NATIONAL HEALTHCARE CORP
Form 10-K
February 20, 2019

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

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FORM 10–K
(Mark One)
[X] ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES AND EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2018
OR
[ ] TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from _____ to _____

Commission File No. 001–13489

_____

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

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

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

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

Title of Each Class	Name of Each Exchange on which Registered
Shares of Common Stock	**NYSE-American**

_____

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

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

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

Indicate by check mark whether the registrant (1) has filed all reports

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted 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 such files). Yes [x] No [ ]

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S–K (§ 229.405 of this chapter) 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, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act. Large accelerated filer [x] Accelerated filer [ ] Non–accelerated filer [ ] Smaller reporting company [ ] Emerging growth company [ ]

If an emerging growth company, indicate by checkmark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. [ ]

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

The aggregate market value of Common Stock held by non–affiliates on June 30, 2018 (based on the closing price of such shares on the NYSE American) was approximately $705 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 18, 2019 was 15,255,921.

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 2019 shareholder's meeting.

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CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

Statements in this annual filing that are not historical facts are forward-looking statements. NHC cautions investors that any forward-looking statements made involve risks and uncertainties and are not guarantees of future performance. The risks and uncertainties include, among others, the following: liabilities and other claims asserted against us and patient care liabilities, as well as the resolution of current litigation; availability of insurance and assets for indemnification; national and local economic conditions, including their effect on the availability and cost of labor, utilities and materials; the effect of government regulations and changes in regulations governing the healthcare industry, including our compliance with such regulations; changes in Medicare and Medicaid payment levels and methodologies and the application of such methodologies by the government and its fiscal intermediaries; and other factors referenced in this annual filing.

Investors should also refer to the risks identified in "Part 1. Item 1A. Risk Factors" for a discussion of various risk factors of the Company and that are inherent in the health care industry. Given these risks and uncertainties, we can give no assurance that these forward-looking statements will, in fact, transpire and, therefore, caution investors not to place undue reliance on them. The risks included here are not exhaustive. All forward-looking statements represent NHC's best judgment as of the date of this filing.

PART 1

ITEM 1. BUSINESS

General Development of Business

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

Narrative Description of the Business

At December 31, 2018, we operated or managed 75 skilled nursing facilities with a total of 9,510 licensed beds. These numbers include 28 facilities that are owned with 3,632 beds, 39 facilities that are leased with 4,963 beds, and eight facilities that are managed for others with 915 beds. Of the 39 leased facilities, 35 are leased from National Health Investors, Inc. ("NHI").

Our 24 assisted living facilities (twelve owned, nine leased, and three managed) have 1,132 units (884 units owned, 205 units leased, and 43 units managed).

Our five independent living facilities (one owned, three leased, and one managed) have 475 retirement apartments (93 apartments owned, 245 apartments leased, and 137 apartments managed).

We acquired a controlling ownership interest in a 14-bed behavioral health hospital in August 2018. This hospital specializes in geriatric behavioral health and is the only behavioral health hospital the Company currently operates.

We operated 35 homecare programs licensed in three states (Tennessee, South Carolina, and Florida) and provided 387,798 homecare patient visits in 2018.

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

We operate specialized care units within some of our healthcare facilities such as Alzheimer's disease care units and sub–acute nursing units. Similar specialty units are under consideration at several of our facilities, as well as free standing projects.

Net Patient Revenues. Health care services we provide include a comprehensive range of services. In fiscal 2018, 95.1% of our net operating revenues were derived from such health care services. Highlights of health care services activities during 2018 were as follows:

Skilled Nursing Facilities. The most significant portion of our business and the base for our other health care services is the operation of our skilled nursing facilities (“SNF’s”). 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. 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 eight facilities that we manage. We generally charge 6% of facility net operating revenues for our management services.

The following table shows the occupancy rates for our owned and leased skilled nursing facilities:

	Year Ended December 31,		
	2018	2017	2016
Overall census	89.8%	90.2%	89.5%

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 1,800 highly trained, professional therapists in 2018. Most of our rehabilitative services are for patients in our owned and managed skilled nursing facilities. However, we also provide services to over 70 additional health care providers. Our rates for these services are competitive with other market rates.

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

Assisted Living Facilities. Our assisted living facilities provide 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. In 2018, the rate of occupancy was 78.7%. The occupancy rate for 2018 is lower primarily due to the two newly constructed assisted living facilities that began operations during 2017. Certificates of Need ("CONs") are not required to build these projects in most states and we believe overbuilding has occurred in some of our markets.

Independent Living Facilities. Our 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 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 to all of our senior care offerings and services.

