

NATIONAL HEALTHCARE CORP
Form 10-K
February 19, 2016

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2015

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
(State of Incorporation)

52-2057472
(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
Shares of Common Stock

Name of Each Exchange on which Registered
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

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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

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 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 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
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

The aggregate market value of Common Stock held by non-affiliates on June 30, 2015 (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 16, 2016 was 15,005,616.

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 2016 shareholder's meeting.

TABLE OF CONTENTS

PART 1

ITEM 1.

Business

3

ITEM 1A.

Risk Factors

12

ITEM 1B.

Unresolved Staff Comments

21

ITEM 2.

Properties

22

ITEM 3.

Legal Proceedings

27

ITEM 4.

Mine Safety Disclosures

28

PART II

ITEM 5.

Market for Registrant's Common Equity, Related Stockholder Matters, and
Issuer Purchases of Equity Securities

28

ITEM 6.

Selected Financial Data

31

ITEM 7.

Management's Discussion and Analysis of Financial Condition and
Results of Operations

31

ITEM 7A.

Quantitative and Qualitative Disclosure About Market Risk

43

ITEM 8.

Financial Statements and Supplementary Data

45

ITEM 9.

Changes in and Disagreements with Accountants on Accounting and
Financial Disclosure

83

ITEM 9A.

Controls and Procedures

83

ITEM 9B.

Other Information

86

PART III

ITEM 10.

Directors, Executive Officers and Corporate Governance

86

ITEM 11.

Executive Compensation

86

ITEM 12.

Security Ownership of Certain Beneficial Owners and Management and
Related Stockholder Matters

86

ITEM 13.

Certain Relationships and Related Transactions and Director Independence

86

ITEM 14.

Principal Accountant Fees and Services

86

PART IV

ITEM 15.

Exhibits and Financial Statement Schedule

87

Signatures

88

Exhibit Index

89

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 with associated assisted living and independent living facilities. Our business activities include providing sub-acute and post-acute skilled nursing care, intermediate nursing care, rehabilitative 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, and insurance services to third party operators of health care facilities. We also own the real estate of thirteen 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, 2015, we operate or manage 74 skilled nursing facilities with a total of 9,403 licensed beds. These numbers include 67 centers with 8,520 beds that we lease or own and seven centers with 883 beds that we manage for others. Of the 67 leased or owned facilities, 39 of the facilities are leased and 28 of the facilities are owned. Of the 39 leased facilities, 35 are leased from National Health Investors, Inc. ("NHI").

Our 20 assisted living facilities (nine leased, eight owned, and three managed) have 935 units (828 units leased or owned and 107 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 operate 36 homecare programs licensed in four states (Tennessee, South Carolina, Missouri and Florida) and provided 455,551 homecare patient visits to 19,711 patients in 2015.

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 1,100 patients per day in 26 locations in Missouri, South Carolina, Tennessee, and Virginia.

We operate specialized care units within certain of our healthcare centers such as Alzheimer's disease care units, sub-acute nursing units and a number of in-house pharmacies. 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 2015, 95.4% of our net operating revenues were derived from such health care services. Highlights of health care services activities during 2015 were as follows:

A.

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, 2015. We manage seven facilities for third party owners. Revenues from the 67 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 seven 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 90.0% during the year ended December 31, 2015.

B.

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 1,600 highly trained, professional therapists in 2015. The majority of our rehabilitative services are for patients in our owned and managed skilled nursing facilities. However, we also provide services to over 75 additional health care providers. Our rates for these services are competitive with other market rates.

C.

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.

D.

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 17 and manage three assisted living facilities. Of these 20 centers, thirteen are located within the physical structure of a skilled nursing facility or retirement center and seven are freestanding. In 2015, the rate of occupancy was 90.6%. Certificates of Need are not required to build these projects and we believe that overbuilding has occurred in some of our markets.

E.

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.

F.

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 21,736 in 2014 and 21,623 in 2015. We served 19,222 patients in 2014 and 19,711 patients in 2015. Visits provided were 477,323 in 2014 and 455,551 in 2015.

G.

Pharmacy Operations. At December 31, 2015, we operated four regional pharmacy operations (one each in east Tennessee, central Tennessee, South Carolina, and Missouri). These pharmacy operations 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 56 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 2015, 4.6% 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 skilled nursing facilities or related types of entities for small operators. No management services are provided for entities in which we provide accounting and financial services. As of December 31, 2015, we perform management services for 11 healthcare facilities 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 Healthcare, L.P. ("Caris"), a business that specializes in hospice care services in NHC owned health care centers and in other settings. Caris currently has twenty-six locations serving four states (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	Acquisition	106 beds	Columbia, TN	September, 2013
SNF	Acquisition	92 beds	Columbia, TN	September, 2013
SNF	Acquisition	139 beds	Knoxville, TN	September, 2013
SNF	Acquisition	107 beds	Springfield, TN	September, 2013
SNF	Acquisition	94 beds	Madisonville, KY	September, 2013
SNF	Acquisition	112 beds	Rossville, GA	September, 2013
SNF	Leased	120 beds	Greenfield, MA	September, 2013
SNF	Leased	102 beds	Holyoke, MA	September, 2013
SNF	Leased	71 beds	Quincy, MA	September, 2013
SNF	Leased	100 beds	Taunton, MA	September, 2013
SNF	Leased	108 beds	Epsom, NH	September, 2013
SNF	Leased	114 beds	Manchester, NH	September, 2013
SNF	Leased	126 beds	Manchester, NH	September, 2013
SNF	New Facility	90 beds	Tullahoma, TN	October, 2013
SNF	Addition	50 beds	Lexington, SC	December, 2013
SNF/AL	Leased	120 beds / 52 units	Independence, MO	March, 2014
SNF	Leased	70 beds	Independence, MO	March, 2014
SNF/AL	Leased	130 beds / 52 units	St. Peters, MO	March, 2014
AL	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/AL	New Facility	92 beds/60 Units	Gallatin, TN	April, 2015
Memory Care	Partnership	60 beds	St. Peters, MO	November, 2015
SNF/AL	New Facility	90 beds / 80 Units	Nashville, TN	Under construction
AL	New Facility	76 Units	Bluffton, SC	Under construction
AL	New Facility	80 Units	Garden City, SC	Under construction
SNF	New Facility	112 beds	Columbia, TN	Under construction

For the projects under construction at December 31, 2015, the 90-bed skilled nursing facility and 80-unit assisted living facility located in Nashville, Tennessee is expected to begin operations in the third quarter of 2016; the 76-unit

assisted living facility in Bluffton, SC is expected to begin operations in the third quarter of 2016; the 80-unit assisted living facility in Garden City, SC is expected to begin operations in the fourth quarter of 2016; and the 112 bed replacement center that will combine the 92 beds of NHC Hillview in Columbia, Tennessee with 20 beds from the existing skilled nursing unit at Maury Regional Medical Center is expected to begin operations in the fourth quarter of 2016.

During 2016, 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 private pay health care centers or 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, 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,		
	2015	2014	2013
Overall census	90.0%	88.9%	89.2%

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:

Source	Year Ended December 31,		
	2015	2014	2013
Medicare	40%	39%	40%
Medicaid	25%	26%	25%
Private Pay and Other	24%	24%	25%
Managed Care	11%	11%	10%
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. Managed care patient days were 259,471 in 2015; 242,621 in 2014; 181,152 in 2013.

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 over 80% 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, in which we are participating in a limited way, 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 January 2015, CMS announced its goal by 2016 to have 30% of Medicare payments through alternative payment models such as ACOs or bundled payments and up to 50% by the end of 2018. 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 2015, CMS released its final rule outlining the fiscal year 2016 Medicare payments for skilled nursing facilities, which began October 1, 2015. The 2016 final rule provides for an approximate 1.2% rate update. This estimated increase consists of a 2.3% market basket increase, reduced by a 0.6% forecast error adjustment and further reduced 0.5% for a multifactor productivity adjustment required by the ACA. CMS estimates the update will increase overall payments to skilled nursing facilities in fiscal year 2016 by \$430 million compared to fiscal year 2015 levels. The effect of the 2016 PPS rate update on our revenues will be dependent upon our census and the mix of our patients at the various PPS pay rates.

In August 2014, CMS released its skilled nursing facility PPS update for the fiscal year 2015, which began October 1, 2014. The final rule provided for a 2.0% rate update, which reflected a 2.5% market basket increase less a 0.5% multifactor productivity adjustment as required by the ACA. CMS estimated the update would increase overall payments to skilled nursing facilities in fiscal year 2015 by \$750 million compared to fiscal year 2014 levels. The 2015 final rule also included wage index updates, revisions to the change of therapy (COT) other Medicare required assessment (OMRA) policy, and comments pertaining to CMS observations on therapy utilization trends.

In July 2013, CMS released its skilled nursing facility PPS update for the fiscal year 2014, which began October 1, 2013. The notice provided for a 1.3% rate update, which reflected a 2.3% market basket increase less a 0.5% multifactor productivity adjustment and a 0.5% adjustment to correct market basket forecasting errors in fiscal year 2012. CMS estimated the update increased overall payments to skilled nursing facilities in fiscal year 2014 by \$470 million compared to fiscal year 2013 levels.

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 2015 and effective January 1, 2016, CMS released its final rule for 2016 home health prospective payment system rates. CMS estimates that the net impact of the PPS rule will result in a 1.5% decrease (\$260 million) in Medicare payments for agencies in 2016. The payment decrease reflects the impact of a 1.9% inflation update offset by a .97% decrease to account for upcoding 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 establishes a value-based purchasing model set to begin January 1, 2016 for Medicare-certified agencies in nine states, including Tennessee and Florida.

In October 2014 and effective January 1, 2015, CMS released its final rule for the 2015 home health prospective payment system. The final rule reduced home health payments overall by 0.3 percent from 2014 payment levels. The payment decrease reflected the impact of the 2.1% home health payment update (\$390 million increase) and the second year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies conversion factor (2.4% or \$450 million decrease). The final rule also made adjustments to the new home health face-to-face requirements and updated the Home Health Quality Reporting Program.

In November 2013 and effective January 1, 2014, CMS issued the final rule for 2014 home health prospective payment system rates, which included (i) a market basket increase of 2.3 percent, (ii) rebasing of Medicare

reimbursement rates, with annual reductions of 3.5 percent for each of the next four years beginning January 2014, (iii) changes in the Wage Index with no overall impact and (iv) rebasing all case mix weights to 1.0 from an average case mix weight of 1.3464 in 2013, as provided for under the Affordable Care Act. The rule also provided for changes in low utilization payments amounts and the removal of 170 diagnosis codes, among other changes.

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 nursing center inflation. States are under pressure to pursue other alternatives to long term care such as community and home-based services.

Effective July 1, 2014 and for the fiscal year 2015, the state of Tennessee implemented individual skilled nursing facility rate changes. With new state legislation being passed for the 2015 fiscal year, there are four components that impact Tennessee Medicaid reimbursement for skilled nursing facilities: a Level I or Level II per diem, a quarterly acuity payment, a quarterly Quality Improvement in Long-Term Services and Supports ("QuILTSS") payment (which are incentives based on qualifying criteria in several categories), and an assessment fee (expense). Effective July 1, 2014, each facility will now be charged an assessment fee based on 4.5% of net patient revenues. The assessment fee is replacing the former bed tax fee. In summary and for the 2015 fiscal year,

the Tennessee Medicaid reimbursement changes increased income before income taxes by approximately \$3,000,000 annually, or \$750,000 per quarter.

Effective July 1, 2015 and for the fiscal year 2016, the state of Tennessee implemented specific individual nursing facility rate increases. We estimate the resulting increase in revenue beginning July 1, 2015 will be approximately \$4,000,000 annually, or \$1,000,000 per quarter.

Effective October 1, 2014 and for the fiscal year 2015, South Carolina implemented specific individual nursing facility rate increases. The resulting increase in revenue beginning October 1, 2014 was approximately \$1,800,000 annually, or \$450,000.

Effective October 1, 2015 and for the fiscal year 2016, South Carolina implemented specific individual nursing facility rate changes. We estimate the resulting rate changes for the 2016 fiscal year will have an immaterial impact on revenues.

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 (HHAs) 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. Four of our six regional vice presidents, our regional administrator, and 49 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, 2015, our Administrative Services Contractor (National Health Corporation) had approximately 13,225 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.

The NHC Compensation Committee Charter Restated 2013.

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".

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 complaint 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 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 regulatory environment in which we operate, there is significant uncertainty as to what will be required to comply with many of the regulations. As a result, we may be required to spend substantially more than we currently estimate, and may need to divert resources from other activities, as we develop our compliance plans.

New accounting pronouncements or new interpretations of existing standards could require us to make adjustments in our accounting policies that could affect our financial statements. The Financial Accounting Standards Board, the SEC, or other accounting organizations or governmental entities issue new pronouncements or new interpretations of existing accounting standards that sometimes require us to change our accounting policies and procedures. Future pronouncements or interpretations could require us to change our policies or procedures and have a significant impact on our future financial statements.

By undertaking to provide management services, advisory services, and/or financial services to other entities, we become at least partially responsible for meeting the regulatory requirements of those entities. We provide management and/or financial services to skilled nursing facilities, assisting living facilities and independent living facilities owned by third parties. At December 31, 2015, we perform management services (which include financial

services) for 11 such centers and accounting and financial services for an additional 20 such centers. The "Risk Factors" contained herein as applying to us may in many instances apply equally to these other entities for which we provide services. We have in the past and may in the future be subject to claims from the entities to which we provide management, advisory or financial services, or to the claims of third parties to those entities. Any adverse determination in any legal proceeding regarding such claims could have a material adverse effect on our business, our results of operation, our financial condition and cash flows.

We provide management services to skilled nursing facilities and other healthcare facilities under terms whereby the payments for our services are subject to subordination to other expenditures of the healthcare facility.

Furthermore, there are certain third parties with whom we have contracted to provide services and which we have determined, based on insufficient historical collections and the lack of expected future collections, that the service revenue realization is uncertain. We may, therefore, make expenditures related to the provision of services for which we are not paid.

The cost to replace or retain qualified nurses, health care professionals and other key personnel may adversely affect our financial performance, and we may not be able to comply with certain states' staffing requirements.

We could experience significant increases in our operating costs due to shortages in qualified nurses, health care professionals and other key personnel. The market for these key personnel is highly competitive. We, like other health care providers, have experienced difficulties in attracting and retaining qualified personnel, especially facility administrators, nurses, certified nurses' aides and other important health care providers. There is currently a shortage of nurses, and trends indicate this shortage will continue or worsen in the future. The difficulty

our skilled nursing facilities are experiencing in hiring and retaining qualified personnel has increased our average wage rate. We may continue to experience increases in our labor costs due to higher wages and greater benefits required to attract and retain qualified health care personnel. Our ability to control labor costs will significantly affect our future operating results.

Certain states in which we operate skilled nursing facilities have adopted minimum staffing standards and additional states may also establish similar requirements in the future. Our ability to satisfy these requirements will depend upon our ability to attract and retain qualified nurses, certified nurses' assistants and other staff. Failure to comply with these requirements may result in the imposition of fines or other sanctions. If states do not appropriate sufficient additional funds (through Medicaid program appropriations or otherwise) to pay for any additional operating costs resulting from minimum staffing requirements, our profitability may be adversely affected.

Although we currently have no collective bargaining agreements with unions at our facilities, there is no assurance this will continue to be the case. If any of our facilities enter into collective bargaining agreements with unions, we could experience or incur additional administrative expenses associated with union representation of our employees.

Our senior management team has extensive experience in the healthcare industry. We believe they have been instrumental in guiding our business, instituting valuable performance and quality monitoring, and driving innovation. Accordingly, our future performance is substantially dependent upon the continued services of our senior management team. The loss of the services of any of these persons could have a material adverse effect upon us.

Future acquisitions may be difficult to complete, use significant resources, or be unsuccessful and could expose us to unforeseen liabilities. We may selectively pursue acquisitions or new developments in our target markets. Acquisitions and new developments may involve significant cash expenditures, debt incurrence, capital expenditures, additional operating losses, amortization of the intangible assets of acquired companies, dilutive issuances of equity securities and other expenses that could have a material adverse effect on our financial condition and results of operations. Acquisitions also involve numerous other risks, including difficulties integrating acquired operations, personnel and information systems, diversion of management's time from existing operations, potential losses of key employees or customers of acquired companies, assumptions of significant liabilities, exposure to unforeseen liabilities of acquired companies and increases in our indebtedness.

We cannot assure that we will succeed in obtaining financing for any acquisitions at a reasonable cost or that any financing will not contain restrictive covenants that limit our operating flexibility. We also may be unable to operate acquired facilities profitably or succeed in achieving improvements in their financial performance.

We also may face competition in acquiring any facilities. Our competitors may acquire or seek to acquire many of the facilities that would be suitable acquisition candidates for us. This could limit our ability to grow by acquisitions or increase the cost of our acquisitions.

Upkeep of healthcare properties is capital intensive, requiring us to continually direct financial resources to the maintenance and enhancement of our physical plant and equipment. As of December 31, 2015, we leased or owned 67 skilled nursing facilities, 20 assisted living facilities, and five independent living facilities. Our ability to maintain and enhance our physical plant and equipment in a suitable condition to meet regulatory standards, operate efficiently and remain competitive in our markets requires us to commit a substantial portion of our free cash flow to continued investment in our physical plant and equipment. Certain of our competitors may operate centers that are not as old as our centers, or may appear more modernized than our centers, and therefore may be more attractive to prospective customers. In addition, the cost to replace our existing centers through acquisition or construction is substantially higher than the carrying value of our centers. We are undertaking a process to allocate more aggressively capital spending within our owned and leased facilities in an effort to address issues that arise in connection with an aging physical plant.

If factors, including factors indicated in these "Risk Factors" and other factors beyond our control render us unable to direct the necessary financial and human resources to the maintenance, upgrade and modernization of our physical plant and equipment, our business, results of operations, financial condition and cash flow could be adversely impacted.

Our business is subject to a variety of federal, state and local environmental laws and regulations. As a healthcare provider, we face regulatory requirements in areas of air and water quality control, medical and low-level radioactive waste management and disposal, asbestos management, response to mold and lead-based paint in our facilities and employee safety.

As an operator of healthcare facilities, we also may be required to investigate and remediate hazardous substances that are located on and/or under the property, including any such substances that may have migrated off, or may have been discharged or transported from the property. Part of our operations involves the handling, use, storage, transportation, disposal and discharge of medical, biological, infectious, toxic, flammable and other hazardous materials, wastes, pollutants or contaminants. In addition, we are sometimes unable to determine with certainty whether prior uses of our facilities and properties or surrounding properties may have produced continuing environmental contamination or noncompliance, particularly where the timing or cost of making such determinations is not deemed cost-effective. These activities, as well as the possible presence of such materials in, on and under our properties, may result in damage to individuals, property or the environment; may interrupt operations or increase costs; may result in legal liability, damages, injunctions or fines; may result in investigations, administrative proceedings, penalties or other governmental agency actions; and may not be covered by insurance.

We believe that we are in material compliance with applicable environmental and occupational health and safety requirements. However, we cannot assure you that we will not encounter environmental liabilities in the future, and such liabilities may result in material adverse consequences to our operations or financial condition.

Provision for losses in our financial statements may not be adequate. Loss provisions in our financial statements for self-insured programs are made on an undiscounted basis in the relevant period. These provisions are based on internal and external evaluations of the merits of individual claims, analysis of claims history and independent actuarially determined estimates. Our management reviews the methods of determining these estimates and establishing the resulting accrued liabilities frequently, with any material adjustments resulting therefrom being reflected in current earnings. Although we believe that our provisions for self-insured losses in our financial statements are adequate, the ultimate liability may be in excess of the amounts recorded. In the event the provisions for loss reflected in our financial statements are inadequate, our financial condition and results of operations may be materially affected.

Implementation of new information technology could cause business interruptions and negatively affect our profitability and cash flows. We continue to refine and implement our information technology to improve customer service, enhance operating efficiencies and provide more effective management of business operations. Implementation of information technology carries risks such as cost overruns, project delays and business interruptions and delays. If we experience a material business interruption as a result of the implementation of our existing or future information technology infrastructure or are unable to obtain the projected benefits of this new infrastructure, it could adversely affect us and could have a material adverse effect on our business, results of operations, financial condition and cash flows.

We depend on the proper function and availability of our information systems. We are dependent on the proper function and availability of our information systems. Though we have taken steps to protect the safety and security of our information systems and the data maintained within those systems, there can be no assurance that our safety and security measures and disaster recovery plan will prevent damage or interruption of our systems and operations and we may be vulnerable to losses associated with the improper functioning, security breach or unavailability of our information systems. Failure to maintain proper function and availability of our information systems could have a

material adverse effect on our business, financial position, results of operations and liquidity.

In addition, certain software supporting our business and information systems are licensed to us by independent software developers. Our inability or the inability of these developers, to continue to maintain and upgrade our information systems and software could disrupt or reduce the efficiency of our operations. In addition, costs and potential problems and interruptions associated with the implementation of new or upgraded systems and technology or with maintenance or adequate support of existing systems also could disrupt or reduce the efficiency of our operations and could have a material adverse effect on our business, financial position, results of operations and liquidity.

