal controls can divert our management's attention from other matters that are important to our business. We may not be able to conclude on an ongoing basis that we have effective internal controls over financial reporting in accordance with Section 404 or our independent registered public accounting firm may not be able to issue an unqualified report if we conclude that our internal controls over financial reporting are not effective. If either we are unable to conclude that we have effective internal controls over financial reporting or our independent registered public accounting firm is unable to provide us with an unqualified report as required by Section 404, investors could lose confidence in our reported financial information and our company, which could result in a decline in the market price of our common stock, and cause us to fail to meet our reporting obligations in the future, which in turn could impact our ability to raise additional financing if needed in the future.

Increasing costs of being publicly owned are likely to impact our future consolidated financial position and results of operations. In connection with the Sarbanes Oxley Act of 2002, we are subject to rules requiring our management to report on the effectiveness of our internal control over financial reporting. If we fail to have effective internal controls and procedures for financial reporting in place, we could be unable to provide timely and reliable financial information which could, in turn, have an adverse effect on our business, results of operations, financial condition and cash flows.

Significant regulatory changes, including the Sarbanes Oxley Act and rules and regulations promulgated as a result of the Sarbanes Oxley Act, have increased, and in the future are likely to further increase, general and administrative costs. In order to comply with the Sarbanes Oxley Act of 2002, the listing standards of the NYSE MKT exchange, and rules implemented by the Securities and Exchange Commission (SEC), we have had to hire additional personnel and utilize additional outside legal, accounting and advisory services, and may continue to require such additional resources. Moreover, in the rapidly changing regula