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

Homecare Programs. Our home health care programs ("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. Under the Medicare reimbursement payment system, we receive a prospectively determined amount per patient per 60-day episode. Under our managed care contracts, we may receive a 60-day episode payment or be paid by a per-visit payment model. Medicare episodes in 2018 were 16,436. In 2018, we served an average census of 3,652 patients and provided 387,798 visits.

Pharmacy Operations. At December 31, 2018, we operated four regional pharmacy locations (two locations in Tennessee and one location each in South Carolina and Missouri). These pharmacies primarily service our patients that are in an inpatient setting using a central location to deliver pharmaceutical supplies. Our regional pharmacies bill Medicare Part D Prescription Drug Plans (PDPs) electronically and directly for inpatients who have selected a PDP.

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 2018, 4.9% 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% of the managed centers' net operating revenues as a fee for these services. Additionally, we provide accounting and financial services to other healthcare operators. No management services are provided for entities in which we provide accounting and financial services. As of December 31, 2018, we perform management services for twelve healthcare facilities (ten management contracts for third parties and two management contracts where we have an equity method investment) and accounting and financial services for 20 healthcare facilities.

B. **Insurance Services.** NHC owns a Tennessee domestic licensed insurance company. The company is licensed in several states and provides workers' compensation coverage to substantially all NHC's managed healthcare 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 healthcare facilities.

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

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

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

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Quality of Patient Care

Centers for Medicare and Medicaid Services ("CMS") introduced the Five-Star Quality Rating System to help consumers, their families and caregivers compare skilled nursing facilities more easily. The Five-Star Quality Rating System gives each skilled nursing operation a rating of between one and five stars in various categories (five stars being the best). The Company has always strived for patient-centered care and quality outcomes as precursors to outstanding financial performance. The average Five-Star rating for all of our skilled nursing facilities was 4.32 for 2018. The table below summarizes our performance in these quality ratings for the most recent three years:

	As of December 31,		
	2018	2017	2016
Total number of skilled nursing facilities, end of year	75	76	74
Number of 4 and 5-star rated skilled nursing facilities	63	62	54
Percentage of 4 and 5-star rated skilled nursing facilities	84%	82%	73%

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	Bed Addition	44 beds	Charleston, SC	May, 2016
SNF/ALF	New Facility	90 beds / 80 units	Nashville, TN	June, 2016
SNF	Bed Addition	8 beds	Kingsport, TN	September, 2016
SNF	New Facility	112 beds	Columbia, TN	January, 2017
ALF	New Facility	78 units	Bluffton, SC	March, 2017
ALF	New Facility	80 units	Garden City, SC	June, 2017
Memory Care	Bed Addition	23 beds	Murfreesboro, TN	July, 2017
SNF	Bed Addition	30 beds	Springfield, MO	April, 2018
Behavioral Health Hospital	Acquisition	14 beds	Osage Beach, MO	August 2018
Memory Care	New Facility	60 beds	Farragut, TN	January 2019

Business Segments

The Company has two reportable operating segments: (1) inpatient services, which includes the operation of skilled nursing facilities, assisted and independent living facilities, and the one behavioral health hospital, and (2) homecare services. The Company also reports an “all other” category that includes revenues from rental income, management and accounting services fees, insurance services, and costs of the corporate office. See Note 5 in the notes to the consolidated financial statements for further disclosure of the Company’s operating segments.

Customers and Sources of Revenues

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

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

	Year Ended December 31,		
Source	2018	2017	2016
Medicare	35 %	35 %	37 %
Managed Care	12 %	13 %	12 %
Medicaid	26 %	26 %	26 %
Private Pay and Other	27 %	26 %	25 %
Total	100 %	100 %	100 %

We attempt to attract an increased percentage of Medicare, managed care, and private pay 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 skilled nursing 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 a wage index in the 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.

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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 based on 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 sub-acute and other medical specialty services by our owned and managed healthcare facilities.

Regulation and Licenses

Health care is an area of extensive regulatory oversight and frequent regulatory change. The federal government and the states in which we operate regulate various aspects of our business. These regulatory bodies, among other things, require us annually to license our skilled nursing facilities, assisted living facilities in some states and other health care businesses, including home health. 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. 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.

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.

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 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 skilled nursing facilities, owned, leased or managed by us are certified to participate in Medicare. All but eight (seven owned and one managed) of our affiliated skilled nursing facilities participate in Medicaid. All of our homecare offices participate in the Medicare and Medicaid programs, with Medicare comprising the majority of their revenue.

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 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 skilled nursing facilities 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.