Cybersecurity risks could harm our ability to operate effectively. Cybersecurity refers to the combination of technologies, processes and procedures established to protect information technology systems and data from unauthorized access, attack, or damage. We rely on our information systems to provide security for processing, transmission and storage of confidential patient, resident and other customer information, such as individually identifiable information, including information relating to health protected by HIPAA. Although we have taken steps to protect the security of our information systems and the data maintained in those systems, it is possible that our safety and security measures will not prevent the systems' improper functioning or damage or the improper access or disclosure of personally identifiable information such as in the event of cyber-attacks. Security breaches, including physical or electronic break-ins, computer viruses, attacks by hackers and similar breaches can create system disruptions or shutdowns or the unauthorized disclosure of confidential information. If personal or otherwise

protected information of our patients is improperly accessed, tampered with or distributed, we may incur significant costs to remediate possible injury to the affected patients and we may be subject to sanctions and civil or criminal penalties if we are found to be in violation of the privacy or security rules under HIPAA or other similar federal or state laws protecting confidential patient health information. Any failure to maintain proper functionality and security of our information systems could interrupt our operations, damage our reputation, subject us to liability claims or regulatory penalties and could have a material adverse effect on our business, financial condition and results of operations.

If we fail to compete effectively with other health care providers, our revenues and profitability may decline. The health care services industry is highly competitive. Our skilled nursing facilities, assisted living centers, independent living facilities, home care services and other operations compete on a local and regional basis with other nursing centers, health care providers, and senior living service providers. Some of our competitors' facilities are located in newer buildings and may offer services not provided by us or are operated by entities having greater financial and other resources than us. Our skilled nursing facilities face competition from skilled nursing, assisted living, independent living facilities, homecare services, and other operations that provide services comparable to those offered by our skilled nursing facilities. Many competing general acute care hospitals are larger and more established than our facilities.

The health care industry is divided into a variety of competitive areas that market similar services. These competitors include skilled nursing, assisted living, independent living facilities, homecare services, hospice providers and other operations. Our facilities generally operate in communities that also are served by similar facilities operated by our competitors. Certain of our competitors are operated by not-for-profit, non-taxpaying or governmental agencies that can finance capital expenditures on a tax exempt basis and that receive funds and charitable contributions unavailable to us. Our facilities compete based on factors such as our reputation for quality care; the commitment and expertise of our staff; the quality and comprehensiveness of our treatment programs; the physical appearance, location and condition of our facilities and to a limited extent, the charges for services. In addition, we compete with other health care providers for customer referrals from hospitals. As a result, a failure to compete effectively with respect to referrals may have an adverse impact on our business. Many of these competing companies have greater financial and other resources than we have. We cannot assure that increased competition in the future will not adversely affect our financial condition and results of operations.

Possible changes in the case mix of patients as well as payor mix and payment methodologies may significantly affect our profitability. The sources and amounts of our patient revenues will be determined by a number of factors, including licensed bed capacity and occupancy rates of our facilities, the mix of patients and the rates of reimbursement among payors. Likewise, reimbursement for therapy services will vary based upon payor and payment methodologies. Changes in the case mix of the patients as well as payor mix among private pay, Medicare and Medicaid will significantly affect our profitability. Particularly, any significant increase in our Medicaid population could have a material adverse effect on our financial position, results of operations and cash flow, especially if states operating these programs continue to limit, or more aggressively seek limits on, reimbursement rates.

Private third-party payors continue to try to reduce health care costs. Private third-party payors are continuing their efforts to control health care costs through direct contracts with health care providers, increased utilization review and greater enrollment in managed care programs and preferred provider organizations. These private payors increasingly

are demanding discounted fee structures and the assumption by health care providers of all or a portion of the financial risk. We could be adversely affected by the continuing efforts of private third-party payors to limit the amount of reimbursement we receive for health care services. We cannot assure you that reimbursement payment under private third-party payor programs will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. Future changes in the reimbursement rates or methods of private or third-party payors, including the Medicare and Medicaid programs, or the implementation of other measures to reduce reimbursement for our services could result in a substantial reduction in our net operating revenues. Finally, as a result of competitive pressures, our ability to maintain operating margins through price increases to private patients is limited.

We are exposed to market risk due to the fact that outstanding debt and future borrowings are or will be subject to wide fluctuations based on changing interest rates. Market risk is the risk of loss arising from adverse changes in market rates and prices such as interest rates, foreign currency exchange rates and commodity prices. Our primary exposure to market risk is interest rate risk associated with variable rate borrowings. We currently have a \$175,000,000 credit agreement. The credit agreement provides for variable rates and if market interest rates rise, so will our required interest payments on any future borrowings under the credit facility.

We currently have \$120 million of debt outstanding and expect to borrow in the future to fund development and acquisitions. In the event we incur additional indebtedness, this could have important consequences to you. For example, it could:

.
make it more difficult for us to satisfy our financial obligations;

.
increase our vulnerability to general adverse economic and industry conditions, including material adverse regulatory changes such as reductions in reimbursement;

.
limit our ability to obtain financing to fund future working capital, capital expenditures and other general corporate requirement, or to carry out other aspects of our business plan;

.
require us to dedicate a substantial portion of our cash flow from operations to payments on indebtedness, thereby reducing the availability of such cash flow to fund working capital, capital expenditures or other general corporate purposes, or to carry out other aspects of our business plan;

.
require us to pledge as collateral substantially all of our assets;

.
require us to maintain certain debt coverage and financial ratios at specified levels, thereby reducing our financial flexibility;

.
limit our ability to make material acquisitions or take advantage of business opportunities that may arise;

expose us to fluctuations in interest rates, to the extent our borrowings bear variable rates of interest;

limit our flexibility in planning for, or reacting to, changes in our business and the industry; and

place us at a competitive disadvantage compared to our competitors that have less debt.

Covenants in our Credit Agreement could restrict our activities and adversely affect our business. Our Credit Agreement contains customary representations and financial covenants which could limit our operating flexibility and prevent us from taking advantage of business opportunities, which would put us at a competitive disadvantage. Our ability to meet these requirements may be affected by events beyond our control, and we may not meet these requirements. Our failure to comply with these covenants may result in an event of default. If such event of default is not cured or waived, we could suffer adverse effects on our operations, business or financial condition.

We are permitted to incur substantially more debt, which could further exacerbate the risks described above. We and our subsidiaries may be able to incur substantial additional indebtedness in the future. The terms of our current debt do not completely prohibit us or our subsidiaries from incurring additional indebtedness. If new debt is added to our current debt levels, the related risks that we now face could intensify.

To service our current as well as anticipated indebtedness and future dividends, we will require a significant amount of cash, the availability of which depends on many factors beyond our control. Our ability to make payments on and to refinance our indebtedness, including our present indebtedness, to fund planned capital expenditures, and to fund future dividend payments will depend on our ability to generate cash in the future. This, to a certain extent, is subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control.

We may not be able to meet all of our capital needs. We cannot assure you that our business will generate cash flow from operations that anticipated revenue growth and improvement of operating efficiencies will be realized or that future borrowings will be available to us in an amount sufficient to enable us to service our indebtedness or to fund our other liquidity needs. We may need to refinance all or a portion of our indebtedness on or before maturity, sell assets or certain discretionary capital expenditures.

The performances of our fixed-income and our equity investment portfolios are subject to a variety of investment risks. Our investment portfolios are comprised principally of fixed-income securities and common equities. Our fixed-income portfolio is actively managed by an investment group and includes short-term investments and fixed-maturity securities. The performances of our fixed-income and our equity portfolios are subject to a number of risks, including:

Interest rate risk the risk of adverse changes in the value of fixed-income securities as a result of increases in market interest rates.

Investment credit risk the risk that the value of certain investments may decrease in value due to the deterioration in financial condition of, or the liquidity available to, one or more issuers of those securities or, in the case of asset-backed securities, due to the deterioration of the loans or other assets that underlie the securities, which, in each case, also includes the risk of permanent loss.

Concentration risk the risk that the portfolio may be too heavily concentrated in the securities of NHI, or certain sectors or industries, which could result in a significant decrease in the value of the portfolio in the event of a deterioration of the financial condition, performance, or outlook of NHI, or those certain sectors or industries.

Liquidity risk the risk that we will not be able to convert investments into cash on favorable terms and on a timely basis or that we will not be able to sell them at all, when we desire to do so. Disruptions in the financial markets or a lack of buyers for the specific securities that we are trying to sell, could prevent us from liquidating securities or cause a reduction in prices to levels that are not acceptable to us.

In addition, the success of our investment strategies and asset allocations in the fixed-income portfolio may vary depending on the market environment. The fixed-income portfolio's performance also may be adversely impacted if, among other factors: there is a lack of transparency regarding the underlying businesses of the issuers of the securities that we purchase; credit ratings assigned to such securities by nationally recognized credit rating agencies are based on incomplete information or prove unwarranted; or our risk mitigation strategies are ineffective for the applicable market conditions.

The common equity portfolio is subject to general movements in the values of equity markets and to the changes in the prices of the securities we hold. Equity markets, sectors, industries, and individual securities may be subject to high volatility and to long periods of depressed or declining valuations.

If the fixed-income or equity portfolios, or both, were to suffer a decrease in value due to market, sector, or issuer-specific conditions to a substantial degree, our liquidity, financial position, and financial results could be materially adversely affected.

Disasters and similar events may seriously harm our business. Natural and man-made disasters and similar events, including terrorist attacks and acts of nature such as hurricanes, tornados, earthquakes and wildfires, may cause damage or disruption to us, our employees and our facilities, which could have an adverse impact on our patients and our business. In order to provide care for our patients, we are dependent on consistent and reliable delivery of food, pharmaceuticals, utilities and other goods to our facilities, and the availability of employees to provide services at our facilities. If the delivery of goods or the ability of employees to reach our facilities were interrupted in any material respect due to a natural disaster or other reasons, it would have a significant impact on our facilities and our business.

Furthermore, the impact, or impending threat, of a natural disaster has in the past and may in the future require that we evacuate one or more facilities, which would be costly and would involve risks, including potentially fatal risks, for the patients. The impact of disasters and similar events is inherently uncertain. Such events could harm our patients and employees, severely damage or destroy one or more of our facilities, harm our business, reputation and financial performance, or otherwise cause our business to suffer in ways that we currently cannot predict.

Our stock price is volatile and fluctuations in our operating results, quarterly earnings and other factors may result in declines in the price of our common stock. Equity markets are prone to, and in the last few years have experienced, extreme price and volume fluctuations. Volatility over the past few years has had a significant impact on the market price of securities issued by many companies, including us and other companies in the healthcare industry.

If we are unable to operate our businesses as profitably as we have in the past or as our stockholders expect us to in the future, the market price of our common stock will likely decline as stockholders could sell shares of our common stock when it becomes apparent that the market expectations may not be realized. In addition to our operating results, many economic and other factors beyond our control could have an adverse effect on the price of our common stock including:

.

general economic conditions;

.

developments generally affecting the healthcare industry;

.

strategic actions, such as acquisitions or restructurings, or the introduction of new services by us or our competitors;

.

new laws or regulations or new interpretations of existing laws or regulations applicable to our business;

.
litigation and governmental investigations;

.
changes in accounting standards, policies, guidance, interpretations or principles;

.
investor perceptions of us and our business;

.
actions by institutional or other large stockholders;

.
quarterly variations in operating results;

.
changes in financial estimates and recommendations by securities analysts;

.
press releases or negative publicity relating to our competitors or us or relating to trends in health care;

.
sales of stock by insiders;

.
natural disasters, terrorist attacks and pandemics; and

.
additions or departures of key personnel.

ITEM 1B.

UNRESOLVED STAFF COMMENTS

None.

ITEM 2.**PROPERTIES****Skilled Nursing Facilities**

				Licensed	Joined
State	City	Center Name	Affiliation	Beds	NHC
Alabama	Anniston	NHC HealthCare, Anniston	Leased ⁽¹⁾	151	1973
	Moulton	NHC HealthCare, Moulton	Leased ⁽¹⁾	136	1973
Georgia	Fort Oglethorpe	NHC HealthCare, Fort Oglethorpe	Owned	135	1989
	Rossville	NHC HealthCare, Rossville	Owned	112	1971
Kentucky	Glasgow	NHC HealthCare, Glasgow	Leased ⁽¹⁾	194	1971
	Madisonville	NHC HealthCare, Madisonville	Owned	94	1973
Massachusetts	Greenfield	Buckley-Greenfield Health Care Center	Leased ⁽¹⁾	120	1999
	Holyoke	Holyoke Health Care Center	Leased ⁽¹⁾	102	1999
	Quincy	John Adams Health Care Center	Leased ⁽¹⁾	71	1999
	Taunton	Longmeadow of Taunton	Leased ⁽¹⁾	100	1999
Missouri	Des Peres	The Quarters at Des Peres	Managed	147	2014
	Desloge	NHC HealthCare, Desloge	Leased ⁽¹⁾	120	1982
	Independence	The Villages of Jackson Creek	Leased	120	2014
	Independence	The Villages of Jackson Creek Memory Care	Leased	70	2014
	Joplin	NHC HealthCare, Joplin	Leased ⁽¹⁾	126	1982
	Kennett	NHC HealthCare, Kennett	Leased ⁽¹⁾	170	1982
	Macon	Macon Health Care Center	Owned	120	1982
	Osage Beach	Osage Beach Rehabilitation and Health Care Center	Owned	94	1982
	St. Charles	NHC HealthCare, St. Charles	Leased ⁽¹⁾	120	1982
	St. Louis	NHC HealthCare, Maryland Heights	Leased ⁽¹⁾	220	1987
	St. Peters	Villages of St. Peters	Leased	130	2014
	Springfield	Springfield Rehabilitation and Health Care Center	Leased	120	1982
	Town & Country	NHC HealthCare, Town & Country	Owned	200	2001
West Plains	NHC HealthCare, West Plains	Owned	120	1982	
New Hampshire	Epsom	Epsom Health Care Center	Leased ⁽¹⁾	108	1999
	Manchester	Maple Leaf Health Care Center	Leased ⁽¹⁾	114	1999
	Manchester	Villa Crest Health Care Center	Leased ⁽¹⁾	126	1999

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Skilled Nursing Facilities
(continued)

				Total	Joined
State	City	Center Name	Affiliation	Beds	NHC
South Carolina	Anderson	NHC HealthCare, Anderson	Leased ⁽¹⁾	290	1973
	Bluffton	NHC HealthCare, Bluffton	Owned	120	2010
	Charleston	NHC HealthCare, Charleston	Owned	88	2009
	Clinton	NHC HealthCare, Clinton	Owned	131	1993
	Columbia	NHC HealthCare, Parklane	Owned	180	1997
	Greenwood	NHC HealthCare, Greenwood	Leased ⁽¹⁾	152	1973
	Greenville	NHC HealthCare, Greenville	Owned	176	1992
	Laurens	NHC HealthCare, Laurens	Leased ⁽¹⁾	176	1973
	Lexington	NHC HealthCare, Lexington	Owned	170	1994
	Mauldin	NHC HealthCare, Mauldin	Owned	180	1997
	Murrells Inlet	NHC HealthCare, Garden City	Owned	148	1992
	North Augusta	NHC HealthCare, North Augusta	Owned	192	1991
	Sumter	NHC HealthCare, Sumter	Managed	138	1985
Tennessee	Athens	NHC HealthCare, Athens	Leased ⁽¹⁾	88	1971
	Chattanooga	NHC HealthCare, Chattanooga	Leased ⁽¹⁾	200	1971
	Columbia	NHC HealthCare, Columbia	Owned	106	1973
	Columbia	NHC HealthCare, Hillview	Owned	92	1971
	Cookeville	NHC HealthCare, Cookeville	Managed	94	1975
	Dickson	NHC HealthCare, Dickson	Leased ⁽¹⁾	191	1971
	Dunlap	NHC HealthCare, Sequatchie	Leased ⁽¹⁾	110	1976
	Farragut	NHC HealthCare, Farragut	Owned	100	1998
	Franklin	NHC Place, Cool Springs	Owned	180	2004
	Franklin	NHC HealthCare, Franklin	Leased ⁽¹⁾	80	1979
	Gallatin	NHC Place, Sumner	Owned	92	2015
	Hendersonville	NHC HealthCare, Hendersonville	Leased ⁽¹⁾	122	1987
	Johnson City	NHC HealthCare, Johnson City	Leased ⁽¹⁾	160	1971
	Kingsport	NHC HealthCare, Kingsport	Owned	52	2014
	Knoxville	NHC HealthCare, Fort Sanders	Owned ⁽²⁾	166	1977
	Knoxville	Holston Health & Rehabilitation Center	Owned	94	2009
	Knoxville	NHC HealthCare, Knoxville	Owned	129	1971
	Lawrenceburg	NHC HealthCare, Lawrenceburg	Managed	96	1985
	Lawrenceburg	NHC HealthCare, Scott	Leased ⁽¹⁾	60	1971
	Lewisburg	NHC HealthCare, Lewisburg	Leased ⁽¹⁾	100	1971
	Lewisburg	NHC HealthCare, Oakwood	Leased ⁽¹⁾	60	1973
	McMinnville	NHC HealthCare, McMinnville	Leased ⁽¹⁾	125	1971
	Milan	NHC HealthCare, Milan	Leased ⁽¹⁾	117	1971
Murfreesboro	AdamsPlace	Owned	90	1997	
Murfreesboro	NHC HealthCare, Murfreesboro	Managed	181	1974	
Nashville		Managed	107	1992	

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		The Health Center of Richland Place			
	Oak Ridge	NHC HealthCare, Oak Ridge	Managed	120	1977
	Pulaski	NHC HealthCare, Pulaski	Leased ⁽¹⁾	102	1971
	Smithville	NHC HealthCare, Smithville	Leased ⁽¹⁾	114	1971
	Somerville	NHC HealthCare, Somerville	Leased ⁽¹⁾	72	1976
	Sparta	NHC HealthCare, Sparta	Leased ⁽¹⁾	105	1975
	Springfield	NHC HealthCare, Springfield	Owned	107	1973
	Tullahoma	NHC HealthCare, Tullahoma	Owned	90	2013
Virginia	Bristol	NHC HealthCare, Bristol	Leased ⁽¹⁾	120	1973

Assisted Living Units

State	City	Center	Affiliation	Units
Alabama	Anniston	NHC Place/Anniston	Owned	67
Georgia	Evans	Camellia Walk Assisted Living and Memory Care	Owned ⁽³⁾	83
Kentucky	Glasgow	NHC HealthCare, Glasgow	Leased ⁽¹⁾	12
Missouri	St. Charles	Lake St. Charles Retirement Center	Leased ⁽¹⁾	26
	Independence	The Villages of Jackson Creek	Leased	52
	St. Peters	Villages of St. Peters	Owned ⁽⁴⁾	52
	St. Peters	Villages of St. Peters Memory Care	Managed	60
New Hampshire	Manchester	Villa Crest Assisted Living	Leased ⁽¹⁾	29
South Carolina	Charleston	The Palmettos of Charleston	Owned	60
	Columbia	The Palmettos of Parklane	Owned	75
	Greenville	The Palmettos of Mauldin	Owned	45
Tennessee	Dickson	NHC HealthCare, Dickson	Leased ⁽¹⁾	20
	Farragut	NHC Place, Farragut	Owned	84
	Franklin	NHC Place, Cool Springs	Owned	89
	Gallatin	NHC Place, Sumner	Owned	60
	Johnson City	NHC HealthCare, Johnson City	Leased ⁽¹⁾	2
	Murfreesboro	AdamsPlace	Owned	83
	Nashville	Richland Place	Managed	24
	Smithville	NHC HealthCare, Smithville	Leased ⁽¹⁾	6
	Somerville	NHC HealthCare, Somerville	Leased ⁽¹⁾	6

Retirement Apartments

State	City	Retirement Apartments	Affiliation	Units	Est.
Missouri	St. Charles	Lake St. Charles Retirement Apts.	Leased ⁽¹⁾	152	1984
Tennessee	Chattanooga	Parkwood Retirement Apartments	Leased ⁽¹⁾	30	1986
	Johnson City	Colonial Hill Retirement Apartments	Leased ⁽¹⁾	63	1987
	Murfreesboro	AdamsPlace	Owned	93	1997
	Nashville	Richland Place Retirement Apts.	Managed	137	1993