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Medicare Legislation and Regulations

Health Care Reform

The health care industry is subject to changing political, regulatory, and other influences, along with the various scientific and technological initiatives. In recent years, the U.S. Congress and certain state legislatures have passed a large number of laws and regulations intended to effect major change within the U.S. health care system, including the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively the "ACA") which represents significant changes to the current U.S. health care system (collectively the "Acts"). However, the law has been subject to legislative and regulatory changes and court challenges. The presidential administration and a number of members of Congress have stated their intent to repeal or make additional significant changes to the ACA, its implementation or interpretation. Effective January 1, 2019, Congress eliminated the penalty associated with the individual mandate to maintain health insurance. In December 2018, as a result of the penalty associated with the individual mandate being eliminated, a federal judge in Texas found that the entire ACA was unconstitutional. However, the law remains in place pending appeal. Additionally, final rules issued in 2018 expand the availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the ACA. These changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased.

Since a significant goal of federal health care reform is to transform the delivery of health care by holding providers accountable for the cost and quality of care provided, Medicare and many commercial third-party payors are implementing Accountable Care Organization ("ACO") models in which groups of providers share in the benefit and risk of providing care to an assigned group of individuals. Other reimbursement methodology reforms in which we are participating or expect to participate in include value–based purchasing, in which a portion of provider reimbursement is redistributed based on relative performance on designated economic, clinical quality, and patient satisfaction metrics. Also, CMS is implementing demonstration programs to bundle acute care and post–acute care reimbursement to hold providers accountable for costs across a broader continuum of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in public and commercial health plans. Providers who respond successfully to these trends and can deliver quality care at lower costs are likely to benefit financially.

Skilled Nursing Facilities

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). At

December 31, 2018, there are 66 classifications of RUG groups.

On August 8, 2018, CMS issued a final rule outlining fiscal year 2019 Medicare payments and quality changes for skilled nursing facilities. The 2019 final rule, which began October 1, 2018, provided for an approximate 2.4% market basket update that was spelled out in the Bipartisan Budget Act of 2018. The market basket increase is expected to increase overall payments to skilled nursing facilities in fiscal year 2019 by $820 million compared to fiscal year 2018 levels.

As part of the final rule and effective October 1, 2019, CMS plans to start using a new case-mix model, called the Patient-Driven Payment Model (“PDPM”), which focuses on a resident’s condition and care needs, rather than the amount of care provided, to determine reimbursement levels. The PDPM utilizes clinically relevant factors for determining Medicare payment by using ICD-10 diagnosis codes and other patient characteristics as the basis for patient classification. PDPM utilizes five case-mix adjusted payment components: physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), nursing and social services (nursing) and non-therapy ancillary services (NTA). It also uses a sixth non-case mix component to cover utilization of SNF resources that do not vary depending on resident characteristics.

PDPM will replace the existing case-mix classification methodology, Resource Utilization Groups, Version IV. The structure of the PDPM moves Medicare towards a more value-based, unified post-acute care payment system. PDPM also removes therapy minutes as the basis for therapy payment and adjusts the SNF per diem payments to reflect varying costs throughout the stay, through the PT, OT and NTA components. In addition, PDPM is intended to reduce paperwork requirements for performing patient assessments. Under the new PDPM system, the payment to skilled nursing facilities will be based heavily on the patient’s condition rather than the specific services provided by each skilled nursing facility.

Homecares (HHAs)

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 based on 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).

On November 13, 2018, CMS published a final rule which updates the Medicare HH PPS rates, including the conversion factor and case-mix weights for calendar years 2019 and 2020. Effective January 1, 2019, CMS estimates the net impact of the PPS rule results in a 2.2% increase ($420 million) in Medicare payments for agencies in 2019. The increase reflects the effects of a 2.2% home health payment update percentage; a 0.1% increase in payments due to decreasing the fixed-dollar-loss ratio in order to pay no more than 2.5% of total payments as outlier payments; and a 0.1% decrease in payments due to the new rural add-on policy mandated by the Bipartisan Budget Act of 2018.

Also published in the final rule and effective January 1, 2020, there will be an elimination of therapy thresholds for payment, implementation of the Patient-Driven Group Model ("PDGM") case-mix methodology refinements and a change in the unit of payment from a sixty (60) day episode to a thirty (30) day episode period. These changes focus on providing value over volume of services to patients. Once the changes are implemented, home health payments will no longer be based on the number of visits provided, but rather the patient's medical condition and care needs.

Medicaid Legislation and Regulations

Skilled Nursing Facilities

State Medicaid plans subject to budget constraints are of particular concern to us. Changes in federal funding coupled with state budget problems and Medicaid expansion under the Affordable Care Act have produced an uncertain environment. States will more likely than not be unable to keep pace with post-acute healthcare inflation. States are under pressure to pursue other alternatives to skilled nursing care such as community and home–based services.