Homecare Programs

State	City	Homecare Programs	Affiliation	Est.
Florida	Carrabelle	NHC HomeCare of Carrabelle	Owned	1994
	Chipley	NHC HomeCare of Chipley	Owned	1994
	Crawfordville	NHC HomeCare of Crawfordville	Owned	1994
	Merritt Island	NHC HomeCare of Merritt Island	Owned	1999
	Panama City	NHC HomeCare of Panama City	Owned	1994
	Port St. Joe	NHC HomeCare of Port St. Joe	Owned	1994
	Quincy	NHC HomeCare of Quincy	Owned	1994
	Vero Beach	NHC HomeCare of Vero Beach	Owned	1997
Missouri	St. Louis	NHC HomeCare of St. Louis	Owned	2012
South Carolina	Aiken	NHC HomeCare of Aiken	Owned	1996
	Bluffton	NHC HomeCare of Beaufort	Owned	2013
	Greenville	NHC HomeCare of Greenville	Owned	2007
	Greenwood	NHC HomeCare of Greenwood	Owned	1996
	Laurens	NHC HomeCare of Laurens	Owned	1996
	Murrells Inlet	NHC HomeCare of Murrells Inlet	Owned	2013
	Rock Hill	NHC HomeCare of Piedmont	Owned	2010
	Summerville	NHC HomeCare of Low Country	Owned	2010
	West Columbia	NHC HomeCare of Midlands	Owned	2010
Tennessee	Athens	NHC HomeCare of Athens	Owned	1984
	Chattanooga	NHC HomeCare of Chattanooga	Owned	1985
	Columbia	NHC HomeCare of Columbia	Owned	1977
	Cookeville	NHC HomeCare of Cookeville	Owned	1976
	Dickson	NHC HomeCare of Dickson	Owned	1977
	Franklin	NHC HomeCare of Franklin	Owned	2007
	Hendersonville	NHC HomeCare of Hendersonville	Owned	2010
	Johnson City	NHC HomeCare of Johnson City	Owned	1978
	Knoxville	NHC HomeCare of Knoxville	Owned	1977
	Lawrenceburg	NHC HomeCare of Lawrenceburg	Owned	1977
	Lewisburg	NHC HomeCare of Lewisburg	Owned	1977
	McMinnville	NHC HomeCare of McMinnville	Owned	1976
	Milan	NHC HomeCare of Milan	Owned	1977
	Murfreesboro	NHC HomeCare of Murfreesboro	Owned	1976
	Pulaski	NHC HomeCare of Pulaski	Owned	1985
	Somerville	NHC HomeCare of Somerville	Owned	1983
Sparta	NHC HomeCare of Sparta	Owned	1984	
Springfield	NHC HomeCare of Springfield	Owned	1984	

Hospice Programs

State	City	Hospice Programs		Affiliation	Est.
Missouri	St. Louis	Caris Healthcare	St. Louis	Caris	2014
	Kansas City	Caris Healthcare	Kansas City	Caris	2015
South Carolina	Anderson	Caris Healthcare	Anderson	Caris	2008
	Charleston	Caris Healthcare	Charleston	Caris	2008
	Columbia	Caris Healthcare	Columbia	Caris	2008
	Greenville	Caris Healthcare	Greenville	Caris	2007
	Greenwood	Caris Healthcare	Greenwood	Caris	2011
	Myrtle Beach	Caris Healthcare	Myrtle Beach	Caris	2008
	Sumter	Caris Healthcare	Sumter	Caris	2008
Tennessee	Athens	Caris Healthcare	Athens	Caris	2006
	Chattanooga	Caris Healthcare	Chattanooga	Caris	2005
	Columbia	Caris Healthcare	Columbia	Caris	2004
	Cookeville	Caris Healthcare	Cookeville	Caris	2004
	Crossville	Caris Healthcare	Crossville	Caris	2009
	Dickson	Caris Healthcare	Dickson	Caris	2007
	Greenville	Caris Healthcare	Greenville	Caris	2007
	Johnson City	Caris Healthcare	Johnson City	Caris	2004
	Knoxville	Caris Healthcare	Knoxville	Caris	2004
	Lenoir City	Caris Healthcare	Lenoir City	Caris	2008
	Milan	Caris Healthcare	Milan	Caris	2004
	Murfreesboro	Caris Healthcare	Murfreesboro	Caris	2005
	Nashville	Caris Healthcare	Nashville	Caris	2004
	Sevierville	Caris Healthcare	Sevierville	Caris	2007
Somerville	Caris Healthcare	Somerville	Caris	2005	
Springfield	Caris Healthcare	Springfield	Caris	2006	
Virginia	Bristol	Caris Healthcare	Bristol	Caris	2011

⁽¹⁾Leased from NHI

⁽²⁾NHC HealthCare/Fort Sanders is owned by a separate limited partnership. The Company owns 25% of the partnership interest and provides management services to Fort Sanders.

⁽³⁾Camellia Walk Assisted Living and Memory Care is owned by a separate limited liability company. The Company owns 10% of the partnership interest and provides management services to Camellia Walk Assisted Living and Memory Care.

⁽⁴⁾Villages of St. Peters Memory Care is owned by a separate limited liability company. The Company owns 25% of the partnership interest and provides management services to the Villages of St. Peters Memory Care.

Healthcare Facilities Leased to Others

The following table includes certain information regarding Healthcare Facilities which are owned by us and leased to others:

Name of Facility	Location	No. of Beds
<i>Skilled Nursing Facilities</i>		
Solaris HealthCare North Naples	Naples, FL	60
Solaris HealthCare Coconut Creek	Coconut Creek, FL	120
Solaris HealthCare Daytona	Daytona Beach, FL	73
Solaris HealthCare Imperial	Naples, FL	113
Solaris HealthCare Windermere	Orlando, FL	120
Solaris HealthCare Charlotte Harbor	Port Charlotte, FL	180
The Health Center at Standifer Place	Chattanooga, TN	444
Solaris HealthCare Lake City	Lake City, FL	120
Solaris HealthCare Pensacola	Pensacola, FL	180

<i>Assisted Living</i>		No. of Units
Solaris Senior Living Vero Beach	Vero Beach, FL	135
Solaris Senior Living Merritt Island	Merritt Island, FL	95
Solaris Senior Living Stuart	Stuart, FL	100
Standifer Place Assisted Living	Chattanooga, TN	74

ITEM 3.

LEGAL PROCEEDINGS

General and Professional Liability Insurance and Lawsuits

The health care industry has experienced significant increases in both the number of personal injury/wrongful death claims and in the severity of awards based upon alleged negligence by skilled nursing facilities and their employees in providing care to residents. As of December 31, 2015, we and/or our managed facilities are currently defendants in 32 such claims covering the years 2006 through December 31, 2015.

In 2002, due to the unavailability and/or prohibitive cost of third-party professional liability insurance coverage, we established and capitalized a wholly-owned licensed liability insurance company incorporated in the Cayman Island, for the purpose of managing our losses related to these risks. Thus, since 2002, insurance coverage for incidents occurring at all NHC owned providers, and most providers managed by us, is provided through this wholly-owned insurance company.

Insurance coverage for all years includes both primary policies and excess policies. Beginning in 2003, both primary and excess coverage is provided through our wholly owned insurance company. The primary coverage is in the amount of \$1.0 million per incident, \$3.0 million per location with an annual primary policy aggregate limit that is adjusted on an annual basis. The excess coverage is \$7.5 million annual excess in the aggregate applicable to years 2005-2007, \$9.0 million annual excess in the aggregate for years 2008-2010, \$4.0 million excess per occurrence for 2011-2013 and \$9.0 million excess per occurrence for 2014-2015.

Beginning in 2008 and continuing through 2015, additional insurance is purchased through third party providers that serve to supplement the coverage provided through our wholly-owned captive insurance company.

As a result of the terms of our insurance policies and our use of a wholly-owned insurance company, we have retained significant self-insured risk with respect to general and professional liability. We use independent actuaries to assist management in estimating our exposures for claims obligations (for both asserted and unasserted claims) related to exposures in excess of coverage limits, and we maintain reserves for these obligations. It is possible that claims against us could exceed our coverage limits and our reserves, which would have a material adverse effect on our financial position, results of operations and cash flows.

General Litigation

Civil Investigation Demand

On December 19, 2013, the Company was served with a civil investigative demand from the U.S. Department of Justice ("DOJ") and the Office of the U.S. Attorney for the Eastern District of Tennessee requesting the production of documents and interrogatory responses regarding the billing and medical necessity of certain rehabilitative therapy services. Based upon our review, the request appears to relate to services provided at our skilled nursing facilities based in Knoxville, Tennessee.

On October 7, 2014, the Company received a subpoena from the Office of Inspector General of the United Department of Health and Human Services (OIG Subpoena) related to the current DOJ Investigation. The OIG Subpoena requests certain financial and organizational documents from the Company and certain of its subsidiaries and SNFs and medical records from certain of the Company's Tennessee-based SNFs.

The Company is cooperating fully with these requests. We are unable to evaluate the outcome of this investigation at this time. It is possible that this claim could have a material adverse effect on our consolidated financial position, results of operations and cash flows.

Caris HealthCare, L.P. Investigation

On December 9, 2014, Caris Healthcare, L.P. (Caris), a business that specializes in hospice care services in Company-owned health care centers and in other settings in Missouri, Tennessee, South Carolina and Virginia,

received notice from the U.S. Attorney's Office for the Eastern District of Tennessee and the Attorney General's Offices for the State of Tennessee and State of Virginia that those government entities were conducting an investigation regarding patient eligibility for hospice services provided by Caris. We have a 75.1% non-controlling ownership interest in Caris.

Caris is cooperating with these government entities in connection with this investigation. We are unable to evaluate the outcome of this investigation at this time. It is possible that this claim could have a material adverse effect on our consolidated financial position, results of operations and cash flows.

There is certain additional litigation incidental to our business, none of which, based upon information available to date, would be material to our financial position, results of operations, or cash flows. In addition, the long-term care industry is continuously subject to scrutiny by governmental regulators, which could result in litigation or claims related to regulatory compliance matters.

ITEM 4.

MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5.

MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS, AND ISSUER PURCHASES OF EQUITY SECURITIES

The shares of common stock of National HealthCare Corporation are listed on the NYSE MKT exchange under the symbol NHC. The closing price for the NHC common shares on February 18, 2016 was \$62.59. On December 31, 2015, NHC had approximately 5,700 stockholders, comprised of approximately 2,100 stockholders of record and an additional 3,600 stockholders indicated by security position listings. The following table sets out the quarterly high and low sales prices and cash dividends declared of NHC's common shares.

	Stock Prices		Cash
	High	Low	Dividends Declared
2015			
1 st Quarter	\$ 66.00	\$ 60.70	\$.34
2 nd Quarter	66.42	60.30	.40
3 rd Quarter	66.50	58.98	.40
4 th Quarter	69.40	59.68	.40
2014			
1 st Quarter	\$56.91	\$ 49.06	\$.32
2 nd Quarter	58.15	50.91	.34
3 rd Quarter	58.92	54.39	.34
4 th Quarter	64.66	54.33	.34

Although we intend to declare and pay regular quarterly cash dividends, there can be no assurance that any dividends will be declared, paid or increased in the future.

Preferred Stock

On November 3, 2015, the Series A Convertible Preferred Stock was redeemed for cash at a redemption price of \$15.75 per share, plus an accrued dividend of \$0.04 per share, for a total of \$15.79 per share. There were 8,290,775 shares of Preferred Stock redeemed under the mandatory redemption for approximately \$130,580,000. As of November 3, 2015, the Preferred Stock is no longer deemed outstanding, and all rights with respect to such stock ceased and terminated, except for the right of the holders to receive payment of the redemption price, without interest.

In lieu of redemption, the holders of the Preferred Stock could have converted any or all of their shares into shares of the Company's common stock. The holders electing to convert their Preferred Shares received 0.24204

shares of common stock for each Preferred Share, together with the cash payable with respect to fractional shares. There were 2,548,561 shares of preferred stock that were converted into 616,757 shares of the Company's common stock during the 2015 year.

Stock Repurchase Programs

On May 7, 2015, the Board of Directors authorized two stock repurchase programs, one that will allow for repurchase of up to \$25 million of its common stock and one that allowed for the repurchase of up to \$25 million of its preferred stock. As of November 3, 2015, all of the Company's preferred stock has been redeemed. Therefore, no future repurchases of the preferred stock will be performed. The common stock repurchase plan expires on August 31, 2016. No repurchases of common stock have been executed under the current program.

Under previously approved repurchase plans, the Company repurchased 125,000 shares of its common stock on August 11, 2014 for a total cost of \$6,995,000. On February 19, 2013, the Company repurchased 100,000 shares for a total cost of \$4,700,000. These two repurchases were funded from cash on hand and were cancelled and returned to the status of authorized but unissued.

Under the common stock repurchase program, the Company may repurchase its common stock from time to time, in amounts and at prices the Company deems appropriate, subject to market conditions and other considerations. The Company's repurchases may be executed using open market purchases, privately negotiated agreements or other transactions. The Company intends to fund repurchases under the new stock repurchase programs from cash on hand, available borrowings or proceeds from potential debt or other capital market sources. The stock repurchase programs may be suspended or discontinued at any time without prior notice. The Company will provide an update regarding any purchases made pursuant to the stock repurchase programs each time it reports its results of operations.

Equity Compensation Plans

The following table sets forth information regarding our equity compensation plans:

Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted-average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
	621,390	48.15	1,938,154

Equity compensation plans approved by security holders			
Equity compensation plans not approved by security holders			
Total	621,390	48.15	1,938,154

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The following graph and chart compare the cumulative total stockholder return for the period from December 31, 2010 through December 31, 2015 on an investment of \$100 in (i) NHC's common stock, (ii) the Standard & Poor's 500 Stock Index ("S&P 500 Index") and (iii) the Standard & Poor's Health Care Index ("S&P Health Care Index").

Cumulative total stockholder return assumes the reinvestment of all dividends. Stock price performances shown in the graph are not necessarily indicative of future price performances.

ITEM 6.**SELECTED FINANCIAL DATA**

The following selected financial information has been derived from the consolidated financial statements of National HealthCare Corporation and should be read in conjunction with those financial statements, accompanying footnotes and Management's Discussion and Analysis.

	2015	As of and for the Year Ended December 31,			2011
		2014	2013	2012	
		<i>(in thousands, except per share data)</i>			
Operating Data:					
Net operating revenues	\$ 906,622	\$ 871,683	\$ 788,957	\$ 761,002	\$ 773,242
Total costs and expenses	(839,496)	(803,672)	(716,876)	(692,766)	(694,391)
Non-operating income	18,148	17,182	30,095	25,245	20,533
Income before income taxes	85,274	85,193	102,176	93,481	99,384
Income tax provision	(32,131)	(31,824)	(37,563)	(34,181)	(34,394)
Net income	53,143	53,369	64,613	59,300	64,990
Dividends to preferred stockholders	(6,819)	(8,670)	(8,671)	(8,671)	(8,671)
Net income available to common stockholders	46,324	44,699	55,942	50,629	56,319
Earnings per common share:					
Basic	\$ 3.34	\$ 3.24	\$ 4.05	\$ 3.65	\$ 4.09
Diluted	3.20	3.14	3.87	3.57	3.96
Cash dividends declared:					
Per preferred share	\$.64	\$.80	\$.80	\$.80	\$.80
Per common share	1.54	1.34	1.26	2.20	1.18
Balance Sheet Data:					
Total assets	\$ 1,045,329	\$ 1,074,123	\$ 984,358	\$ 924,700	\$ 870,424
Accrued risk reserves	98,508	106,218	110,557	110,331	98,732
Long-term debt	120,000	10,000	10,000	10,000	10,000
Stockholders' equity	630,996	734,148	688,112	656,148	606,869

ITEM 7.**MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS**

Overview

National HealthCare Corporation, which we also refer to as NHC or the Company, is a leading provider of post-acute care and senior health care services. At December 31, 2015 we operate or manage 74 skilled nursing facilities with 9,403 licensed beds, 20 assisted living facilities, five independent living facilities, and 36 homecare programs located in ten states. These operations are provided by separately funded and maintained subsidiaries. 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, and insurance services to third party operators of healthcare properties. We also own the real estate of thirteen healthcare properties and lease these properties to third party operators.

Executive Summary

Earnings

To monitor our earnings, we have developed budgets and management reports to monitor labor, census, and the composition of revenues. Inflationary increases in our costs may cause net earnings from patient services to decline.

Occupancy

A primary area of management focus continues to be the rates of occupancy within our skilled nursing facilities. The overall census in owned and leased skilled nursing facilities for 2015 was 90.0% compared to 88.9% and 89.2% in 2014 and 2013, respectively. Increased availability of assisted living facilities, as well as the rapid growth of home and community based services, has amplified the challenge of maintaining desirable patient census levels. Management has undertaken a number of steps in order to best position our current and future health care

facilities. This includes working internally to examine and improve systems to be most responsive to referral sources and payors. Additionally, NHC is in various stages of partnerships with hospital systems, payors, and other post-acute alliances in positioning ourselves to be an active participant in the health delivery systems as they develop.

Development and Growth

We are undertaking to expand our long-term 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	Acquisition	106 beds	Columbia, TN	September, 2013
SNF	Acquisition	92 beds	Columbia, TN	September, 2013
SNF	Acquisition	139 beds	Knoxville, TN	September, 2013
SNF	Acquisition	107 beds	Springfield, TN	September, 2013
SNF	Acquisition	94 beds	Madisonville, KY	September, 2013
SNF	Acquisition	112 beds	Rossville, GA	September, 2013
SNF	Leased	120 beds	Greenfield, MA	September, 2013
SNF	Leased	102 beds	Holyoke, MA	September, 2013
SNF	Leased	71 beds	Quincy, MA	September, 2013
SNF	Leased	100 beds	Taunton, MA	September, 2013
SNF	Leased	108 beds	Epsom, NH	September, 2013
SNF	Leased	114 beds	Manchester, NH	September, 2013
SNF	Leased	126 beds	Manchester, NH	September, 2013
SNF	New Facility	90 beds	Tullahoma, TN	October, 2013
SNF	Addition	50 beds	Lexington, SC	December, 2013
SNF/AL	Leased	120 beds / 52 units	Independence, MO	March, 2014
SNF	Leased	70 beds	Independence, MO	March, 2014
SNF/AL	Leased	130 beds / 52 units	St. Peters, MO	March, 2014
AL	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/AL	New Facility	92 beds/60 Units	Gallatin, TN	April, 2015
Memory Care	Partnership	60 beds	St. Peters, MO	November, 2015
SNF/AL	New Facility	90 beds / 80 Units	Nashville, TN	Under construction
AL	New Facility	76 Units	Bluffton, SC	Under construction
AL	New Facility	80 Units	Garden City, SC	Under construction
SNF	New Facility	112 beds	Columbia, TN	Under construction

For the projects under construction at December 31, 2015, the 90-bed skilled nursing facility and 80-unit assisted living facility located in Nashville, Tennessee is expected to begin operations in the third quarter of 2016; the 76-unit assisted living facility in Bluffton, SC is expected to begin operations in the third quarter of 2016; the 80-unit assisted

living facility in Garden City, SC is expected to begin operations in the fourth quarter of 2016; and the 112 bed replacement center that will combine the 92 beds of NHC Hillview in Columbia, Tennessee with 20 beds from the existing skilled nursing unit at Maury Regional Medical Center is expected to being operations in the fourth quarter of 2016.

During 2016, 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 private pay health care centers or assisted living communities.

Medicare Reimbursement Rate Changes

In July 2015, CMS released its final rule outlining the fiscal year 2016 Medicare payments for skilled nursing facilities, which began October 1, 2015. The 2016 final rule provides for an approximate 1.2% rate update. This estimated increase consists of a 2.3% market basket increase, reduced by a 0.6% forecast error adjustment and further reduced 0.5% for a multifactor productivity adjustment required by the ACA. CMS estimates the update will increase overall payments to skilled nursing facilities in fiscal year 2016 by \$430 million compared to fiscal year 2015 levels. The effect of the 2016 PPS rate update on our revenues will be dependent upon our census and the mix of our patients at the various PPS pay rates.

In August 2014, CMS released its skilled nursing facility PPS update for the fiscal year 2015, which began October 1, 2014. The final rule provided for a 2.0% rate update, which reflected a 2.5% market basket increase less a 0.5% multifactor productivity adjustment as required by the ACA. CMS estimated the update would increase

overall payments to skilled nursing facilities in fiscal year 2015 by \$750 million compared to fiscal year 2014 levels. The 2015 final rule also included wage index updates, revisions to the change of therapy (COT) other Medicare required assessment (OMRA) policy, and comments pertaining to CMS observations on therapy utilization trends.

For 2015, our average Medicare per diem rate for skilled nursing facilities increased 0.9% compared to the same period in 2014.

Accrued Risk Reserves

Our accrued professional liability reserves, workers compensation reserves and health insurance reserves totaled \$98,508,000 and \$106,218,000 at December 31, 2015 and 2014, respectively, and are a primary area of management focus. We have set aside restricted cash and marketable securities to fund our professional liability and workers compensation reserves.

As to exposure for professional liability claims, we have developed for our centers performance certification criteria to measure and bring focus to the patient care issues most likely to produce professional liability exposure, including in house acquired pressure ulcers, significant weight loss and numbers of falls. These programs for certification, which we regularly modify and improve, have produced measurable improvements in reducing these incidents. Our experience is that achieving goals in these patient care areas improves both patient and employee satisfaction.

Application of Critical Accounting Policies

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires us to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates and cause our reported net income to vary significantly from period to period.

Our critical accounting policies that are both important to the portrayal of our financial condition and results and require our most difficult, subjective or complex judgments are as follows:

Revenue Recognition - Third Party Payors

Medicare and Medicaid program revenues, as well as certain Managed Care program revenues, are subject to audit and retroactive adjustment by government representatives or their agents. In our opinion, adequate provision has been made for any adjustments that may result from these reviews. Any differences between our original estimates of reimbursements and subsequent revisions are reflected in operations in the period in which the revisions are made often due to final determination or the period of payment no longer being subject to audit or review. We have made provisions of approximately \$16,654,000 and \$22,931,000 as of December 31, 2015 and 2014, respectively, for various Medicare, Medicaid, and Managed Care claims reviews and current and prior year cost reports.