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Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid payments are made under a prospective payment system or under programs which negotiate payment levels with individual providers. The ACA, as currently structured, requires states to expand Medicaid coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level. However, states may opt out of the expansion without losing existing federal Medicaid funding. Some states use, or have applied to use, waivers granted by CMS to implement expansion, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. The presidential administration and a number of members of Congress have indicated their intent to increase state flexibility in the administration of Medicaid programs, including allowing states to condition enrollment on work or other community engagement.

Effective July 1, 2018 and for the fiscal year 2019, the state of Tennessee implemented specific individual nursing facility rate increases. We estimate the resulting increase in revenue for the 2019 fiscal year will be approximately $2,100,000 annually, or $525,000 per quarter.

Effective October 1, 2018 and for the fiscal year 2019, South Carolina implemented specific individual nursing facility rate changes. The resulting increase in revenue beginning October 1, 2018 will be approximately $2,200,000 annually, or $550,000 per quarter.

Effective July 1, 2018 and for the fiscal year 2019, the state of Missouri approved a Medicaid rate increase of $7.76 per patient day to Missouri skilled nursing providers. We estimate the resulting increase in revenue for the 2019 fiscal year will be approximately $2,000,000 annually, or $500,000 per quarter.

Competition

In most of the communities in which we operate health care centers, we compete with other health care centers in the area. We operate 75 skilled nursing facilities located in nine states, all of which require a certificate of need prior to 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 can broaden our patient base and to differentiate our facilities from competing skilled nursing facilities.

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

We experience competition in employing and retaining nurses, technicians, aides and other high quality professional and non–professional employees. 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, which is 24 months in duration, for the professional training of administrators. Presently, we have six full–time individuals in this program. Two of our three regional senior vice presidents, three regional vice presidents, one regional administrator, and 53 of our 75 health care center administrators are graduates of this program.

We experience competition in providing management and accounting services to other senior 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 healthcare facilities 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 ensure 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, 2018, our Administrative Services Contractor (National Health Corporation) had 14,891 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 www.sec.gov.

You may also find on our website at www.nhccare.com electronic copies of our annual reports 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 posted 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.

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We also maintain the following documents on the website:

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.

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 888–568–8578 and the communications may be incognito, if desired.

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 "Business - Medicare Legislation and Regulations".

The industry trend toward value-based purchasing may negatively impact our revenues. There is a growing trend in the healthcare industry among both government and commercial payors toward value-based purchasing of healthcare services. Value-based purchasing programs emphasize quality and efficiency of services, rather than volume of services. For example, the SNF Value-Based Purchasing Program makes incentive payments available based on past performance on specified quality measures related to hospital readmissions. Failure to report quality data or poor performance may negatively impact the amount of reimbursement received.

Other initiatives aimed at improving the cost of care include alternative payment models, such as ACOs and bundled payment arrangements. Medicare and many commercial third-party payors are implementing ACO models in which groups of providers share in the benefit and risk of providing care to an assigned group of individuals at a lower cost. In addition, CMS is implementing programs to bundle acute care and post-acute care reimbursement to hold providers accountable for costs across a broader continuum of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in public and commercial health plans. Providers who respond successfully to these trends and can deliver quality care at lower cost are likely to benefit financially. If we fail to meet or exceed quality performance standards under any applicable value-based purchasing program, perform at a level below the outcomes demonstrated by our competitors, or otherwise fail to effectively provide or coordinate the efficient delivery of quality health care services, our reputation in the industry may be negatively impacted, we may receive reduced reimbursement amounts, and we may owe repayments to payors, causing our revenues to decline. In addition, various healthcare programs and regulations may be ultimately implemented at the federal or state level. Failure to respond successfully to these trends could negatively impact our business, results of operations and/or financial condition.

We cannot predict the effect that further healthcare reform, the possible repeal and replacement of the ACA, and other changes in government programs may have on our business, financial condition or results of operations. Since the adoption of the ACA in 2010, the law has been subject to legislative and regulatory court challenges. The presidential administration and a number of members of Congress have stated their intent to repeal or make additional

significant changes to the ACA, its implementation or interpretation. Effective January 1, 2019, Congress eliminated the penalty associated with the individual mandate to maintain health insurance. In December 2018, as a result of the penalty associated with the individual mandate being eliminated, a federal judge in Texas found that the entire ACA was unconstitutional. However, the law remains in place pending appeal. Additionally, final rules issued in 2018 expand the availability of association health plans and allow the sale of short-term, limited-duration health plans, neither of which are required to cover all of the essential health benefits mandated by the ACA. These changes may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased.