Revenue Recognition - Private Pay

For private pay patients in skilled nursing or assisted living facilities, we bill room and board charges for the current month with payment being due upon receipt of the statement in the month the services are performed. Charges for ancillary, pharmacy, therapy and other services to private patients are billed in the month following the performance of services; however, all billings are recognized as revenue when the services are performed.

Revenue Recognition - Subordination of Fees and Uncertain Collections

We provide management services to healthcare operators and to others we provide accounting and financial services. We generally charge 6% to 7% of net operating revenues for our management services and a predetermined fixed rate per bed for the accounting and financial services. Our policy is to recognize revenues associated with both management services and accounting and financial services on an accrual basis as the services are provided. However, under the terms of our management contracts, payments for our management services are subject to subordination to other expenditures of the long-term care center being managed. Furthermore, for certain of the third parties with whom we have contracted to provide services and which we have determined, based on insufficient historical collections and the lack of expected future collections, that collection is not reasonably assured, our policy is to recognize revenues only in the period in which the amounts are realized. We may receive

payment for the unpaid and unrecognized management fees in whole or in part in the future only if cash flows from the operating and investing activities of the centers or proceeds from the sale of the centers are sufficient to pay the fees. There can be no assurance that such future cash flows will occur. The realization of such previously unrecognized revenue could cause our reported net income to vary significantly from period to period.

We agree to subordinate our fees to the other expenses of a managed center because we believe we know how to improve the quality of patient services and finances of a skilled nursing or assisted living facility and because subordinating our fees demonstrates to the owner and employees of the managed center how confident we are of the impact we can have in making the center operations successful. We may continue to provide services to certain managed centers despite not being fully paid currently so that we may be able to collect unpaid fees in the future from improved operating results and because the incremental savings from discontinuing services to a center may be small compared to the potential benefit. Also, we may benefit from providing other ancillary services to the managed center.

Accrued Risk Reserves

We are principally self-insured for risks related to employee health insurance, workers' compensation and professional and general liability claims. Our accrued risk reserves primarily represent the accrual for self-insured risks associated with employee health insurance, workers' compensation and professional and general liability claims. The accrued risk reserves include a liability for reported claims and estimates for incurred but unreported claims. Our policy with respect to a significant portion of our workers' compensation and professional and general liability claims is to use an actuary to assist management in estimating our exposure for claims obligations (for both asserted and unasserted claims). Our health insurance reserve is based on our known claims incurred and an estimate of incurred but unreported claims determined by our analysis of historical claims paid. We reassess our accrued risk reserves on a quarterly basis.

Professional liability remains an area of particular concern to us. The entire health care industry has seen a dramatic increase in personal injury/wrongful death claims based on alleged negligence by nursing homes and their employees in providing care to residents. As of December 31, 2015, we and/or our managed centers are defendants in 32 such claims inclusive of years 2006 through 2015. It remains possible that those pending matters plus potential unasserted claims could exceed our reserves, which could have a material adverse effect on our financial position, results of operations and cash flows. It is also possible that future events could cause us to make significant adjustments or revisions to these reserve estimates and cause our reported net income to vary significantly from period to period.

We maintain insurance coverage for incidents occurring in all healthcare facilities owned or leased by us, and most healthcare facilities managed by us. The coverages include both primary policies and excess policies. In all years, settlements, if any, in excess of available insurance policy limits and our own reserves would be expensed by us.

Uncertain Tax Positions

Uncertain tax positions may arise where tax laws may allow for alternative interpretations or where the timing of recognition of income is subject to judgment. We believe we have made adequate provision for unrecognized tax benefits related to uncertain tax positions including related penalties and interest.

The above listing is not intended to be a comprehensive list of all of our accounting policies. In many cases, the accounting treatment of a particular transaction is specifically dictated by generally accepted accounting principles, with limited need for management's judgment in their application. There are also areas in which management's judgment in selecting any available alternative would not produce a materially different result. See our audited consolidated financial statements and notes thereto which contain accounting policies and other disclosures required by generally accepted accounting principles.

Government Program Financial Changes

Cost containment will continue to be a priority for Federal and State governments for health care services, including the types of services we provide. Government reimbursement programs such as Medicare and Medicaid prescribe, by law, the billing methods and amounts that health care providers may charge and be reimbursed to care for patients covered by these programs. Congress has passed a number of laws that have effected major changes in the Medicare and Medicaid programs. The Balanced Budget Act of 1997 sought to achieve a balanced federal budget by, among other things, reducing federal spending on Medicare and Medicaid to various providers. The Balanced Budget Act of 1997 defined the Medicare Prospective Payment System ("PPS") and this system has

subsequently been refined in 1999, 2000, 2005, 2006 and 2010.

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, in which we are participating in a limited way, 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 January 2015, CMS announced its goal by 2016 to have 30% of Medicare payments through alternative payment models such as ACOs or bundled payments and up to 50% by the end of 2018. Providers who respond successfully to these trends and are able to deliver quality care at lower costs are likely to benefit financially.

Medicare – Skilled Nursing Facilities

In July 2015, CMS released its final rule outlining the fiscal year 2016 Medicare payments for skilled nursing facilities, which began October 1, 2015. The 2016 final rule provides for an approximate 1.2% rate update. This estimated increase consists of a 2.3% market basket increase, reduced by a 0.6% forecast error adjustment and further reduced 0.5% for a multifactor productivity adjustment required by the ACA. CMS estimates the update will increase overall payments to skilled nursing facilities in fiscal year 2016 by \$430 million compared to fiscal year 2015 levels. The effect of the 2016 PPS rate update on our revenues will be dependent upon our census and the mix of our patients at the various PPS pay rates.

In August 2014, CMS released its skilled nursing facility PPS update for the fiscal year 2015, which began October 1, 2014. The final rule provided for a 2.0% rate update, which reflected a 2.5% market basket increase less a 0.5% multifactor productivity adjustment as required by the ACA. CMS estimated the update would increase overall

payments to skilled nursing facilities in fiscal year 2015 by \$750 million compared to fiscal year 2014 levels. The 2015 final rule also included wage index updates, revisions to the change of therapy (COT) other Medicare required assessment (OMRA) policy, and comments pertaining to CMS observations on therapy utilization trends.

In July 2013, CMS released its skilled nursing facility PPS update for the fiscal year 2014, which began October 1, 2013. The notice provided for a 1.3% rate update, which reflected a 2.3% market basket increase less a 0.5% multifactor productivity adjustment and a 0.5% adjustment to correct market basket forecasting errors in fiscal year 2012. CMS estimated the update increased overall payments to skilled nursing facilities in fiscal year 2014 by \$470 million compared to fiscal year 2013 levels.

For 2015, our average Medicare per diem rate for skilled nursing facilities increased 0.9% compared to the same period in 2014. No assurances can be given as to whether Congress will increase or decrease reimbursement in the future, the timing of any action or the form of relief, if any, that may be enacted.

Medicare Homecare Programs

In October 2015 and effective January 1, 2016, CMS released its final rule for 2016 home health prospective payment system rates. CMS estimates that the net impact of the PPS rule will result in a 1.5% decrease (\$260 million) in Medicare payments for agencies in 2016. The payment decrease reflects the impact of a 1.9% inflation update offset by a .97% decrease to account for upcoding 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 establishes a value-based purchasing model set to begin January 1, 2016 for Medicare-certified agencies in nine states, including Tennessee and Florida.

In October 2014 and effective January 1, 2015, CMS released its final rule for the 2015 home health prospective payment system. The final rule reduced home health payments overall by 0.3 percent from 2014 payment levels. The payment decrease reflected the impact of the 2.1% home health payment update (\$390 million increase) and the second year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies conversion factor (2.4% or \$450 million decrease). The final rule also made adjustments to the new home health face-to-face requirements and updated the Home Health Quality Reporting Program.

In November 2013 and effective January 1, 2014, CMS issued the final rule for 2014 home health prospective payment system rates, which included (i) a market basket increase of 2.3 percent, (ii) rebasing of Medicare reimbursement rates, with annual reductions of 3.5 percent for each of the next four years beginning January 2014, (iii) changes in the Wage Index with no overall impact and (iv) rebasing all case mix weights to 1.0 from an average case mix weight of 1.3464 in 2013, as provided for under the Affordable Care Act. The rule also provided for changes in low utilization payments amounts and the removal of 170 diagnosis codes, among other changes.

Medicaid Skilled Nursing Facilities

Effective July 1, 2014 and for the fiscal year 2015, the state of Tennessee implemented individual skilled nursing facility rate changes. With new state legislation being passed for the 2015 fiscal year, there are four components that impact Tennessee Medicaid reimbursement for skilled nursing facilities: a Level I or Level II per diem, a quarterly acuity payment, a quarterly Quality Improvement in Long-Term Services and Supports ("QuILTSS") payment (which are incentives based on qualifying criteria in several categories), and an assessment fee (expense). Effective July 1, 2014, each facility will now be charged an assessment fee based on 4.5% of net patient revenues. The assessment fee is replacing the former bed tax fee. In summary and for the 2015 fiscal year, the Tennessee Medicaid reimbursement changes increased income before income taxes by approximately \$3,000,000 annually, or \$750,000 per quarter.

Effective July 1, 2015 and for the fiscal year 2016, the state of Tennessee implemented specific individual nursing facility rate increases. We estimate the resulting increase in revenue beginning July 1, 2015 will be approximately \$4,000,000 annually, or \$1,000,000 per quarter.

Effective October 1, 2014 and for the fiscal year 2015, South Carolina implemented specific individual nursing facility rate increases. The resulting increase in revenue beginning October 1, 2014 was approximately \$1,800,000 annually, or \$450,000.

Effective October 1, 2015 and for the fiscal year 2016, South Carolina implemented specific individual nursing facility rate changes. We estimate the resulting rate changes for the 2016 fiscal year will have an immaterial impact on revenues.

Overall our average Medicaid per diem increased 1.6% in 2015 compared to 2014. We face challenges with respect to states' Medicaid payments, because many currently do not cover the total costs incurred in providing care to those patients. States will continue to control Medicaid expenditures and also look for adequate funding sources, including provider assessments. The Deficit Reduction Act includes several provisions designed to reduce Medicaid spending. These provisions include, among others, provisions strengthening the Medicaid asset transfer restrictions for persons seeking to qualify for Medicaid long-term care coverage, which could, due to the timing of the penalty period, increase facilities' exposure to uncompensated care. Other provisions could increase state funding for home and community-based services, potentially having an impact on funding for nursing facilities. There is no assurance that the funding for our services will increase or decrease in the future.

Results of Operations

The following table and discussion sets forth items from the consolidated statements of income as a percentage of net operating revenues for the years ended December 31, 2015, 2014 and 2013.

Percentage of Net Operating Revenues

	Year Ended December 31,		
	2015	2014	2013
Revenues:			
Net patient revenues	95.4%	95.1%	93.3%
Other revenues	4.6	4.9	6.7
Net operating revenues	100.0	100.0	100.0
Costs and Expenses:			
Salaries, wages and benefits	58.8	58.5	57.5
Other operating	25.0	24.9	24.7
Rent	4.4	4.7	5.0
Depreciation and amortization	4.1	3.9	3.6
Interest	0.3	0.2	0.0
Total costs and expenses	92.6	92.2	90.8
Income before non-operating income	7.4	7.8	9.2
Non-operating income	2.0	2.0	3.8
Income before income taxes	9.4	9.8	13.0
Income tax provision	(3.5)	(3.7)	(4.8)
Net income	5.9	6.1	8.2
Dividends to preferred stockholders	(0.8)	(1.0)	(1.1)
Net income available to common stockholders	5.1	5.1	7.1

The following table sets forth the increase or (decrease) in certain items from the consolidated statements of income as compared to the prior period.

Period to Period Increase (Decrease)

<i>(dollars in thousands)</i>	2015 vs. 2014		2014 vs. 2013	
	Amount	Percent	Amount	Percent
Revenues:				
Net patient revenues	\$ 35,559	4.3	\$ 93,450	12.7
Other revenues	(620)	(1.5)	(10,724)	(20.2)
Net operating revenues	34,939	4.0	82,726	10.5
Costs and Expenses:				
Salaries, wages and benefits	22,486	4.4	56,689	12.5
Other operating	9,929	4.6	22,154	11.4
Rent	236	0.6	282	0.7
Depreciation and amortization	2,730	7.9	5,837	20.4
Interest	443	20.5	1,834	554.1
Total costs and expenses	35,824	4.5	86,796	12.1
Income before non-operating income	(885)	(1.3)	(4,070)	(5.6)
Non-operating income	966	5.6	(12,913)	(42.9)
Income before income taxes	81	0.1	(16,983)	(16.6)
Income tax provision	(307)	1.0	5,739	(15.3)
Net income	(226)	(0.4)	(11,244)	(17.4)
Dividends paid to preferred stockholders	1,851	(21.3)	1	0.0
Net income available to common stockholders	\$ 1,625	3.6	\$ (11,243)	(20.1)

2015 Compared to 2014

Results for 2015 compared to 2014 include a 4.0% increase in net operating revenues and a 0.1% increase in income before income taxes. Excluding the operations of the two newly constructed skilled nursing facilities and one assisted living facility placed in service less than twelve months ago, net operating revenues would have increased 3.2% and income before income taxes for the year ended December 31, 2015 would have increased 6.2% compared to 2014.

The overall average census in owned and leased skilled nursing facilities for 2015 was 90.0% compared to 88.9% in 2014. The composite skilled nursing facility per diem increased 2.6% in 2015 compared to 2014. Medicare and Managed Care per diem rates increased 0.9% and 1.1%, respectively, in 2015 compared to 2014. Medicaid and private pay per diem rates increased 1.6% and 2.7%, respectively, in 2015 compared to 2014.

Net patient revenues totaled \$864,846,000, an increase of \$35,559,000, or 4.3%, compared to the prior year. The majority of the increase in net patient revenues was derived from our same-facility skilled nursing facilities (\$24,769,000). These centers benefitted from a census increase in 2015 of 110 basis points and a higher percentage of Medicare and Managed Care patients compared to 2014. Three newly constructed healthcare properties that began operations in December 2014 and April 2015 enhanced net patient revenues by \$7,129,000 compared to the prior year.

Other revenues this year were \$41,776,000, a decrease of \$620,000, or 1.5%, as further detailed in Note 3 of the consolidated financial statements. Other revenues in 2015 include management and accounting service fees of \$14,586,000 (\$15,184,000 in 2014), insurance services revenue of \$7,012,000 (\$7,215,000 in 2014) and rental revenues of \$19,191,000 (\$19,123,000 in 2014).

The decrease in other revenues was primarily the result of the discontinuance of accounting and financial services to seven healthcare facilities beginning October 1, 2014 (\$1,200,000 decrease in 2015).

At December 31, 2015, the Company provides accounting and financial services to 20 healthcare facilities (compared to 20 at December 31, 2014). No management services are provided for entities in which we provide accounting and financial services.

We provide management services for seven skilled nursing facilities, three assisted living facilities, and one independent living facility.

As to rental revenues, effective January 1, 2016, we entered into a new triple net lease agreement for eleven of the thirteen healthcare properties that we own and lease to third party operators. The new lease agreement is for a ten year period and is expected to increase rental income by approximately \$2,000,000 annually over the previous lease agreement.

Total costs and expenses for 2015 increased \$35,824,000 or 4.5%, to \$839,496,000 from \$803,672,000 in 2014.

Salaries, wages and benefits, the largest operating costs of the company, increased \$22,486,000, or 4.4%, to \$532,735,000 from \$510,249,000. These costs were 59% of net operating revenues for both 2015 and 2014. The same-facility nursing center increase for 2015 (\$15,912,000) includes increased costs for therapy services (\$11,223,000), health insurance (\$2,574,000) and inflationary wage increases. Three newly constructed healthcare properties that began operations in December 2014 and April 2015 increased salaries, wages and benefits by \$4,990,000.

Other operating expenses increased \$9,929,000, or 4.6%, to \$227,072,000 for 2015 compared to \$217,143,000 in 2014. These costs were 25% of net operating revenues for both 2015 and 2014. The increase in other operating expenses is primarily due to the new operations of the three healthcare facilities compared to the prior year (\$5,855,000).

Rent expense increased \$236,000, or 0.6%, to \$39,967,000.

Depreciation and amortization increased 7.9% to \$37,114,000. The majority of the increase in depreciation expense is due to the three newly constructed healthcare facilities.

Interest expense increased to \$2,608,000 from \$2,165,000 in 2014. The increase (\$443,000) in interest expense is primarily from the line of credit borrowings that took place during the fourth quarter of 2015 when the Company's Preferred Stock was redeemed. At December 31, 2015, we have \$110 million outstanding on our credit facility compared to \$-0- in the prior year.

Non-operating income in 2015 increased \$966,000, or 5.6%, to \$18,148,000, as further detailed in Note 4 of the consolidated financial statements. The increase in non-operating income is primarily from the increased interest and dividend income from our marketable securities and our restricted marketable securities (\$1,796,000). The increase in investment income is offset in part by a decrease (\$707,000) in earnings from our largest equity method investment (Caris).

The income tax provision for 2015 is \$32,131,000 (an effective income tax rate of 37.7%). The income tax provision and effective tax rate for 2015 were unfavorably impacted by adjustments to unrecognized tax benefits of \$2,674,000, excluding statute of limitation expirations, and favorably impacted by permanent differences including nondeductible expenses of \$(15,000) resulting in an increase in the provision. The income tax provision and effective tax rate for 2015 were favorably impacted by statute of limitation expirations resulting in a benefit to the provision of \$2,141,000 or 2.5% of income before taxes in 2015.

The income tax provision for 2014 is \$31,824,000 (an effective income tax rate of 37.4%). The income tax provision and effective tax rate for 2014 were unfavorably impacted by adjustments to unrecognized tax benefits of \$512,000 and permanent differences of \$829,000 including nondeductible expenses resulting in an increase in the provision. The income tax provision and effective tax rate for 2014 were favorably impacted by statute of limitation expirations resulting in a benefit to the provision of \$1,542,000 or 1.8% of income before taxes in 2014.

The effective tax rate for 2016 is expected to be in the range of 35% to 39%.

2014 Compared to 2013

Results for 2014 compared to 2013 include a 10.5% increase in net operating revenues and a 16.6% decrease in income before income taxes.

The overall average census in owned and leased skilled nursing facilities for 2014 was 88.9% compared to 89.2% in 2013. The composite skilled nursing facility per diem increased 0.8% in 2014 compared to 2013. The composite per diem increase consisted of: Medicare, Medicaid and private pay per diem rates increased 1.5%, 2.4% and 3.5%, respectively, in 2014 compared to 2013. Managed care per diem rates decreased 1.9% in 2014 compared to 2013.

Net patient revenues increased \$93,450,000, or 12.7%, compared to the prior year. The majority of the increase in net patient revenues consisted of the twelve newly constructed or leased skilled nursing facilities compared to the 2013 year. We began operating four of the skilled nursing facilities during the 2014 year (three in Missouri and one in Tennessee) and we began operating eight of the skilled nursing facilities during the second half of the 2013 year (four in Massachusetts, three in New Hampshire, and one in Tennessee). These twelve newly constructed or leased facilities helped increase net patient revenues by \$77,394,000 over the 2013 year. We also had an increase in net patient revenues from our same facility skilled nursing facilities in the amount of \$8,278,000 compared to the prior year.

Other revenues this year decreased \$10,724,000, or 20.2%, to \$42,396,000, as further detailed in Note 3 of the Company's 2014 Form 10-K. Other revenues in 2014 include management and accounting service fees of \$15,184,000 (\$18,160,000 in 2013) and insurance services revenue of \$7,215,000 (\$15,143,000 in 2013). Rental income was \$19,123,000 in 2014 (\$19,132,000 in 2013).

At December 31, 2014, NHC provided management services for eight skilled nursing facilities, two assisted living facilities, and one independent living facility. During the 2014 year, we began managing two new healthcare facilities. In February 2014, we assumed management of a 147-bed skilled nursing facility located in Des Peres, Missouri. In June 2014, we began managing an 83-unit assisted living facility located in Augusta, Georgia.

As discussed in Notes 4 and 16 of the Company's 2013 Form 10-K, we discontinued our relationship with the SeniorTrust and ElderTrust non-profit organizations during 2013. The discontinuation of management and insurance services to the SeniorTrust and ElderTrust organizations caused other revenues to decrease by approximately \$8,253,000 in 2014 compared to 2013. Other revenues also decreased in the 2014 year compared to the prior year by approximately \$2,769,000 as a result of a 2013 favorable workers compensation insurance settlement.

At December 31, 2014, the Company provided accounting and financial services to 20 healthcare facilities (compared to 27 at December 31, 2013). No management services are provided for entities in which we provide accounting and financial services.

Total costs and expenses for 2014 increased \$86,796,000 or 12.1%, to \$803,672,000 from \$716,876,000 in 2013. Salaries, wages and benefits, the largest operating costs of the company, increased \$56,689,000, or 12.5%, to \$510,249,000 from \$453,560,000. Other operating expenses increased \$22,154,000, or 11.4%, to \$217,143,000 for 2014 compared to \$194,989,000 in 2013. Rent expense increased \$282,000, or 0.7%, to \$39,731,000. Depreciation and amortization increased 20.4% to \$34,384,000. Interest expense increased to \$2,165,000.