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There is uncertainty regarding whether, when, and how the ACA may be further changed, what alternative provisions, if any, will be enacted, the timing of enactment and implementation of alternative provisions, the impact of alternative provisions on healthcare industry participants, the ultimate outcome of court challenges and how the law will be interpreted and implemented. Changes by Congress or government agencies could eliminate or alter provisions beneficial to us, while leaving in place provisions reducing our reimbursement or otherwise negatively impacting our business. Members of Congress have also proposed measures that would expand government-sponsored coverage, including single-payor proposals. Other industry participants, such as private payors and large employer groups and their affiliates, may also introduce financial or delivery system reforms. We are unable to predict the nature and success of such initiatives.

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. 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 or fee-splitting arrangements between health care providers that are designed to induce the referral of patients to a provider for medical products and services. Furthermore, many states prohibit business corporations from providing or holding themselves out as a provider of medical care.

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.

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, during 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.

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. Furthermore, should we lose licenses or certifications for many 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 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. 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. 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 and security of health information. The Health Insurance Portability and Accountability Act of 1996, or ("HIPAA"), requires the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. In addition, as required by HIPAA, the U.S. Department of Health and Human Services ("HHS") has issued privacy and security regulations that extensively regulate the use and disclosure of individually identifiable health information (known as Protected Health Information, or PHI) and require covered entities, including healthcare providers and health plans, and vendors known as "business associates," to implement administrative, physical and technical safeguards to protect the security of PHI. Covered entities must report breaches of unsecured PHI without

unreasonable delay to affected individuals, HHS and, in the case of larger breaches, the media. The privacy, security and breath notification regulations have imposed, and will continue to impose, significant compliance costs on our operations.

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. These laws vary and may impose additional obligations or penalties. For example, various state laws and regulations may require us to notify affected individuals in the event of a data breach involving individually identifiable information (even if no health-related information is involved). In addition, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions in response to data breaches. To the extent we fail to comply with one or more federal and/or state privacy and security requirements or if we are found to be responsible for the non-compliance of our vendors, we could be subject to substantial fines or penalties, as well as third-party claims, and suffer harm to our reputation, which could have a material adverse effect on our business, financial position, results of operations and liquidity.

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

Due to the rising cost and limited availability of professional liability and workers' compensation insurance, we are largely self–insured on all of these programs and as a result, there is no limit on the maximum number of claims or amount for which we or our insurance subsidiaries can be liable in any policy period. Although we base our loss estimates on independent actuarial analyses using the information we have to date, the amount of the losses could exceed our estimates. In the event our actual liability exceeds our estimates for any given period, our results of operations and financial condition could be materially adversely impacted. In addition, our insurance coverage might not cover all claims made against us. If we are unable to maintain our current insurance coverage, if judgments are obtained in excess of the coverage we maintain, if we are required to pay uninsured punitive damages, or if the number of claims settled within the self–insured retention currently in place significantly increases, we could be exposed to substantial additional liabilities. We cannot assure you that the claims we pay under our self–insurance programs will not exceed the reserves we have set aside to pay claims. The number of claims within the self–insured retention may increase.

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

Testing and maintaining internal controls can divert our management's attention from other matters that are important to our business. We may not be able to conclude on an ongoing basis that we have effective internal controls over financial reporting in accordance with Section 404 or our independent registered public accounting firm may not be able to issue an unqualified report if we conclude that our internal controls over financial reporting are not effective. If either we are unable to conclude that we have effective internal controls over financial reporting or our independent

registered public accounting firm is unable to provide us with an unqualified report as required by Section 404, investors could lose confidence in our reported financial information and our company, which could result in a decline in the market price of our common stock, and cause us to fail to meet our reporting obligations in the future, which in turn could impact our ability to raise additional financing if needed in the future.

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

Significant regulatory changes, including the Sarbanes–Oxley Act and rules and regulations promulgated as a result of the Sarbanes–Oxley Act, have increased, and in the future, are likely to further increase general and administrative costs. In order to comply with the Sarbanes–Oxley Act of 2002, the listing standards of the NYSE 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 ("FASB"), 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.

In February 2016 the FASB issued ASU No. 2016-02, "Leases (Topic 842)." The objective of this update is to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. This ASU is effective for fiscal years beginning after December 15, 2018, including interim periods within those annual periods and is to be applied utilizing a modified retrospective approach. We anticipate this standard will have a material impact on our consolidated financial statements and will result in an increase to total assets and total liabilities. We are currently evaluating the impact this standard will have on our policies and procedures and internal control framework. Though these changes will not have any direct impact on our overall financial condition, these changes could cause investors or others to believe that we are highly leveraged and could change the calculations of financial metrics and covenants, as well as third party financial models regarding our financial condition.

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, 2018, we perform management services (which include financial services) for 12 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.

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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, 2018, we leased or owned 67 skilled nursing facilities, 21 assisted living facilities, and four 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.

We are subject to employment-related laws and regulations which could increase our cost of doing business and subject us to significant back pay awards, fines and lawsuits. Our operations are subject to a variety of federal, state and local employment-related laws and regulations, including, but not limited to, the U.S. Fair Labor Standards Act, which governs such matters as minimum wages, the Family Medical Leave Act, overtime pay, compensable time, record keeping and other working conditions, Title VII of the Civil Rights Act, the Employee Retirement Income Security Act, the Americans with Disabilities Act, the National Labor Relations Act, regulations of the Equal Employment Opportunity Commission, regulations of the Office of Civil Rights, regulations of the Department of Labor (DOL), federal and state wage and hour laws, and a variety of similar laws enacted by the federal and state governments that govern these and other employment-related matters. Because labor represents such a large portion of our operating costs, compliance with these evolving federal and state laws and regulations could substantially increase or cost of doing business while failure to do so could subject us to significant back pay awards, fines and lawsuits. In addition, federal proposals to introduce a system of mandated health insurance and flexible work time and other similar initiatives could, if implemented, adversely affect our operations. Our failure to comply with federal and state employment-related laws and regulations could have a material adverse effect on our business, financial position, results of operations and liquidity.

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.

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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, medical devices that store sensitive data, and the data maintained in those systems and devices, it is possible that our safety and security measures will not prevent improper functioning or the improper access or disclosure of personally identifiable information such as in the event of cyber attacks. 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.

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. As cyber threats continue to evolve, we may be required to expend significant additional resources to continue to modify or enhance our protective measures or to investigate and remediate any cybersecurity vulnerabilities. The occurrence of any of these events could result in harm to patients; business interruptions or delays; the loss, misappropriation, corruption or unauthorized access of data; litigation and potential liability under privacy, security and consumer protection laws or other applicable laws; reputational damage; or federal and state governmental inquiries. Any failure to maintain proper functionality and security of our information systems 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 facilities, 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 that provide services similar to those we offer. 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. 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. Consolidations of not-for-profit entities may intensify this competitive pressure. Many competing general acute care hospitals are larger and more established than our facilities.

There is also increasing consolidation in the third-party payer industry, including vertical integration efforts among third-party payers and healthcare providers. Healthcare industry participants are increasingly implementing physician alignment strategies, such as employing physicians, acquiring physician practice groups and participating in ACOs or other clinical integration models. Other industry participants, such as large employer groups and their affiliates, may intensify competitive pressure and affect the industry in ways that are difficult to predict. Trends toward clinical transparency and value-based purchasing may impact our competitive position and patient volumes.

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 extend, the charges for services. In addition, we compete with other health care providers for customer referrals from hospitals and other providers. As a result, a failure to compete effectively with respect to referrals may have an adverse impact on our business. We cannot assure that increased competition in the future will not adversely affect our financial condition and results of operations.

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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 $110,000,000 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 $55.0 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 waiver, 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.

We are subject to federal and state income taxes. Changes in tax laws and regulations or the interpretation of such laws could adversely affect our position on income taxes and estimated income liabilities. We are subject to both state and federal income taxes in the U.S. and our operations, plans and results are affected by tax and other initiatives. The enactment of The U.S. Tax Cuts and Jobs Act (the "Tax Act") in December 2017 has had a favorable impact on our 2018 net income, earnings per share, and operating cash flow. The year ended December 31, 2017 in connection with the Tax Act, we recorded a tax benefit of $8.5 million during the fourth quarter of 2017. This estimated benefit was due from the revaluation of our net deferred tax liability based on the new lower corporate

income tax rate. The Company considers the accounting for the deferred tax re-measurements and other items to be complete, but ongoing accounting guidance and interpretation could result in adjustments to the consolidated financial statements.

We are also subject to regular reviews, examinations, and audits by the Internal Revenue Service and other taxing authorities with respect to our taxes. There are uncertainties and ambiguities in the application of the Tax Act and it is possible that the IRS cold issue subsequent guidance or take positions on audit that differ from our interpretations and assumptions. Although we believe our tax estimates are reasonable, if a taxing authority disagrees with the positions we have taken, we could face additional tax liability, including interest and penalties. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, change in tax laws and regulations, changes in our interpretations of tax laws, including the Tax Act. Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability. There can be no assurance that payment of such additional amounts upon final adjudication of any disputes will not have a material impact on our results of operations and financial position.

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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 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, tornadoes, 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.