Salaries, wages and benefits as a percentage of net operating revenues was 58.5% and 57.5% for the years ended December 31, 2015 and 2013, respectively. The increase in salaries, wages and benefits is primarily due to the new operations of the twelve newly constructed or leased healthcare facilities compared to the prior year (\$43,319,000).

We also had increased costs for therapist services of \$4,864,000, increased cost related to our self-insured health insurance plan of \$3,168,000 compared to the 2013 year, and inflationary wage increases for the Company's partners.

Other operating expense as a percentage of net operating revenues was 24.9% and 24.7% for the years ended December 31, 2015 and 2013, respectively. The increase in other operating expenses is primarily due to the new operations of the twelve newly constructed or leased healthcare facilities compared to the prior year (\$28,973,000).

The 2014 increase in other operating expenses was offset in part by the 2013 expenses incurred by providing management and insurance services for the SeniorTrust and ElderTrust non-profit organizations. Since the Company was no longer providing these services in 2014, other operating expenses decreased by approximately \$6,398,000 compared to the 2013 year.

Rent expense in 2014 increased by approximately \$282,000 compared to the prior year. The seven new healthcare facilities we began leasing and operating from NHI on September 1, 2013 increased rent expense \$2,300,000 in 2014 compared to 2013. In a separate transaction on September 1, 2013, we purchased six skilled nursing facilities from NHI for \$21 million, which lowered rent expense in 2014 by approximately \$2,215,000 compared to 2013. The net of the two transactions leaves a slight increase in rent expense for 2014 when compared to the prior year.

The increase in depreciation expense is due to the new skilled nursing facilities and the increase in interest expense is due to the capital leases recorded for the three Missouri healthcare facilities we began operating during the first quarter of 2014.

Non-operating income in 2014 decreased \$12,913,000, or 42.9%, to \$17,182,000, as further detailed in Note 4 of the Company's 2014 Form 10-K. The decrease is primarily due to our equity method investment in Caris, a hospice provider, which decreased \$6,196,000 in 2014 compared to the prior year. The decrease is also due to the 2013 event in which a gain was recorded in the prior year on the recovery of notes receivable (\$5,454,000) from the collection of certain notes receivable. The Company also has two new equity method investments in 2014: a 60% non-controlling ownership interests in a 14-bed geriatric psychiatric hospital in Osage Beach, Missouri and 10% ownership interest in an 83-unit assisted living facility in Augusta, Georgia. These two equity method investments decreased non-operating income by \$1,222,000 in 2014 compared to 2013.

The income tax provision for 2014 is \$31,824,000 (an effective income tax rate of 37.4%). The income tax provision and effective tax rate for 2014 were unfavorably impacted by adjustments to unrecognized tax benefits of \$512,000 and permanent differences of \$829,000 including nondeductible expenses resulting in an increase in the provision. The income tax provision and effective tax rate for 2014 were favorably impacted by statute of limitation expirations resulting in a benefit to the provision of \$1,542,000 or 1.8% of income before taxes in 2014.

The income tax provision for 2013 is \$37,563,000 (an effective income tax rate of 36.8%). The income tax provision and effective tax rate for 2013 were unfavorably impacted by adjustments to unrecognized tax benefits of \$1,107,000 and permanent differences of \$(26,000) including nondeductible expenses resulting in an increase in the provision. The income tax provision and effective tax rate for 2013 were favorably impacted by statute of limitation expirations resulting in a benefit to the provision of \$1,605,000 or 1.6% of income before taxes in 2013.

Liquidity, Capital Resources and Financial Condition

Sources and Uses of Funds

Our primary sources of cash include revenues from the healthcare and senior living facilities we operate, homecare services, insurance services, management services and accounting services. Our primary uses of cash include salaries, wages and benefits, operating costs of the healthcare facilities we operate, the cost of additions to and acquisitions of real property, rent expenses, and dividend distributions. These sources and uses of cash are reflected in our consolidated statements of cash flows and are discussed in further detail below. The following is a summary of our sources and uses of cash flows (dollars in thousands):

	Year Ended		One Year Change		Year	Two Year Change	
	12/31/15	12/31/14	\$	%	Ended 12/31/13	\$	%
Cash and cash equivalents at beginning of period	\$ 69,767	\$ 81,705	\$(11,938)	(14.6)	\$ 66,701	\$ 3,066	4.6
Cash provided by operating activities	73,963	75,694	(1,731)	(2.3)	102,348	(28,385)	(27.7)
Cash used in investing activities	(63,847)	(57,508)	(6,339)	(11.0)	(56,300)	(7,547)	(13.4)
Cash used in financing activities	(41,675)	(30,124)	(11,551)	(38.3)	(31,044)	(10,631)	(34.2)

Cash and cash equivalents at end of period	\$ 38,208	\$ 69,767	\$(31,559)	(45.2)	\$ 81,705	\$(43,497)	(53.2)
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Operating Activities

Net cash provided by operating activities for the year ended December 31, 2015 was \$73,963,000 as compared to \$75,694,000 and \$102,348,000 for the years ended December 31, 2014 and 2013, respectively. In 2015, cash provided by operating activities consisted of net income of \$53,143,000, adjustments for non-cash items of \$45,031,000, and \$24,305,000 was used for working capital. The Company also had cash provided by distributions from equity method investments that exceeded equity method earnings of \$660,000, which was offset by the gains on the sale of marketable securities of \$566,000,

Working capital primarily consisted of an increase in restricted cash and cash equivalents of \$9,392,000, an increase in accounts receivable of \$11,835,000, a decrease in amounts due to third party payors of \$6,277,000, and a decrease in accrued risk reserves of \$7,710,000.

The increase in restricted cash and cash equivalents is from NHC and other healthcare facilities paying insurance premiums into NHC insurance companies, which restrict the cash payment. The increase in accounts receivable is from the new operations of the three healthcare facilities that began operating during the 2015 year and also the timing of collections of accounts receivable from some of our managed healthcare facilities. The decrease in amounts due to third party payors is primarily due to the payback of funds involving the South Carolina Medicaid cost report audit that is currently under appeal. The decrease in accrued risk reserves is due to payments of claims and adjustments to estimates within our self-insured workers' compensation and professional liability companies.

Investing Activities

Cash used in investing activities totaled \$63,847,000 for the year ended December 31, 2015, as compared to \$57,508,000 and \$56,300,000 for the years ended December 31, 2014 and 2013, respectively. Cash used for property and equipment additions was \$58,416,000, \$53,298,000, and \$43,438,000 for the years ended December 31, 2015 and 2014 and 2013, respectively. In 2015 and 2014, cash was used to make investments into unconsolidated partnerships in the amount of \$674,000 and \$1,975,000, respectively. In 2015 and 2014, cash was used to make investments into notes receivable in the amounts of \$5,676,000 and \$767,000, respectively. Cash provided by collections of notes receivable was \$4,948,000 in 2015 compared to \$2,389,000 and \$11,865,000 in 2014 and 2013, respectively.

Purchases and sales of marketable securities resulted in a net use of cash of \$4,029,000 in 2015 compared to \$3,856,000 and \$3,727,000 in 2014 and 2013, respectively.

Construction costs included in additions to property and equipment in 2015 include \$25,403,000 for the construction and current development of a 90-bed skilled nursing facility and 80-unit assisted living facility in Nashville, Tennessee; \$4,704,000 for the construction completion of the 92-bed skilled nursing facility and 60-unit assisted living facility in Gallatin, Tennessee; \$6,028,000 for the construction and current development of two assisted living facilities in South Carolina; and \$2,477,000 for the construction and current development of the 112-bed skilled nursing facility in Columbia, Tennessee, which is the partnership between NHC and Maury Regional Medical Center.

The purchases of marketable securities were funded from restricted cash and cash equivalents to earn a better rate of return. In 2013, the collections of notes receivable increased substantially due to the payoff of four promissory notes in the amount of \$10,587,000.

Financing Activities

Net cash used in financing activities totaled \$41,675,000, \$30,124,000 and \$31,044,000 for the years ended December 31, 2015, 2014, and 2013, respectively.

On November 3, 2015, the Series A Convertible Preferred Stock was redeemed for cash at a redemption price of \$15.75 per share, plus an accrued dividend of \$0.04 per share, for a total of \$15.79 per share. There were 8,288,098 shares of Preferred Stock redeemed under the mandatory redemption for approximately \$130,538,000. The funding of the Preferred Stock redemption was provided by the Company's cash on hand and borrowings under the credit facility of approximately \$110,000,000. Dividends paid to preferred stockholders were \$8,986,000 in 2015 and \$8,670,000 and \$8,671,000 in 2014 and 2013, respectively. As of November 3, 2015, the Preferred Stock is no longer deemed outstanding, and all rights with respect to such stock ceased and terminated, except for the right of the holders to receive payment of the redemption price, without interest. With the redemption of the Preferred Stock, the Company expects to increase its cash flows from financing activities by approximately \$5,500,000 to \$6,500,000 annually.

Dividends paid to common stockholders for the 2015 year were \$21,089,000 compared to \$18,704,000 and \$17,469,000 in 2014 and 2013, respectively. Proceeds from the issuance of common stock, primarily from the exercise of stock options, totaled \$10,634,000 in 2015 compared to \$7,429,000 and \$991,000 for 2014 and 2013, respectively. On March 1, 2014, the Company entered into capital lease agreements to operate three skilled nursing facilities in the state of Missouri. The principal payments under the capital lease obligations were \$3,089,000 for 2015 and \$2,436,000 for the 2014 year. Our continuing care retirement center issued entrance fee deposit refunds of \$354,000 and \$501,000 in 2015 and 2014, respectively, compared to accepting deposits of \$40,000 in 2013.

Table of Contractual Cash Obligations

Our contractual cash obligations for periods subsequent to December 31, 2015 are as follows (in 000 \$):

		Less than	1-3	3-5	After
	Total	1 year	Years	Years	5 Years
Long-term debt principal	\$ 120,000	\$	\$ 10,000	\$ 110,000	\$
Long-term debt interest	9,215	2,105	3,912	3,198	
Construction obligations	29,850	29,850			
Operating and capital leases	424,416	39,400	78,800	78,800	227,416
Total contractual cash obligations	\$ 583,481	\$ 71,355	\$ 92,712	\$ 191,998	\$ 227,416

Income taxes payable for uncertain tax positions under ASC 740 of \$5,831,000 attributable to permanent differences, at December 31, 2015 has not been included in the above table because of the inability to estimate the period in which payment is expected to occur. See Note 12 of the consolidated financial statements for a discussion on income taxes.

Short-term liquidity

We expect to meet our short-term liquidity requirements primarily from our cash flows from operating activities. In addition to cash flows from operations, our current cash on hand of \$38,208,000, marketable securities of \$116,168,000 and as needed, our borrowing capacity on the credit facility, are expected to be adequate to meet our contractual obligations, operating liquidity, and our growth and development plans in the next twelve months.

Long-term liquidity

We expect to meet our long-term liquidity requirements primarily from our cash flows from operating activities, our current cash on hand of \$38,208,000, marketable securities of \$116,168,000, and our borrowing capacity on the credit facility. At December 31, 2015, the outstanding balance on the credit facility is \$110,000,000; therefore, leaving \$65,000,000 available for future borrowings. The maturity date on the credit facility is October 7, 2020. The credit facility is available for general corporate purposes, including working capital and acquisitions.

Our ability to refinance the credit agreement, to meet our long-term contractual obligations and to finance our operating requirements, growth and development plans will depend upon our future performance, which will be affected by business, economic, financial and other factors, including potential changes in state and federal government payment rates for health care, customer demand, success of our marketing efforts, pressures from competitors, and the state of the economy, including the state of financial and credit markets.

Contingencies

Impact of Inflation

Inflation has remained relatively low during the past three years. However, rates paid under the Medicare and Medicaid programs do not necessarily reflect all inflationary changes and are subject to cuts unrelated to inflationary costs. Therefore, there can be no assurance that future rate increases will be sufficient to offset future inflation increases in our labor and other health care service costs.

See Note 15 to the consolidated financial statements for additional information on pending litigation and other contingencies.

Guarantees

We started paying quarterly dividends in the second quarter of 2004. Although we intend to declare and pay regular quarterly cash dividends, there can be no assurance that any dividends will be declared, paid or increased in the future.

At December 31, 2015, we have no agreements to guarantee the debt obligations of other parties.

We have no outstanding letters of credit. We may or may not in the future elect to use financial derivative instruments to hedge interest rate exposure in the future. At December 31, 2015, we did not participate in any such financial investments.

New Accounting Pronouncements

See Note 1 to the consolidated financial statements for the impact of new accounting standards.

ITEM 7A.

QUANTITATIVE AND QUALITATIVE DISCLOSURE ABOUT MARKET RISK

Market risk represents the potential economic loss arising from adverse changes in the fair value of financial instruments. Currently, our exposure to market risk relates primarily to our fixed-income and equity portfolios. These investment portfolios are exposed primarily to, but not limited to, interest rate risk, credit risk, equity price risk, and concentration risk. We also have exposure to market risk that includes our cash and cash equivalents, notes receivable, revolving credit facility, and long-term debt. The Company's senior management has established comprehensive risk management policies and procedures to manage these market risks.

Interest Rate Risk

The fair values of our fixed-income investments fluctuate in response to changes in market interest rates. Increases and decreases in prevailing interest rates generally translate into decreases and increases, respectively, in the fair values of those instruments. Additionally, the fair values of interest rate sensitive instruments may be affected by the creditworthiness of the issuer, prepayment options, the liquidity of the instrument and other general market conditions.

At December 31, 2015, we have available for sale debt marketable securities in the amount of \$169,866,000. The fixed income portfolio is comprised of investments with primarily short-term and intermediate-term maturities. The portfolio composition allows flexibility in reacting to fluctuations of interest rates. The fixed income portfolio allows our insurance company subsidiaries to achieve an adequate risk-adjusted return while maintaining sufficient liquidity to meet obligations. At December 31, 2015, our debt marketable securities had gross realized gains of \$929,000 and gross unrealized losses of \$2,237,000.

As of December 31, 2015, both our long-term debt and credit facility bear interest at variable interest rates. Currently, we have long-term debt outstanding of \$120.0 million. Based on our outstanding long-term debt, a 1% change in interest rates would change our interest cost by approximately \$1,200,000.

Approximately \$5.3 million of our notes receivable bear interest at variable rates (generally at the prime rate plus 2%). Because the interest rates of these instruments are variable, a hypothetical 1% change in interest rates would result in a related increase or decrease in interest income of approximately \$53,000.

Our cash and cash equivalents consist of highly liquid investments with a maturity of less than three months when purchased. As a result of the short-term nature of our cash instruments, a hypothetical 1% change in interest rates would have minimal impact on our future earnings and cash flows related to these instruments.

We do not currently use any derivative instruments to hedge our interest rate exposure. We have not used derivative instruments for trading purposes and the use of such instruments in the future would be subject to approvals by the Investment Committee of the Board.

Credit Risk

Credit risk is managed by diversifying the fixed income portfolio to avoid concentrations in any single industry group or issuer and by limiting investments in securities with lower credit ratings. Corporate debt securities and mortgage-backed securities comprise approximately 77.7% of the fair value of the fixed income portfolio. At December 31, 2015, the credit quality ratings for our fixed income portfolio consisted of the following investment grades (as a percent of fair value): 31.0% AAA rated, 12.7% AA rated, 42.2% A rated, and 14.1% BBB rated.

Equity Price and Concentration Risk

Our available for sale equity securities are recorded at their fair market value based on quoted market prices. Thus, there is exposure to equity price risk, which is the potential change in fair value due to a change in quoted market prices. At December 31, 2015, the fair value of our equity marketable securities is approximately \$116,168,000. Of the \$116.2 million equity securities portfolio, our investment in National Health Investors, Inc. (NHI) comprises approximately \$99,257,000, or 85.4%, of the total fair value. We manage our exposure to NHI by closely monitoring the financial condition, performance, and outlook of the company. Hypothetically, a 10% change in quoted market prices would result in a related increase or decrease in the fair value of our equity investments of approximately \$11,617,000. At December 31, 2015, our equity marketable securities had unrealized gains of \$85,992,000. Of the \$85,992,000 unrealized gains, \$74,523,000 is related to NHI.

ITEM 8.

FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Stockholders

National HealthCare Corporation

We have audited the accompanying consolidated balance sheets of National HealthCare Corporation as of December 31, 2015 and 2014 and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2015. Our audits also included the financial statement schedule listed in the Index and Item 15(a). These financial statements and schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of National HealthCare Corporation at December 31, 2015 and 2014 and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2015, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

As discussed in Note 1 to the consolidated financial statements, the Company changed its presentation of deferred tax assets and liabilities as a result of the adoption of the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update 2015-17, *Income Taxes: Balance Sheet Classification of Deferred Taxes*, effective December 31, 2015.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), National HealthCare Corporation's internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework) and our report dated February 19, 2016, expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee

February 19, 2016

NATIONAL HEALTHCARE CORPORATION

Consolidated Statements of Income

(in thousands, except share and per share amounts)

	Year Ended December 31,		
	2015	2014	2013
Revenues:			
Net patient revenues	\$ 864,846	\$ 829,287	\$ 735,837
Other revenues	41,776	42,396	53,120
Net operating revenues	906,622	871,683	788,957
Costs and Expenses:			
Salaries, wages and benefits	532,735	510,249	453,560
Other operating	227,072	217,143	194,989
Facility rent	39,967	39,731	39,449
Depreciation and amortization	37,114	34,384	28,547
Interest	2,608	2,165	331
Total costs and expenses	839,496	803,672	716,876
Income Before Non-Operating Income	67,126	68,011	72,081
Non-Operating Income	18,148	17,182	30,095
Income Before Income Taxes	85,274	85,193	102,176
Income Tax Provision	(32,131)	(31,824)	(37,563)
Net Income	53,143	53,369	64,613
Dividends to Preferred Stockholders	(6,819)	(8,670)	(8,671)
Net Income Available to Common Stockholders	\$ 46,324	\$ 44,699	\$ 55,942
Earnings Per Common Share:			
Basic	\$ 3.34	\$ 3.24	\$ 4.05
Diluted	\$ 3.20	\$ 3.14	\$ 3.87
Weighted Average Common Shares Outstanding:			
Basic	13,889,134	13,816,095	13,829,626
Diluted	14,491,433	14,222,133	16,698,803
Dividends Declared Per Common Share	\$ 1.54	\$ 1.34	\$ 1.26

The accompanying notes to consolidated financial statements are an integral part of these consolidated statements.

NATIONAL HEALTHCARE CORPORATION**Consolidated Statements of Comprehensive Income***(in thousands)*

	Year Ended December 31,		
	2015	2014	2013
Net Income	\$ 53,143	\$ 53,369	\$ 64,613
Other Comprehensive Income (Loss):			
Unrealized gains (losses) on investments in marketable securities	(17,740)	30,416	(7,211)
Reclassification adjustment for realized gains on sale of securities	(566)	(379)	(39)
Income tax (expense) benefit related to items of other comprehensive income (loss)	7,062	(11,614)	2,627
Other comprehensive income (loss), net of tax	(11,244)	18,423	(4,623)
Comprehensive Income	\$ 41,899	\$ 71,792	\$ 59,990

The accompanying notes to consolidated financial statements are an integral part of these consolidated statements.

NATIONAL HEALTHCARE CORPORATION

Consolidated Balance Sheets

(in thousands)

	December 31,	
	2015	2014
Assets		
Current Assets:		
Cash and cash equivalents	\$ 38,208	\$ 69,767
Restricted cash and cash equivalents	8,793	7,020
Marketable securities	116,168	132,535
Restricted marketable securities	18,276	19,805
Accounts receivable, less allowance for doubtful accounts of \$5,583 and \$5,738, respectively	84,095	78,843
Inventories	7,568	7,127
Prepaid expenses and other assets	2,171	2,260
Notes receivable, current portion	460	441
Federal income tax receivable	3,203	4,727
Total current assets	278,942	322,525
Property and Equipment:		
Property and equipment, at cost	875,287	821,792
Accumulated depreciation and amortization	(339,241)	(307,048)
Net property and equipment	536,046	514,744
Other Assets:		
Restricted cash and cash equivalents	2,313	3,631
Restricted marketable securities	151,590	138,468
Deposits and other assets	8,451	8,791
Goodwill	17,600	17,600
Notes receivable, less current portion	12,704	12,548
Deferred income taxes		18,700
Investments in limited liability companies	37,683	37,116
Total other assets	230,341	236,854
Total assets	\$ 1,045,329	\$ 1,074,123

The accompanying notes to consolidated financial statements are an integral part of these consolidated statements.