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We may not be able to pay or maintain dividends and the failure to do so would adversely affect our stock price. We currently pay a quarterly dividend on our common stock and our Board intends to continue to pay a quarterly dividend. However, our ability to pay and maintain cash dividends is based on many factors, including our financial condition, funds from operations, the level of our capital expenditures and future business prospects, our ability to make and finance acquisitions, anticipated operating cost levels, the level of demand for our beds, the rates we charge and actual results that may vary substantially from estimates. Some of the factors are beyond our control and a change in any such factor could affect our ability to pay or maintain dividends. The failure to pay or maintain dividends could adversely affect our stock price.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

Skilled Nursing Facilities

State	City	Center Name	Affiliation	Licensed Beds
Alabama	Anniston	NHC HealthCare, Anniston	Leased[(1)]	151
	Moulton	NHC HealthCare, Moulton	Leased[(1)]	136
Georgia	Fort Oglethorpe	NHC HealthCare, Fort Oglethorpe	Owned	135
	Rossville	NHC HealthCare, Rossville	Owned	112
Kentucky	Glasgow	NHC HealthCare, Glasgow	Leased[(1)]	194
Massachusetts	Greenfield	Buckley–Greenfield Health Care Center	Leased[(1)]	120
	Holyoke	Holyoke Health Care Center	Leased[(1)]	102
	Quincy	John Adams Health Care Center	Leased[(1)]	71
	Taunton	Longmeadow of Taunton	Leased[(1)]	100
Missouri	Desloge	NHC HealthCare, Desloge	Leased[(1)]	120
	Independence	The Villages of Jackson Creek	Leased	120
	Independence	The Villages of Jackson Creek Memory Care	Leased	70
	Joplin	NHC HealthCare, Joplin	Leased[(1)]	126

	Kennett	NHC HealthCare, Kennett	Leased[1]	170
	Macon	Macon Health Care Center	Owned	120
	Osage Beach	Osage Beach Rehabilitation and Health Care Center	Owned	94
	St. Charles	NHC HealthCare, St. Charles	Leased[1]	120
	St. Louis	NHC HealthCare, Maryland Heights	Leased[1]	220
	St. Peters	Villages of St. Peters	Leased	130
	Springfield	Springfield Rehabilitation and Health Care Center	Leased	146
	Town & Country	NHC HealthCare, Town & Country	Owned	200
	West Plains	NHC HealthCare, West Plains	Owned	120
New Hampshire	Epsom	Epsom Health Care Center	Leased[1]	108
	Manchester	Maple Leaf Health Care Center	Leased[1]	114
	Manchester	Villa Crest Health Care Center	Leased[1]	126

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Skilled Nursing Facilities (continued)

State	City	Center Name	Affiliation	Licensed Beds
South Carolina	Anderson	NHC HealthCare, Anderson	Leased[1]	290
	Bluffton	NHC HealthCare, Bluffton	Owned	120
	Charleston	NHC HealthCare, Charleston	Owned	132
	Clinton	NHC HealthCare, Clinton	Owned	131
	Columbia	NHC HealthCare, Parklane	Owned	180
	Greenwood	NHC HealthCare, Greenwood	Leased[1]	152
	Greenville	NHC HealthCare, Greenville	Owned	176
	Laurens	NHC HealthCare, Laurens	Leased[1]	176
	Lexington	NHC HealthCare, Lexington	Owned	170
	Mauldin	NHC HealthCare, Mauldin	Owned	180
	Murrells Inlet	NHC HealthCare, Garden City	Owned	148
	North Augusta	NHC HealthCare, North Augusta	Owned	192
	Sumter	NHC HealthCare, Sumter	Managed	138
Tennessee	Athens	NHC HealthCare, Athens	Leased[1]	88
	Chattanooga	NHC HealthCare, Chattanooga	Leased[1]	200
	Columbia	NHC HealthCare, Columbia	Owned	106
	Columbia	NHC-Maury Regional Transitional Care Center	Owned	112
	Cookeville	NHC HealthCare, Cookeville	Managed	94
	Dickson	NHC HealthCare, Dickson	Leased[1]	191
	Dunlap	NHC HealthCare, Sequatchie	Leased[1]	110
	Farragut	NHC HealthCare, Farragut	Owned	106
	Franklin	NHC Place, Cool Springs	Owned	180
	Franklin	NHC HealthCare, Franklin	Leased[1]	80
	Gallatin	NHC Place, Sumner	Owned	92
	Hendersonville	NHC HealthCare, Hendersonville	Leased[1]	122
	Johnson City	NHC HealthCare, Johnson City	Leased[1]	160
	Kingsport	NHC HealthCare, Kingsport	Owned	60
	Knoxville	NHC HealthCare, Fort Sanders	Owned[2]	166
	Knoxville	Holston Health & Rehabilitation Center	Owned	94
	Knoxville	NHC HealthCare, Knoxville	Owned	129
	Lawrenceburg	NHC HealthCare, Lawrenceburg	Managed	96
	Lawrenceburg	NHC HealthCare, Scott	Leased[1]	60
	Lewisburg	NHC HealthCare, Lewisburg	Leased[1]	100
	Lewisburg	NHC HealthCare, Oakwood	Leased[1]	60
	McMinnville	NHC HealthCare, McMinnville	Leased[1]	115
	Milan	NHC HealthCare, Milan	Leased[1]	117
	Murfreesboro	AdamsPlace	Owned	90
	Murfreesboro	NHC HealthCare, Murfreesboro	Managed	181
	Nashville	Lakeshore, Heartland	Managed	66
	Nashville	Lakeshore, The Meadows	Managed	113
	Nashville	The Health Center of Richland Place	Managed	107
	Nashville	NHC Place at The Trace	Owned	90