NATIONAL HEALTHCARE CORPORATION

Consolidated Balance Sheets

(in thousands, except share and per share amounts)

	December 31,	
	2015	2014
Liabilities and Stockholders' Equity		
Current Liabilities:		
Trade accounts payable	\$ 20,128	\$ 15,877
Capital lease obligations, current portion	3,279	3,088
Accrued payroll	65,338	59,859
Amounts due to third party payors	16,654	22,931
Accrued risk reserves, current portion	27,069	26,825
Deferred income taxes		35,506
Other current liabilities	12,192	12,472
Dividends payable	5,996	7,000
Total current liabilities	150,656	183,558
Long-term debt	120,000	10,000
Capital lease obligations, less current portion	30,228	33,508
Accrued risk reserves, less current portion	71,439	79,393
Refundable entrance fees	9,865	10,219
Obligation to provide future services	3,440	3,927
Deferred income taxes	9,096	
Other noncurrent liabilities	16,294	16,011
Deferred revenue	3,315	3,359
Stockholders' Equity:		
Series A convertible preferred stock; \$.01 par value; 25,000,000 shares authorized; -0- and 10,836,659 shares, respectively, issued and outstanding; stated at liquidation value of \$15.75 per share		170,494
Common stock, \$.01 par value; 30,000,000 shares authorized; 15,000,616 and 14,110,859 shares, respectively, issued and outstanding	150	140
Capital in excess of par value	209,469	154,965
Retained earnings	368,013	343,941
Accumulated other comprehensive income	53,364	64,608
Total stockholders' equity	630,996	734,148
Total liabilities and stockholders equity	\$ 1,045,329	\$ 1,074,123

The accompanying notes to consolidated financial statements are an integral part of these consolidated statements.

NATIONAL HEALTHCARE CORPORATION

Consolidated Statements of Cash Flows

(in thousands)

	Year Ended December 31,		
	2015	2014	2013
Cash Flows From Operating Activities:			
Net income	\$ 53,143	\$ 53,369	\$ 64,613
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	37,114	34,384	28,547
Provision for doubtful accounts	6,583	6,228	5,226
Equity in earnings of unconsolidated investments	(5,845)	(6,675)	(14,188)
Distributions from unconsolidated investments	6,505	10,288	15,473
Gains on sale of marketable securities	(566)	(379)	(39)
Gain on recovery of notes receivable			(5,454)
Deferred income taxes	(648)	(1,434)	(2,404)
Stock-based compensation	1,982	2,021	2,298
Changes in operating assets and liabilities, net of the effect of acquisitions:			
Restricted cash and cash equivalents	(9,392)	(6,245)	(10,405)
Accounts receivable	(11,835)	(5,215)	(13,778)
Income tax receivable	1,524	(4,727)	5,933
Inventories	(441)	19	(486)
Prepaid expenses and other assets	89	(2,587)	(76)
Trade accounts payable	4,251	2,827	2,495
Accrued payroll	5,479	(3,603)	26,219
Amounts due to third party payors	(6,277)	1,312	2,352
Other current liabilities and accrued risk reserves	(7,455)	(5,652)	(6,401)
Obligation to provide future services	(487)	238	1,898
Other noncurrent liabilities	283	1,486	635
Deferred revenue	(44)	39	(110)
Net cash provided by operating activities	73,963	75,694	102,348
Cash Flows From Investing Activities:			
Additions to property and equipment	(58,416)	(53,298)	(43,438)
Investments in unconsolidated limited liability companies	(674)	(1,975)	
Acquisition of real estate of six skilled nursing facilities			(21,000)
Acquisition of non-controlling interest		(768)	
Investments in notes receivable	(5,676)	(767)	
Collections of notes receivable	4,948	3,156	11,865
Decrease in restricted cash and cash equivalents	8,937	9,523	8,039
Purchases of marketable securities	(60,540)	(62,165)	(93,155)
Sale of marketable securities	47,574	48,786	81,389
Net cash used in investing activities	(63,847)	(57,508)	(56,300)

Cash Flows From Financing Activities:

Borrowings under credit facility	110,000		
Redemption of preferred shareholders	(130,538)		
Tax benefit (expense) from stock-based compensation	1,942	201	(225)
Principal payments under capital lease obligations	(3,089)	(2,436)	
Dividends paid to preferred stockholders	(8,986)	(8,670)	(8,671)
Dividends paid to common stockholders	(21,089)	(18,704)	(17,469)
Issuance of common shares	10,634	7,429	991
Repurchase of common shares		(6,995)	(4,700)
Debt issuance costs	(601)		
Entrance fee deposits (refunds)	(354)	(501)	40
Increase in deposits	406	(448)	(1,010)
Net cash used in financing activities	(41,675)	(30,124)	(31,044)
Net Increase (Decrease) in Cash and Cash Equivalents	(31,559)	(11,938)	15,004
Cash and Cash Equivalents, Beginning of Period	69,767	81,705	66,701
Cash and Cash Equivalents, End of Period	\$ 38,208	\$ 69,767	\$ 81,705

NATIONAL HEALTHCARE CORPORATION**Consolidated Statements of Cash Flows***(continued)*

<i>(in thousands)</i>	Year Ended December 31,		
	2015	2014	2013
Supplemental Information:			
Cash payments for interest	\$ 2,965	\$ 2,242	\$ 497
Cash payments for income taxes	29,183	36,642	34,273
Non-cash financing and investing activities include:			
Buildings, personal property, and obligations recorded under capital lease agreements		39,032	

The accompanying notes to consolidated financial statements are an integral part of these consolidated statements.

NATIONAL HEALTHCARE CORPORATION**Consolidated Statements of Stockholders Equity***(in thousands, except for share and per share amounts)*

	Preferred Stock		Common Stock		Capital in Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders Equity
	Shares	Amount	Shares	Amount				
Balance at January 1, 2013	10,838,412	\$ 170,514	14,158,127	\$ 141	\$ 154,692	\$ 279,993	\$ 50,808	656,148
Net income						64,613		64,613
Other comprehensive loss							(4,623)	(4,623)
Stock-based compensation					2,298			2,298
Tax expense from exercise of stock options					(225)			(225)
Shares sold options exercised			19,722		991			991
Repurchase of common shares			(100,000)	(1)	(4,699)			(4,700)
Shares issued in conversion of preferred stock to common stock	(747)	(4)	179		4			
Dividends declared to preferred stockholders (\$0.80 per share)						(8,671)		(8,671)
Dividends declared to common stockholders (\$1.26 per share)						(17,719)		(17,719)
Balance at December 31,	10,837,665	\$ 170,510	14,078,028	\$ 140	\$ 153,061	\$ 318,216	\$ 46,185	688,112

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2013								
Net income						53,369		53,369
Other comprehensive income							18,423	18,423
Stock-based compensation						2,021		2,021
Tax benefit from exercise of stock options						201		201
Shares sold options exercised			157,590	1	7,428			7,429
Repurchase of common shares			(125,000)	(1)	(6,994)			(6,995)
Shares issued in conversion of preferred stock to common stock	(1,006)	(16)	241		16			
Acquisition of noncontrolling interest						(768)		(768)
Dividends declared to preferred stockholders (\$0.80 per share)						(8,670)		(8,670)
Dividends declared to common stockholders (\$1.34 per share)						(18,974)		(18,974)
Balance at December 31, 2014	10,836,659 \$	170,494	14,110,859 \$	140	\$154,965	\$ 343,941	64,608 \$	734,148
Net income						53,143		53,143
Other comprehensive loss							(11,244)	(11,244)
Stock-based compensation						1,982		1,982
Tax benefit from exercise of stock options						1,942		1,942
Shares sold options exercised			273,000	3	10,631			10,634
	(2,548,561)	(39,956)	616,757	7	39,949			

Shares issued in conversion of preferred stock to common stock										
Redemption of preferred stock	(8,288,098)	(130,538)				(130,538)				
Dividends declared to preferred stockholders (\$0.64 per share)			(6,819)			(6,819)				
Dividends declared to common stockholders (\$1.54 per share)			(22,252)			(22,252)				
Balance at December 31, 2015	\$	15,000,616	\$	150,209,469	\$	368,013	\$	53,364	\$	630,996

The accompanying notes to consolidated financial statements are an integral part of these consolidated statements.

Notes to Consolidated Financial Statements

Note 1 Summary of Significant Accounting Policies

Nature of Operations

National HealthCare Corporation ("NHC" or "the Company") operates, manages or provides services to skilled nursing facilities, assisted living facilities, independent living facilities, and home health care programs located in 10 Southeastern, Northeastern and Midwestern states in the United States. The most significant part of our business relates to skilled and intermediate nursing care in which setting we provide assisted living and retirement services, rehabilitative therapy services, and home health care. We also have a non-controlling ownership interest in a hospice care business that services NHC owned health care centers and others. The health care environment has continually undergone changes with regard to Federal and state reimbursement programs and other payor sources, compliance regulations, competition among other health care providers and patient care litigation issues. We continually monitor these industry developments as well as other factors that affect our business.

Principles of Consolidation and Basis of Presentation

The consolidated financial statements which are prepared in accordance with U.S. generally accepted accounting principles (GAAP) include our wholly owned and controlled subsidiaries and affiliates. Variable interest entities (VIEs) in which we have an interest have been consolidated when we have been identified as the primary beneficiary. Investments in ventures in which we have the ability to exercise significant influence but do not have control over are accounted for using the equity method. Equity method investments are initially recorded at cost and subsequently are adjusted for our share of the venture's earnings or losses and cash distributions. Our most significant equity method investment is a 75.1% non-controlling ownership interest in Caris Healthcare, LP (Caris), a business that specializes in hospice care services. Investments in entities in which we lack the ability to exercise significant influence are included in the consolidated financial statements at cost unless there has been a decline in the market value of our investment that is deemed to be other than temporary. All material intercompany transactions and balances have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Net Patient Revenues and Accounts Receivable

Revenues are derived from services rendered to patients for skilled and intermediate nursing, rehabilitation therapy, hospice, assisted living and retirement and home health care services.

Revenues are recorded when services are provided based on established rates adjusted to amounts expected to be received under governmental programs and other third-party contractual arrangements based on contractual terms. These revenues and receivables are stated at amounts estimated by management to be at their net realizable value.

For private pay patients in skilled nursing, assisted living and independent living facilities, the Company bills for room and board charges, with the remittance being due on receipt of the statement and generally by the 10th day of the month the services are performed. A portion of the episodic Medicare payments for home health services are also received in advance of the services being rendered. All advance billings are initially deferred and then are recognized as revenue when the services are performed.

We receive payments from the Medicare program under a prospective payment system ("PPS"). For skilled nursing services, Medicare pays a fixed fee per Medicare patient per day, based on the acuity level of the patient, to cover all post-hospital extended care routine service costs, ancillary costs and capital related costs.

Medicaid program payments for long-term care services are generally based on fixed per diem rates subject to program cost ceilings.

For homecare services, Medicare pays based on the acuity level of the patient and based on episodes of care. An episode of care is defined as a length of care up to 60 days with multiple continuous episodes allowed. The services covered by the episode payment include all disciplines of care, in addition to medical supplies, within the scope of the home health benefit. We are allowed to make a request for anticipated payment at the start of care equal to 60% of the expected payment for the initial episode. The remaining balance due is paid following the submission of the final claim at the end of the episode. Revenues are recognized when services are provided based on the number of days of service rendered in the episode. Deferred revenue is recorded for payments received for which the related services have not yet been provided.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Noncompliance with such laws and regulations can be subject to regulatory actions including fines, penalties, and exclusion from the Medicare and Medicaid programs. We believe that we are in compliance with all applicable laws and regulations.

Medicare and Medicaid program revenues, as well as certain Managed Care program revenues, are subject to audit and retroactive adjustment by government representatives or their agents. The Medicare PPS methodology requires that patients be assigned to Resource Utilization Groups ("RUGs") based on the acuity level of the patient to determine the amount paid to us for patient services. The assignment of patients to the various RUG categories is subject to post-payment review by Medicare intermediaries or their agents. In our opinion, adequate provision has been made for any adjustments that may result from these reviews. Retroactive adjustments are estimated in the recording of revenues in the period the related services are rendered. Any differences between our original estimates of reimbursements and subsequent revisions are reflected in operations in the period in which the revisions are made often due to final determination or the period of payment no longer being subject to audit or review. We believe currently that any differences between the net revenues recorded and final determination will not materially affect the consolidated financial statements. We have made provisions of approximately \$16,654,000 and \$22,931,000 as of December 31, 2015 and 2014, respectively, for various Medicare, Medicaid, and Managed Care claims reviews and current and prior year cost reports.

Other Revenues

As discussed in Note 3 other revenues include revenues from the provision of insurance services, management and accounting services to other long-term care providers, and rental income. Our insurance revenues consist of premiums that are generally paid in advance and then amortized into income as earned over the related policy period. We charge for management services based on a percentage of net revenues. We charge for accounting services based on a monthly fee or a fixed fee per bed of the long-term care center under contract. We generally record other revenues on the accrual basis based on the terms of our contractual arrangements. However, with respect to management and accounting services revenue from certain long-term care providers, including but not limited to National Health Corporation ("National") as discussed in Note 3, where collection is not reasonably assured based on insufficient historical collections and the lack of expected future collections, our policy is to recognize income only in the period in which collection is assured and the amounts at question are believed by management to be fixed or determined.

Certain management contracts, including, but not limited to contracts with National, subordinate the payment of management fees earned under those contracts to other expenditures of the long-term care center and to the availability of cash provided by the facility's operations. Revenues from management services provided to the facilities that generate insufficient cash flow to pay the management fee, as prioritized under the contractual arrangement, are not recognized until such time as the amount of revenue earned is fixed or determinable and collectability is reasonably assured. This recognition policy could cause our reported revenues and net income from management services to vary significantly from period to period.

We recognize rental income based on the terms of our operating leases. Under certain of our leases, we receive contingent rent, which is based on the increase in revenues of a lessee over a base year. We recognize contingent rent annually or monthly, as applicable, when, based on the actual revenue of the lessee, receipt of such income is assured. We identify leased real estate properties as nonperforming if a required payment is not received within 30 days of the date it is due. Our policy related to rental income on non-performing leased real estate properties is to recognize rental income in the period when the income is received.

Provision for Doubtful Accounts

We evaluate the collectability of our accounts receivable based on factors such as payor type, historical collection trends and aging categories. We review these factors and determine an estimated provision for doubtful accounts. Historically, bad debts have resulted primarily from uncollectible private balances or from uncollectible coinsurance and deductibles. Receivables that are deemed to be uncollectible are written off against the allowance. The allowance for doubtful accounts balance is assessed on a quarterly basis, with changes in estimated losses being recorded in the consolidated statements of income in the period first identified.

The Company includes provisions for doubtful accounts in operating expenses in its consolidated statements of income. The provisions for doubtful accounts were \$6,583,000, \$6,228,000, and \$5,226,000 for 2015, 2014 and 2013, respectively.

Other Operating Expenses

Other operating expenses include the costs of care and services that we provide to the residents of our facilities and the costs of maintaining our facilities. Our primary patient care costs include drugs, medical supplies, purchased professional services, food, professional insurance and licensing fees. The primary facility costs include utilities and property insurance.

General and Administrative Costs

With the Company being a healthcare provider, the majority of our expenses are "cost of revenue" items. Costs that could be classified as "general and administrative" by the Company would include its corporate office costs, which were \$34.7 million, \$36.2 million, and \$40.9 million for the years ended December 31, 2015, 2014, and 2013, respectively.

Cash and Cash Equivalents

Cash equivalents include highly liquid investments with an original maturity of three months or less when purchased.

Restricted Cash and Cash Equivalents and Restricted Marketable Securities

Restricted cash and cash equivalents and restricted marketable securities primarily represent assets that are held by our wholly-owned limited purpose insurance companies for workers' compensation and professional liability claims.

Investments in Marketable Securities and Restricted Marketable Securities

Our investments in marketable securities and restricted marketable securities include available for sale securities, which are recorded at fair value. Unrealized gains and losses on available for sale securities that are deemed temporary are recorded as a separate component of stockholders' equity. If any adjustment to fair value reflects a significant decline in the value of the security, we consider all available evidence to evaluate the extent to which the decline is "other than temporary". Credit losses are identified when we do not expect to receive cash flows sufficient to recover the amortized cost basis of a security. In the event of a credit loss, only the amount associated with the credit loss is recognized in earnings, with the amount of loss relating to other factors recorded as a separate component of stockholders' equity.

Inventories

Inventories consist generally of food and supplies and are valued at the lower of cost or market, with cost determined on a first-in, first-out (FIFO) basis.

Mortgage and Other Notes Receivable

In accordance with Accounting Standards Codification ("ASC") Topic 310, *Receivables*, NHC evaluates the carrying values of its mortgage and other notes receivable on an instrument by instrument basis. On a quarterly basis, NHC reviews its notes receivable for recoverability when events or circumstances, including the non-receipt of contractual principal and interest payments, significant deteriorations of the financial condition of the borrower and significant adverse changes in general economic conditions, indicate that the carrying amount of the note receivable may not be recoverable. If necessary, impairment is measured as the amount by which the carrying amount exceeds the discounted cash flows expected to be received under the note receivable or, if foreclosure is probable, the fair value of the collateral securing the note receivable.

Property and Equipment

Property and equipment are recorded at cost. Depreciation is provided by the straight-line method over the expected useful lives of the assets estimated as follows: buildings and improvements, 20-40 years and equipment and furniture, 3-15 years. Leasehold improvements are amortized over periods that do not exceed the non-cancelable respective lease terms using the straight-line method.

Expenditures for repairs and maintenance are charged against income as incurred. Betterments, which significantly extend the useful life, are capitalized. We remove the costs and related allowances for accumulated depreciation or amortization from the accounts for properties sold or retired, and any resulting gains or losses are included in income.

In accordance with ASC Topic 360, *Property, Plant, and Equipment*, we evaluate the recoverability of the carrying values of our properties on a property by property basis. We review our properties for recoverability when events or circumstances, including significant physical changes in the property, significant adverse changes in general economic conditions, and significant deteriorations of the underlying cash flows of the property, indicate that the carrying amount of the property may not be recoverable. The need to recognize impairment is based on estimated future undiscounted cash flows from a property over the remaining useful life compared to the carrying value of that property. If recognition of impairment is necessary, it is measured as the amount by which the carrying amount of the property exceeds the estimated fair value of the property.

Goodwill

The Company accounts for goodwill under ASC Topic 350, *Intangibles – Goodwill and Other*. Under the provisions of this guidance, goodwill and intangible assets with indefinite useful lives are not amortized but are subject to impairment tests based on their estimated fair value. Unamortized goodwill is continually reviewed for impairment in accordance with ASC. The Company performs its annual impairment assessment on the first day of the fourth quarter.

Accrued Risk Reserves

We are principally self-insured for risks related to employee health insurance and utilize wholly-owned limited purpose insurance companies for workers' compensation and professional liability claims. Accrued risk reserves primarily represent the accrual for risks associated with employee health insurance, workers' compensation and professional liability claims. The accrued risk reserves include a liability for unpaid reported claims and estimates for

incurred but unreported claims. Our policy with respect to a significant portion of our workers' compensation and professional and general liability claims is to use an actuary to assist management in estimating our exposure for claims obligation (for both asserted and unasserted claims). Our health insurance reserve is based on our known claims incurred and an estimate of incurred but unreported claims determined by our analysis of historical claims paid. We reassess our accrued risk reserves on a quarterly basis, with changes in estimated losses being recorded in the consolidated statements of income in the period first identified.

Other Current Liabilities

Other current liabilities primarily represent accruals for current federal and state income taxes, real estate taxes and other current liabilities.

Continuing Care Contracts and Refundable Entrance Fees

We have one continuing care retirement center (CCRC) within our operations. Residents at this retirement center may enter into continuing care contracts with us. The contract provides that 10% of the resident entry fee becomes non-refundable upon occupancy, and the remaining refundable portion of the entry fee is calculated using the lessor of the price at which the apartment is re-assigned or 90% of the original entry fee, plus 40% of any appreciation if the apartment exceeds the original resident's entry fee. In each case, we amortize the non-refundable part of these fees into revenue over the actuarially determined remaining life of the resident, which is the expected period of occupancy by the resident. We pay the refundable portion of our entry fees when residents relocate from our community and the apartment is re-occupied. Refundable entrance fees are classified as non-current liabilities and non-refundable entrance fees are classified as deferred revenue in the Company's consolidated balance sheets. The balances of refundable entrance fees as of December 31, 2015 and December 31, 2014 were \$9,865,000 and \$10,219,000, respectively.

Obligation to Provide Future Services

We annually estimate the present value of the net cost of future services and the use of facilities to be provided to the current CCRC residents and compare that amount with the balance of non-refundable deferred revenue from entrance fees received. If the present value of the net cost of future services exceeds the related anticipated revenues, a liability is recorded (obligation to provide future services) with a corresponding charge to income. At December 31, 2015 and 2014, we have recorded a future service obligation in the amounts of \$3,440,000 and \$3,927,000, respectively.

Other Noncurrent Liabilities

Other noncurrent liabilities include reserves primarily related to various uncertain income tax positions (see Note 12).

Deferred Revenue

Deferred revenue includes the deferred gain on the sale of assets to National (as discussed in Note 2) and entrance fees that have been and are currently being received upon reservation and occupancy in the independent living centers we operate. The non-refundable portion (10%) of the entrance fee is included in deferred revenue and is being recognized over the remaining life expectancies of the residents.

Income Taxes

We utilize ASC Topic 740, *Income Taxes*, which requires an asset and liability approach for financial accounting and reporting for income taxes. Under this guidance, deferred tax assets and liabilities are determined based upon differences between financial reporting and tax basis of assets and liabilities and are measured using the enacted tax laws that will be in effect when the differences are expected to reverse. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. See Note 12 for further discussion of our accounting for income taxes.

Also under ASC Topic 740, *Income Taxes*, tax positions are evaluated for recognition using a more-likely-than-not threshold, and those tax positions requiring recognition are measured at the largest amount of tax benefit that is greater than 50 percent likely of being realized upon ultimate settlement with a taxing authority that has full knowledge of all relevant information. Liabilities for income tax matters include amounts for income taxes, applicable penalties, and interest thereon and are the result of the potential alternative interpretations of tax laws and the judgmental nature of the timing of recognition of taxable income.

Stock-Based Compensation

Stock-based awards granted include stock options, restricted stock units, and stock purchased under our employee stock purchase plan. Stock-based compensation cost is measured at the grant date, based on the fair value of the awards, and is recognized as expense over the requisite service period only for those equity awards expected to vest.

The fair value of the restricted stock units is determined based on the stock price on the date of grant. We estimated the fair value of stock options and stock purchased under our employee stock purchase plan using the Black-Scholes model. This model utilizes the estimated fair value of common stock and requires that, at the date of grant, we use the expected term of the grant, the expected volatility of the price of our common stock, risk-free interest rates and

expected dividend yield of our common stock. The fair value is amortized on a straight-line basis over the requisite service periods of the awards.

Concentration of Credit Risks

Our credit risks primarily relate to cash and cash equivalents, restricted cash and cash equivalents, accounts receivable, marketable securities, restricted marketable securities and notes receivable. Cash and cash equivalents are primarily held in bank accounts and overnight investments. Restricted cash and cash equivalents is primarily invested in commercial paper and certificates of deposit with financial institutions and other interest bearing accounts.

Accounts receivable consist primarily of amounts due from patients (funded through Medicare, Medicaid, other contractual programs and through private payors) and from other health care companies for management, accounting and other services. We perform continual credit evaluations of our clients and maintain allowances for doubtful accounts on these accounts receivable. Marketable securities and restricted marketable securities are held primarily in accounts with brokerage institutions. Notes receivable relate primarily to secured loans with health care facilities (recorded as notes receivable in the consolidated balance sheets) as discussed in Note 10.

At any point in time we have funds in our operating accounts and restricted cash accounts that are with third party financial institutions. These balances in the U.S. may exceed the Federal Deposit Insurance Corporation (FDIC) insurance limits. While we monitor the cash balances in our operating accounts, these cash and restricted cash balances could be impacted if the underlying financial institutions fail or could be subject to other adverse conditions in the financial markets.

Our financial instruments, principally our notes receivable, are subject to the possibility of loss of the carrying values as a result of the failure of other parties to perform according to their contractual obligations. We obtain various collateral and other protective rights, and continually monitor these rights in order to reduce such possibilities of loss.

We evaluate the need to provide reserves for potential losses on our financial instruments based on management's periodic review of the portfolio on an instrument by instrument basis. See Note 10 for additional information on the notes receivable.

Comprehensive Income

ASC Topic 220, *Comprehensive Income*, requires that changes in the amounts of certain items, including unrealized gains and losses on marketable securities, be shown in the consolidated financial statements as comprehensive income. We report comprehensive income in the consolidated statements of comprehensive income and also in the consolidated statements of stockholders' equity.

Segment Disclosures

ASC Topic 280, *Segment Reporting*, establishes standards for the way that public business enterprises report information about operating segments in annual and interim financial reports issued to stockholders. Management believes that substantially all of our operations are part of the post-acute health care industry segment. See Note 3 for a detail of other revenues provided by our operations within the post-acute health care industry segment. Information about the costs and expenses associated with each of the components of other revenues is not separately identifiable.

New Accounting Pronouncements

In January 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update ("ASU") No. 2016-01, *Financial Instruments - Recognition and Measurement of Financial Assets and Financial Liabilities (Topic 825)* . ASU No. 2016-01 revises the classification and measurement of investments in certain equity investments and the presentation of certain fair value changes for certain financial liabilities measured at fair value. ASU No. 2016-01 requires the change in fair value of many equity investments to be recognized in net income. ASU No. 2016-01 is effective for interim and annual periods beginning after December 15, 2017, with early adoption permitted. Adopting ASU No. 2016-01 may result in a cumulative effect adjustment to the Company's retained earnings as of the beginning of the year of adoption. We are currently evaluating the potential effects of adopting the provisions of ASU No. 2016-01.

In November 2015, the FASB issued ASU No. 2015-17, *Income Taxes* which requires that deferred tax liabilities and assets be classified as noncurrent in a classified balance sheet. Prior to the issuance of the standard, deferred tax liabilities and assets were required to be separately classified into a current amount and a noncurrent amount in the balance sheet. The new accounting guidance represents a change in accounting principle and the standard is required to be adopted in annual periods beginning after December 15, 2016. Early adoption is permitted and the Company elected to early adopt this guidance as of December 31, 2015 and to apply the guidance prospectively to the 2015 presentation. Because the application of this guidance affects classification only, such reclassifications did not have a material effect on the Company's consolidated financial position or results of operations.

In April 2015, the FASB issued ASU 2015-03, "Imputation of Interest (Sub-Topic 835.30): Simplifying the Presentation of Debt Issuance Costs". ASU 2015-03 requires debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. In August 2015, the FASB issued ASU 2015-15 clarifying the application of this guidance to line of credit arrangements. The amendments in the ASUs are effective retrospectively for fiscal years, and for interim periods within those fiscal years, beginning after December 15, 2015. Early adoption is permitted for financial statements not previously issued. The Company does not expect the adoption of this guidance to have a material impact on its consolidated financial statements.

In February 2015, the FASB issued ASU No. 2015-02 Amendments to the Consolidation Analysis. This update is in response to stakeholders that have expressed concerns that current generally accepted accounting principles (GAAP) might require a reporting entity to consolidate another legal entity in situations in which the reporting entity's contractual rights do not give it the ability to act primarily on its own behalf, the reporting entity does not hold a majority of the legal entity's voting rights, or the reporting entity is not exposed to a majority of the legal entity's economic benefits or obligations. Thus, the update modifies the evaluation of whether limited partnerships and similar legal entities are variable interest entities (VIEs) or voting interest entities. It eliminates the presumption that a general partner should consolidate a limited partnership, for limited partnerships and similar legal entities that qualify as voting interest entities; a limited partner with a controlling financial interest should consolidate a limited partnership. A controlling financial interest may be achieved through holding a limited partner interest that provides substantive kick-out rights. Finally, it requires consideration of the effects of fee arrangements and related parties on the primary beneficiary determination. The amendments in this update are effective for annual reporting periods beginning after December 15, 2015, including interim periods within that reporting period. When adopted, the Company does not expect this standard to have a material impact on our consolidated financial statements.

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2014-09 Revenue from Contracts with Customers. This update is the result of a collaborative effort by the FASB and the International Accounting Standards Board to simplify revenue recognition guidance, remove inconsistencies in the application of revenue recognition, and to improve comparability of revenue recognition practices across entities, industries, jurisdictions, and capital markets. The FASB is amending the Accounting Standards Codification and creating a new Topic 606, Revenue from Contracts with Customers. The core principle of the guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. For a public entity, the amendments in this update are effective for annual reporting periods beginning after December 15, 2017, including interim periods within that reporting period. Early application is not permitted. The Company is currently evaluating the impact of this guidance on our consolidated financial statements and control framework.

In April 2014, the FASB issued ASU No. 2014-08, Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity. This standard changes the requirements for reporting discontinued operations by raising the threshold for a disposal to qualify as a discontinued operation and requires new disclosures of both discontinued operations and certain other disposals that do not meet the definition of a discontinued operation. The standard limits discontinued operations reporting to disposals of components of an entity that represent strategic shifts that have (or will have) a major effect on an entity's operations and financial results. This standard is effective for the Company on a prospective basis for annual periods beginning on January 1, 2015 and interim periods within that year. This standard did not have a material impact on our consolidated financial statements.

Note 2 Relationship with National Health Corporation

National Health Corporation ("National"), which is wholly-owned by the National Health Corporation Leveraged Employee Stock Ownership Plan ("ESOP"), was formed in 1986 and is our administrative services affiliate and contractor. As discussed below, all of the personnel conducting our business, including our executive management

team, are employees of National and may have ownership interests in National only through their participation as employees in the ESOP.

Management Contracts

We currently manage five skilled nursing facilities for National under a management contract. The management contract has been extended until January 1, 2018. See Note 3 for additional information regarding management services fees recognized from National.

Financing Activities

During 1991, we borrowed \$10,000,000 from National. The term note payable currently requires quarterly interest payments at the prime rate minus .85 percent. The entire principal is due at maturity in 2018.

In conjunction with our management contract, we have entered into a line of credit arrangement whereby we may have amounts due from National from time to time. The maximum loan commitment under the line of credit is \$2,000,000. At December 31, 2015, National did not have an outstanding balance on the line of credit.

The maximum line of credit commitment amount of \$2,000,000 is also the amount of a deferred gain that has been outstanding since NHC sold certain assets to National in 1988. The amount of the deferred gain is expected to remain deferred until the management contract with National expires, currently scheduled in January 2018. The deferred gain is included in deferred revenue in the consolidated balance sheets.

Payroll and Related Services

The personnel conducting our business, including our executive management team, are employees of National and may have ownership interests in National only through their participation in the ESOP. National provides payroll services to NHC, provides employee fringe benefits, and maintains certain liability insurance. We pay to National all the costs of personnel employed for our benefit, as well as an administrative fee equal to 1% of payroll costs. Such costs of personnel totaling approximately \$532,735,000, \$510,249,000, and \$453,560,000, for 2015, 2014 and 2013 respectively, are reflected as salaries, wages and benefits in the accompanying consolidated statements of income. The administrative fee paid to National for 2015, 2014, and 2013 was \$4,542,000, \$4,395,000, and \$3,693,000, respectively. At December 31, 2015, the Company has recorded \$3,965,000 in accounts receivable and \$4,439,000 in accounts payable in the consolidated balance sheets as a result of the timing differences between interim payments for payroll and employee benefits services costs. At December 31, 2014, the Company recorded \$2,155,000 in accounts

receivable in the consolidated balance sheets as a result of these timing differences.

National's Ownership of Our Stock

At December 31, 2015, National owns 1,214,763 shares (or approximately 8.1%) of our outstanding common stock.

Consolidation Considerations

Because of the contractual and management relationships between NHC and National as described in this note above, we have considered whether National should be consolidated by NHC under the guidance provided in ASC Topic 810, *Consolidation*. We do not consolidate National because (1) NHC does not have any obligation or rights (current or future) to absorb losses or to receive benefits from National. The ESOP participants bear the current and future financial gain or burden of National, (2) National's equity at risk is sufficient to finance its activities without past or future subordinated support from NHC or other parties, and (3) the equity holders of National (that is collectively the ESOP, its trustees, and the ESOP participants) possess the characteristics of a controlling financial interest, including voting rights that are proportional to their economic interests. Supporting the assertions above is the following: (1) substantive independent trustees are appointed for the benefit of the ESOP participants when decisions must be made that may create the appearance of a conflict of interest between NHC and the ESOP, and (2) National was designed, formed and is operated for the purpose of creating variability and passing that variability along to the ESOP participants that is, to provide retirement benefits and value to the employees of NHC and NHC's affiliates. The contractual and management relationships between NHC and National are with the skilled nursing facilities that are substantially less than 50% of the fair value of the total assets of National. NHC does not have a variable interest in National as a whole.

Note 3 Other Revenues

Other revenues are outlined in the table below. Revenues from insurance services include premiums for workers compensation and professional liability insurance policies that our wholly-owned insurance subsidiaries have written for certain healthcare operators to which we provide management or accounting services. Revenues from management and accounting services include fees provided to manage and provide accounting services to other healthcare operators. Revenues from rental income include health care real estate properties owned by us and leased to third party operators. Other revenues include miscellaneous health care related earnings.

	Year Ended December 31,		
	2015	2014	2013

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		<i>(in thousands)</i>	
Insurance services	\$ 7,012	\$ 7,215	\$ 15,143
Management and accounting service fees	14,586	15,184	18,160
Rental income	19,191	19,123	19,132
Other	987	874	685
	\$ 41,776	\$ 42,396	\$ 53,120

Insurance Services

For workers' compensation insurance services, the premium revenues reflected in the consolidated statements of income for the years ended December 31, 2015, 2014 and 2013 were \$4,215,000, \$4,434,000, and \$7,720,000, respectively. Associated losses and expenses are reflected in the consolidated statements of income as "Salaries, wages and benefits."

For professional liability insurance services, the premium revenues reflected in the consolidated statements of income for the years ended December 31, 2015, 2014 and 2013 were \$2,797,000, \$2,781,000, and \$3,418,000, respectively. Associated losses and expenses including those for self-insurance are included in the consolidated statements of income as "Other operating costs and expenses".

Management Fees from National

We have managed skilled nursing facilities for National since 1988, and we currently manage five centers. See Note 2 regarding our relationship with National.

During 2015, 2014 and 2013, National paid and we recognized approximately \$3,599,000, \$3,544,000, and \$3,491,000, respectively, of management fees and interest on management fees. Unrecognized and unpaid management fees and interest on management fees from National total \$21,345,000, \$21,338,000, and \$21,349,000 at December 31, 2015, 2014 and 2013, respectively. We have recognized approximately \$44,764,000 of management fees and interest from these facilities since 1988.

The unpaid fees from these five facilities, because the amount collectable could not be reasonably determined when the management services were provided, and because we cannot estimate the timing or amount of expected future collections, will be recognized as revenues only when the collectability of these fees can be reasonably assured. Under the terms of our management agreement with National, the payment of these fees to us may be subordinated to other expenditures of the five skilled nursing facilities. We continue to manage these facilities so that we may be able to collect our fees in the future and because the incremental savings from discontinuing services to a facility may be small compared to the potential benefit. We may receive payment for the unrecognized management fees in whole or in part in the future only if cash flows from the operating and investing activities of centers or proceeds from the sale

of the centers are sufficient to pay the fees. There can be no assurance that such future improved cash flows will occur.

Management Fees and Financial and Accounting Services for Other Healthcare Centers

During 2015 and 2014, we provided management services to six healthcare facilities (in addition to the five National centers) operated by third party owners. For the years ended December 31, 2015 and 2014, we recognized management fees of \$2,490,000 and \$2,205,000 from these centers, respectively. During 2013, we provided management services to 21 healthcare centers and recognized management fees of \$4,413,000 from these centers.

During 2015, we provided accounting and financial services to 20 healthcare facilities. During 2014 and 2013, we provided accounting and financial services to 27 healthcare facilities. No management services are provided for entities in which we provide accounting and financial services.

Rental Income

The health care properties currently owned and leased to third party operators are located in the states of Florida and Tennessee. These properties consist of nine skilled nursing facilities and four assisted living facilities. Effective January 1, 2016, we entered into a new triple net lease agreement for eleven of the thirteen properties. The new lease agreement is for a ten year period and ends on December 31, 2025.

Note 4 Non-Operating Income

Non-operating income is outlined in the table below. Non-operating income includes equity in earnings of unconsolidated investments, dividends and other realized gains and losses on securities, interest income, and other miscellaneous non-operating income. Our most significant equity method investment is a 75.1% non-controlling ownership interest in Caris, a business that specializes in hospice care services. See Note 16 for additional disclosures regarding Caris. For the year ended December 31, 2013, the gain on the recovery of notes receivable was due to the collection of certain notes receivable. The Company had previously written down these notes due to their deteriorated credit qualities.

	Year Ended December 31,		
	2015	2014	2013

		<i>(in thousands)</i>	
Equity in earnings of unconsolidated investments	\$ 5,845	\$ 6,675	\$ 14,188
Dividends and net realized gains on sales of securities	6,809	5,957	5,216
Interest income	5,494	4,550	5,237
Gain on the recovery of notes receivable			5,454
	\$ 18,148	\$ 17,182	\$ 30,095

Note 5 Long-Term Leases

Capital Leases

Effective March 1, 2014, NHC began leasing and operating three senior healthcare facilities in the state of Missouri under three separate lease agreements. Two of the healthcare facilities are skilled nursing facilities that also include assisted living facilities and the third healthcare facility is a memory care facility. Each of the leases is a ten year lease with two five-year renewal options. Under the terms of the leases, base rent totals \$5,200,000 annually with rent thereafter escalating by 4% of the increase in facility revenue over the 2014 base year. The leases also contain certain non-performance default provisions which resulted in capital lease classification. However, the initial measurement and recording of the capital lease assets and obligations does not include any expected payments under such default provisions, as the Company does not expect to incur an obligation for such payments.

Fixed assets recorded under the capital leases, which are included in property and equipment in the consolidated balance sheets, are as follows:

	December 31, 2015	<i>(in thousands)</i>	December 31, 2014
Buildings and personal property	\$ 39,032		\$ 39,032
Accumulated amortization	(7,196)		(3,271)
	\$ 31,836		\$ 35,761

Operating Leases

At December 31, 2015, we lease from National Health Investors, Inc. ("NHI") the real property of 35 skilled nursing facilities, seven assisted living centers and three independent living centers under two separate lease agreements. As part of the first lease agreement, we sublease four Florida skilled nursing facilities to a third party operator.

On January 1, 2007, a 15-year lease extension began which included three additional five-year renewal options. On December 26, 2012, NHC extended the lease agreement through the first of the three additional five-year renewal options, which extended the lease date through 2026. The two additional five-year renewal options on the lease still remain. Under the terms of the lease, base rent totals \$30,750,000 with rent thereafter escalating by 4% of the increase in facility revenue over a 2007 base year.

On September 1, 2013 and under the second lease agreement, NHC began operating seven skilled nursing facilities in New Hampshire and Massachusetts. The 15 year lease term consists of base rent of \$3,450,000 annually with rent escalating by 4% of the increase in facility revenue over a 2014 base year. Additionally, NHC has the option to purchase the seven facilities from NHI in the 13th year of the lease for a purchase price of \$49,000,000.

Base rent expense under both NHI lease agreements totals \$34,200,000. Percentage rent under the leases is based on a quarterly calculation of revenue increases and is payable on a quarterly basis. Percentage rent expense under both leases for 2015, 2014, and 2013 was approximately \$2,510,000, \$2,334,000, and \$2,526,000, respectively.

Each lease with NHI is a "triple net lease" under which we are responsible for paying all taxes, utilities, insurance premium costs, repairs and other charges relating to the ownership of the facilities. We are obligated at our expense to maintain adequate insurance on the facilities' assets.

We have a right of first refusal with NHI to purchase any of the properties should NHI receive an offer from an unrelated party during the term of the lease or up to 180 days after termination of the related lease.

Minimum Lease Payments

The approximate future minimum lease payments required under all leases that have remaining non-cancelable lease terms at December 31, 2015 are as follows:

	Operating Leases	Capital Leases
	<i>(in thousands)</i>	
2016	\$ 34,200	\$ 5,200
2017	34,200	5,200
2018	34,200	5,200
2019	34,200	5,200
2020	34,200	5,200
Thereafter	210,950	16,466
Total minimum lease payments	\$ 381,950	\$ 42,466

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Less: Amounts representing interest		(8,959)
Present value of minimum lease payments		33,507
Less: Current portion		(3,279)
Long-term capital lease obligations	\$	30,228

Note 6 Earning Per Share

The following table summarizes the earnings and the weighted average number of common shares used in the calculation of basic and diluted earnings per share.

		Year Ended December 31,		
		2015	2014	2013
		<i>(dollars in thousands, except share and per share amounts)</i>		
Basic:				
	Weighted average common shares outstanding	13,889,134	13,816,095	13,829,626
	Net income	\$ 53,143	\$ 53,369	\$ 64,613
	Dividends to preferred stockholders	6,819	8,670	8,671
	Net income available to common stockholders	\$ 46,324	\$ 44,699	\$ 55,942
	Earnings per common share, basic	\$ 3.34	\$ 3.24	\$ 4.05
Diluted:				
	Weighted average common shares outstanding	13,889,134	13,816,095	13,829,626
	Dilutive effect of stock options	144,793	73,678	9,091
	Dilutive effect of restricted stock	1,183	3,691	4,740
	Dilutive effect of contingent issuable stock	456,323	328,669	232,118
	Convertible preferred stock			2,623,228
	Assumed average common shares outstanding	14,491,433	14,222,133	16,698,803
	Net income available to common stockholders	\$ 46,324	\$ 44,699	\$ 55,942
	Add dilutive preferred stock dividends for effect of assumed conversion of preferred stock			8,671
	Net income for diluted earnings per common share	\$ 46,324	\$ 44,699	\$ 64,613
	Earnings per common share, diluted	\$ 3.20	\$ 3.14	\$ 3.87

For the year ended December 31, 2013, 929,000 shares associated with stock options have been excluded in the table above due to their antidilutive impact.

Note 7 Investments in Marketable Securities

Our investments in marketable securities include available for sale securities. Realized gains and losses from securities sales are determined on the specific identification of the securities. Marketable securities and restricted marketable securities consist of the following:

	December 31, 2015		December 31, 2014	
	Amortized	Fair	Amortized	Fair
	Cost	Value	Cost	Value
<i>(in thousands)</i>				
Investments available for sale:				
Marketable equity securities	\$ 30,176	\$ 116,168	\$ 30,176	\$ 132,535
Restricted investments available for sale:				
Corporate debt securities	71,960	71,143	68,594	68,916
Mortgage-backed securities	61,645	60,910	63,351	63,252
U.S. Treasury securities	21,123	21,033	14,623	14,728
State and municipal securities	16,446	16,780	11,074	11,377
	\$ 201,350	\$ 286,034	\$ 187,818	\$ 290,808

Included in the available for sale marketable equity securities are the following *(in thousands, except share amounts)*:

	December 31, 2015			December 31, 2014		
	Shares	Cost	Fair Value	Shares	Cost	Fair Value
NHI Common Stock	1,630,642	\$ 24,734	\$ 99,257	1,630,642	\$ 24,734	\$ 114,080

The amortized cost and estimated fair value of debt securities classified as available for sale, by contractual maturity, are as follows:

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<i>(in thousands)</i>	December 31, 2015		December 31, 2014	
	Cost	Fair Value	Cost	Fair Value
Maturities:				
Within 1 year	\$ 23,291	\$ 23,273	\$ 11,161	\$ 11,190
1 to 5 years	74,747	74,671	83,542	84,028
6 to 10 years	71,442	70,223	58,863	58,872
Over 10 years	1,694	1,699	4,076	4,183
	\$ 171,174	\$ 169,866	\$ 157,642	\$ 158,273

Gross unrealized gains related to available for sale securities are \$86,921,000 and \$103,814,000 as of December 31, 2015 and 2014, respectively. Gross unrealized losses related to available for sale securities were \$2,237,000 and \$824,000 as of December 31, 2015 and 2014, respectively. For the marketable securities in gross unrealized loss positions, (a) it is more likely than not that the Company will not be required to sell the investment securities before recovery of the unrealized losses, and (b) the Company expects that the contractual principal and interest will be received on the investment securities. As a result, the Company recognized no other-than-temporary impairments for the years ended December 31, 2015 and 2014.

Proceeds from the sale of investments in marketable securities during the years ended December 31, 2015, 2014 and 2013 were \$47,574,000, \$48,786,000, and \$81,389,000, respectively. Net investment gains of \$566,000, \$379,000, and \$39,000 were realized on these sales during the years ended December 31, 2015, 2014, and 2013, respectively.

Note 8 Fair Value Measurements

The accounting standard for fair value measurements provides a framework for measuring fair value and requires expanded disclosures regarding fair value measurements. Fair value is defined as the price that would be received for an asset or the exit price that would be paid to transfer a liability in the principal or most advantageous market in an orderly transaction between market participants on the measurement date. This accounting standard establishes a fair value hierarchy, which requires an entity to maximize the use of observable inputs, where available. The following summarizes the three levels of inputs that may be used to measure fair value:

Level 1 The valuation is based on quoted prices in active markets for identical instruments.

Level 2 The valuation is based on observable inputs such as quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market.

Level 3 The valuation is based on unobservable inputs that are supported by minimal or no market activity and that are significant to the fair value of the instrument. Level 3 valuations are typically performed using pricing models, discounted cash flow methodologies, or similar techniques that incorporate management's own estimates of assumptions that market participants would use in pricing the instrument, or valuations that require significant

management judgment or estimation.

A financial instrument's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement.

Valuation of Marketable Securities

The Company determines fair value for marketable securities with Level 1 inputs through quoted market prices. The Company determines fair value for marketable securities with Level 2 inputs through broker or dealer quotations or alternative pricing sources with reasonable levels of price transparency. Our Level 2 marketable securities have been initially valued at the transaction price and subsequently valued, at the end of each month, typically utilizing third party pricing services or other market observable data. The pricing services utilize industry standard valuation models, including both income and market based approaches and observable market inputs to determine value. These observable market inputs include reportable trades, benchmark yields, credit spreads, broker/dealer quotes, bids, offers, and other industry and economic events.

We validated the prices provided by our broker by reviewing their pricing methods, obtaining market values from other pricing sources, analyzing pricing data in certain instances and confirming that the relevant markets are active. After completing our validation procedures, we did not adjust or override any fair value measurements provided by our broker as of December 31, 2015 or 2014. We did not have any transfers of assets between Level 1 and Level 2 of the fair value measurement hierarchy during the years ended December 31, 2015, 2014, or 2013.

Other

The carrying amounts of cash and cash equivalents, restricted cash and cash equivalents, accounts receivable, and accounts payable approximate fair value due to their short-term nature. The estimated fair value of notes receivable approximates the carrying value based principally on their underlying interest rates and terms, maturities, collateral and credit status of the receivables. Our long-term debt approximates fair value due to variable interest rates. At December 31, 2015 and 2014, there were no material differences between the carrying amounts and fair values of NHC's financial instruments.

The following table summarizes fair value measurements by level at December 31, 2015 and December 31, 2014 for assets and liabilities measured at fair value on a recurring basis (*in thousands*):

Fair Value Measurements Using

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		Quoted Prices in Active Markets		
	Fair	For Identical Assets	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
December 31, 2015	Value	(Level 1)		
Cash and cash equivalents	\$ 38,208	\$ 38,208	\$	\$
Restricted cash and cash equivalents	11,106	11,106		
Marketable equity securities	116,168	116,168		
Corporate debt securities	71,143	32,683	38,460	
Mortgage-backed securities	60,910		60,910	
U.S. Treasury securities	21,033	21,033		
State and municipal securities	16,780		16,780	
Total financial assets	\$ 335,348	\$ 219,198	\$ 116,150	\$

		Fair Value Measurements Using Quoted Prices in Active Markets		
	Fair	For Identical Assets	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
December 31, 2014	Value	(Level 1)		
Cash and cash equivalents	\$ 69,767	\$ 69,767	\$	\$
Restricted cash and cash equivalents	10,651	10,651		
Marketable equity securities	132,535	132,535		
Corporate debt securities	68,916	39,909	29,007	
Mortgage-backed securities	63,252		63,252	
U.S. Treasury securities	14,728	14,728		
State and municipal securities	11,377	2,216	9,161	
Total financial assets	\$ 371,226	\$ 269,806	\$ 101,420	\$

Note 9 Property and Equipment

Property and equipment, at cost, consists of the following:

	2015	December 31, (in thousands)	2014
Land	\$ 59,831		\$ 58,672

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Leasehold improvements	103,445	98,302
Buildings and improvements	507,627	487,021
Furniture and equipment	150,357	142,110
Construction in progress	54,027	35,687
	875,287	821,792
Less: Accumulated depreciation	(339,241)	(307,048)
	\$ 536,046	\$ 514,744

The Company estimates the cost to complete construction in progress is approximately \$29,850,000 at December 31, 2015.

Note 10 Notes Receivable

At December 31, 2015 and 2014, we have notes receivable from managed and other skilled nursing facilities totaling \$13,164,000 and \$12,989,000, respectively, reflected in the accompanying consolidated balance sheets. The notes are first and second mortgages with interest rates ranging from prime plus 2% to 8% fixed rate with periodic payments required prior to maturity. The notes mature in the years from 2016 through 2023. The proceeds of the notes were used by the skilled nursing facilities for construction costs, development costs incurred during construction, and working capital.

Note 11 Long-Term Debt

Long-term debt consists of the following (*dollars in thousands*):

	Interest Rate at Dec. 31, 2015	Maturities	December 31,	
			2015	2014
Credit Facility, interest payable monthly	Variable, 1.6%	2020	\$ 110,000	\$
Unsecured term note payable to National, interest payable quarterly, principal payable at maturity	Variable, 3.0%	2018	10,000 120,000	10,000 10,000
Less current portion			\$ 120,000	\$ 10,000

\$175,000,000 Credit Facility

On October 7, 2015, we entered into a \$175 million Credit Agreement with Bank of America that replaces our former \$75 million credit facility. The maturity date of the new credit facility is October 7, 2020. Loans bear interest at either (i) LIBOR plus 1.40% or (ii) the base rate plus 0.40%. The base rate is defined as the highest of (a) the Federal Funds Rate plus ½ of 1%, (b) the Bank of America prime rate, and (c) LIBOR plus 1.00%. The credit facility is available for general corporate purposes, including working capital and acquisitions. NHC is permitted, upon required notice to the lender, to prepay the loans outstanding under the credit facility at any time, without penalty.

The Credit Agreement contains customary representations and financial covenants, including covenants that restrict, among other things, asset dispositions, mergers and acquisitions, dividends, restricted payments, debt, liens, investments and affiliate transactions. The Credit Agreement contains customary events of default.

The aggregate maturities of long-term debt for the five years subsequent to December 31, 2015 are as follows:

	Long-Term Debt (in thousands)	
2016	\$	–
2017		–
2018		10,000
2019		–
2020		110,000
Total	\$	120,000

Note 12 – Income Taxes

The provision for income taxes is comprised of the following components:

	2015	Year Ended December 31, 2014		2013
		(in thousands)		
Current Tax Provision				
Federal	\$ 29,322	\$ 30,235	\$	34,680

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State	3,568	3,095	5,588
	32,890	33,330	40,268
Deferred Tax Provision			
Federal	(532)	(1,172)	(2,226)
State	(227)	(334)	(479)
	(759)	(1,506)	(2,705)
Income Tax Provision	\$ 32,131	\$ 31,824	\$ 37,563

During November 2015, the FASB issued ASU 2015-17, "Balance Sheet Classification of Deferred Taxes, which simplifies the presentation of deferred income taxes. This ASU requires that deferred tax assets and liabilities be classified as non-current in a statement of financial position. We early adopted ASU 2015-17 effective December 31, 2015 on a prospective basis. Adoption of this ASU resulted in a reclassification of our net current deferred tax liability to the net non-current deferred tax liability in our Consolidated Balance Sheet as of December 31, 2015. No prior periods were retrospectively adjusted.

The deferred tax assets and liabilities, consisting of temporary differences tax effected at the respective income tax rates, are as follows:

	December 31,	
	2015	2014
	<i>(in thousands)</i>	
Current deferred tax asset:		
Allowance for doubtful accounts receivable	\$ 2,055	\$ 2,138
Accrued risk reserves	842	964
Accrued expenses	4,860	3,635
	7,757	6,737
Current deferred tax liability:		
Unrealized gains on marketable securities	(33,502)	(39,958)
Other	(2,344)	(2,284)
	(35,846)	(42,242)
Net current deferred tax liability	\$ (28,089)	\$ (35,505)
Noncurrent deferred tax asset:		
Unrealized gains on marketable securities	\$ 423	\$ (183)
Financial reporting depreciation in excess of tax depreciation	9,142	7,191
Deferred gain on sale of assets (net)	(3,135)	(3,135)
Tax basis intangible asset in excess of financial reporting basis	(945)	(409)
Stock-based compensation	3,511	2,879
Long-term investments	(2,962)	(2,445)
Nonrefundable entrance fees	163	129
Refundable entrance fees	1,830	1,739
Obligation to provide future services	1,342	1,532
Accrued risk reserves, less current portion	1,806	2,295
Accrued expenses	3,560	2,910
Deferred revenue	4,258	6,197
Net noncurrent deferred tax asset	\$ 18,993	\$ 18,700
Net deferred income tax liability	\$ (9,096)	\$ (16,805)

A reconciliation of income tax expense and the amount computed by applying the statutory federal income tax rate to income before income taxes is as follows:

	Year Ended December 31,		
	2015	2014	2013
		<i>(in thousands)</i>	
Tax provision at federal statutory rate	\$ 29,846	\$ 29,818	\$ 35,762
Increase (decrease) in income taxes			
resulting from:			
State, net of federal benefit	1,767	2,207	2,325
Nondeductible expenses	351	363	197
Insurance expense	6	27	35
Other, net	(372)	439	(258)
Unrecognized tax benefits	2,674	512	1,107
Expiration of statute of limitations	(2,141)	(1,542)	(1,605)
	2,285	2,006	1,801
Effective income tax expense	\$ 32,131	\$ 31,824	\$ 37,563

The exercise of non-qualified stock options results in state and federal income tax benefits to the Company related to the difference between the market price at the date of exercise and the option exercise price. During 2015, 2014 and 2013, \$1,942,000, \$201,000, and \$(225,000), respectively, attributable to the tax benefit of stock options exercised and restricted stock vested, was credited to additional paid-in capital.

Our deferred tax assets have been evaluated for realization based on historical taxable income, tax planning strategies, the expected timing of reversals of existing temporary differences and future taxable income anticipated. Our deferred tax assets are more likely than not to be realized in full due to the existence of sufficient taxable income of the appropriate character under the tax law. As such, there is no need for a valuation allowance.

Uncertain tax positions may arise where tax laws may allow for alternative interpretations or where the timing of recognition of income is subject to judgment. We believe we have adequate provisions for unrecognized tax benefits related to uncertain tax positions. However, because of uncertainty of interpretation by various tax authorities and the possibility that there are issues that have not been recognized by management, we cannot guarantee we have accurately estimated our tax liabilities. We believe that our liabilities reflect the anticipated outcome of known uncertain tax positions in conformity with ASC Topic 740 *Income Taxes*. Our liabilities for unrecognized tax benefits are presented in the consolidated balance sheets within other noncurrent liabilities.

Also under ASC Topic 740, tax positions are evaluated for recognition using a more likely than not threshold, and those tax positions requiring recognition are measured at the largest amount of tax benefit that is greater than 50 percent likely of being realized upon ultimate settlement with a taxing authority that has full knowledge of all relevant

information.

In accordance with current guidance, the Company has established a liability for unrecognized tax benefits, which are differences between a tax position taken or expected to be taken in a tax return and the benefit recognized and measured. Generally a liability is created for an unrecognized tax benefit because it represents a company's potential future obligation to a taxing authority for a tax position that was not recognized per above.

A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows (in thousands):

	Deferred Tax Asset	Liability For Unrecognized Tax Benefits	Liability For Interest and Penalties	Liability Total
Balance, January 1, 2013	\$ 8,655	\$ 11,996	\$ 1,894	\$ 13,890
Additions based on tax positions related to the current year	—	1,832	198	2,030
Additions for tax positions of prior years	2,120	1,427	641	2,068
Reductions for statute of limitation expirations	(2,177)	(2,802)	(661)	(3,463)
Balance, December 31, 2013	8,598	12,453	2,072	14,525
Additions based on tax positions related to the current year	—	2,008	216	2,224
Additions for tax positions of prior years	2,032	1,218	706	1,924
Reductions for statute of limitation expirations	(1,523)	(2,059)	(603)	(2,662)
Balance, December 31, 2014	9,107	13,620	2,391	16,011
Additions based on tax positions related to the current year	—	1,595	308	1,903
Additions for tax positions of prior years	490	498	1,298	1,796
Reductions for statute of limitation expirations	(1,779)	(2,551)	(865)	(3,416)
Balance, December 31, 2015	\$ 7,818	\$ 13,162	\$ 3,132	\$ 16,294

During the year ended December 31, 2015, we have recognized a \$2,551,000 decrease in unrecognized tax benefits (including \$1,275,000 of temporary differences and \$1,276,000 of permanent differences) and an accompanying \$865,000 decrease of related interest and penalties due to the effect of statute of limitations lapse. The favorable impact on our tax provision was \$2,141,000 composed of \$1,276,000 tax and \$769,000 interest and penalties on permanent differences and \$96,000 interest and penalties on temporary differences.

At December 31, 2015, we had \$13,162,000 of unrecognized tax benefits, composed of \$7,331,000 of deferred tax assets and \$5,831,000 of permanent differences. Accrued interest and penalties of \$3,132,000 related to unrecognized tax benefits at December 31, 2015. Unrecognized tax benefits of \$5,831,000, net of federal benefit, at December 31, 2015, attributable to permanent differences, would favorably impact our effective tax rate if recognized. Accrued interest and penalties of \$2,960,000 relate to these permanent differences at December 31, 2015. We do not expect to recognize significant increases or decreases in unrecognized tax benefits within the twelve months beginning December 31, 2015, except for the effect of decreases related to the lapse of statute of limitations estimated at \$2,060,000, composed of temporary differences of \$842,000 and permanent differences of \$1,218,000. Interest and penalties of \$620,000 relate to these temporary and permanent difference changes within 12 months beginning December 31, 2015.

During the year ended December 31, 2014, we have recognized a \$2,059,000 decrease in unrecognized tax benefits (including \$1,120,000 of temporary differences and \$939,000 of permanent differences) and an accompanying \$603,000 decrease of related interest and penalties due to the effect of statute of limitations lapse. The favorable impact on our tax provision was \$1,542,000 composed of \$939,000 tax and \$492,000 interest and penalties on permanent differences and \$111,000 interest and penalties on temporary differences.

At December 31, 2014, we had \$13,620,000 of unrecognized tax benefits, composed of \$8,725,000 of deferred tax assets and \$4,895,000 of permanent differences. Accrued interest and penalties of \$2,391,000 related to unrecognized tax benefits at December 31, 2014. Unrecognized tax benefits of \$4,895,000, net of federal benefit, at December 31, 2014, attributable to permanent differences, would favorably impact our effective tax rate if recognized. Accrued interest and penalties of \$2,118,000 relate to these permanent differences at December 31, 2014. We do not expect to recognize significant increases or decreases in unrecognized tax benefits within the twelve months beginning December 31, 2014, except for the effect of decreases related to the lapse of statute of limitations estimated at \$2,585,000, composed of temporary differences of \$1,520,000, and permanent differences of \$1,065,000. Interest and penalties of \$615,000 relate to these temporary and permanent difference changes within 12 months beginning December 31, 2014.

During the year ended December 31, 2013, we have recognized a \$2,802,000 decrease in unrecognized tax benefits (including \$1,817,000 of temporary differences and \$985,000 of permanent differences) and an accompanying \$661,000 decrease of related interest and penalties due to the effect of statute of limitations lapse. The favorable impact on our tax provision was \$1,605,000 composed of \$976,000 tax and \$451,000 interest and penalties on permanent differences and \$178,000 interest and penalties on temporary differences.

At December 31, 2013, we had \$12,453,000 of unrecognized tax benefits, composed of \$8,253,000 of deferred tax assets and \$4,200,000 of permanent differences. Accrued interest and penalties of \$2,072,000 related to unrecognized tax benefits at December 31, 2013. Unrecognized tax benefits of \$4,200,000, net of federal benefit, at December 31, 2013, attributable to permanent differences, would favorably impact our effective tax rate if recognized. Accrued interest and penalties of \$1,835,000 relate to these permanent differences at December 31, 2013. We do not expect to recognize significant increases or decreases in unrecognized tax benefits within the twelve months beginning December 31, 2013, except for the effect of decreases related to the lapse of statute of limitations estimated at \$2,330,000, composed of temporary differences of \$1,390,000, and permanent differences of \$940,000. Interest and penalties of \$566,000 relate to these temporary and permanent difference changes within 12 months beginning

December 31, 2013.

Interest and penalties expense related to U.S. federal and state income tax returns are included within income tax expense. Interest and penalties expense was \$740,000, \$319,000, and \$178,000 for the years ended December 31, 2015, 2014, and 2013, respectively.

The Company is no longer subject to U.S. federal and state examinations by tax authorities for years before 2012 (with few state exceptions). Currently, the 2012 U.S. federal return is under examination.

Note 13 Stock Repurchase Program

On May 7, 2015, the Board of Directors authorized two new stock repurchase programs, one that will allow for repurchase of up to \$25 million of its common stock and one that allowed for the repurchase of up to \$25 million of its preferred stock. As of November 3, 2015, all of the Company's preferred stock was redeemed. Therefore, no future repurchases of the preferred stock will be performed. The common stock repurchase plan expires on August 31, 2016. No repurchases of common stock have been executed under the current program.

Under the previously approved repurchase plans, the Company repurchased 125,000 shares of its common stock on August 11, 2014 for a total cost of \$6,995,000. On February 19, 2013, the Company repurchased 100,000 shares for a total cost of \$4,700,000. These two repurchases were funded from cash on hand and were cancelled and returned to the status of authorized but unissued.

Under the common stock repurchase program, the Company may repurchase its common stock from time to time, in amounts and at prices the Company deems appropriate, subject to market conditions and other considerations. The Company's repurchases may be executed using open market purchases, privately negotiated agreements or other transactions. The Company intends to fund repurchases under the new stock repurchase programs from cash on hand, available borrowings or proceeds from potential debt or other capital market sources. The stock repurchase programs may be suspended or discontinued at any time without prior notice. The Company will provide an update regarding any purchases made pursuant to the stock repurchase programs each time it reports its results of operations.

Note 14 Stock-Based Compensation

NHC recognizes stock-based compensation for all stock options and restricted stock granted over the requisite service period using the fair value for these grants as estimated at the date of grant either using the Black-Scholes pricing model for stock options or the quoted market price for restricted stock.

The 2005 and 2010 Stock-Based Compensation Plans

The Compensation Committee of the Board of Directors ("the Committee") has the authority to select the participants to be granted options; to designate whether the option granted is an incentive stock option ("ISO"), a non-qualified option, or a stock appreciation right; to establish the number of shares of common stock that may be issued upon exercise of the option; to establish the vesting provision for any award; and to establish the term any award may be outstanding. The exercise price of any ISOs granted will not be less than 100% of the fair market value of the shares of common stock on the date granted and the term of an ISO may not be any more than ten years. The exercise price of