	Oak Ridge	NHC HealthCare, Oak Ridge	Managed	120
	Pulaski	NHC HealthCare, Pulaski	Leased[1]	102
	Smithville	NHC HealthCare, Smithville	Leased[1]	114
	Somerville	NHC HealthCare, Somerville	Leased[1]	72
	Sparta	NHC HealthCare, Sparta	Leased[1]	90
	Springfield	NHC HealthCare, Springfield	Owned	107
	Tullahoma	NHC HealthCare, Tullahoma	Owned	90
Virginia	Bristol	NHC HealthCare, Bristol	Leased[1]	120

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Behavioral Health Hospital

State	City	Name	Affiliation	Licensed Beds
Missouri	Osage Beach	Osage Beach Center for Cognitive Disorders	Owned[4]	14

Assisted Living Units

State	City	Center	Affiliation	Units
Alabama	Anniston	NHC Place/Anniston	Owned	67
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	Leased	52
	St. Peters	Villages of St. Peters Memory Care	Owned[3]	60
New Hampshire	Manchester	Villa Crest Assisted Living	Leased[1]	29
South Carolina	Bluffton	The Palmettos of Bluffton	Owned	78
	Charleston	The Palmettos of Charleston	Owned	60
	Columbia	The Palmettos of Parklane	Owned	75
	Greenville	The Palmettos of Mauldin	Owned	45
	Murrells Inlet	The Palmettos of Garden City	Owned	80
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	106
	Nashville	Lakeshore Heartland	Managed	9
	Nashville	Lakeshore, The Meadows	Managed	10
	Nashville	Richland Place	Managed	24
	Nashville	The Place at the Trace	Owned	80
	Smithville	NHC HealthCare, Smithville	Leased[1]	6
	Somerville	NHC HealthCare, Somerville	Leased[1]	6

Retirement Apartments

State	City	Retirement Apartments	Affiliation	Units
Missouri	St. Charles	Lake St. Charles Retirement Apts.	Leased[1]	152
Tennessee	Chattanooga	Parkwood Retirement Apartments	Leased[1]	30
	Johnson City	Colonial Hill Retirement Apartments	Leased[1]	63
	Murfreesboro	AdamsPlace	Owned	93
	Nashville	Richland Place Retirement Apts.	Managed	137

[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]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.

[4]Osage Beach Center for Cognitive Disorders is owned by a separate limited liability company. The Company owns 80% of the partnership interest.

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Homecare Programs

State	City	Homecare Programs
Florida	Carrabelle	NHC HomeCare of Carrabelle
	Chipley	NHC HomeCare of Chipley
	Crawfordville	NHC HomeCare of Crawfordville
	Merritt Island	NHC HomeCare of Merritt Island
	Panama City	NHC HomeCare of Panama City
	Port St. Joe	NHC HomeCare of Port St. Joe
	Quincy	NHC HomeCare of Quincy
	Vero Beach	NHC HomeCare of Vero Beach
South Carolina	Aiken	NHC HomeCare of Aiken
	Bluffton	NHC HomeCare of Beaufort
	Greenville	NHC HomeCare of Greenville
	Greenwood	NHC HomeCare of Greenwood
	Laurens	NHC HomeCare of Laurens
	Murrells Inlet	NHC HomeCare of Murrells Inlet
	Rock Hill	NHC HomeCare of Piedmont
	Summerville	NHC HomeCare of Low Country
	West Columbia	NHC HomeCare of Midlands
Tennessee	Athens	NHC HomeCare of Athens
	Chattanooga	NHC HomeCare of Chattanooga
	Columbia	NHC HomeCare of Columbia
	Cookeville	NHC HomeCare of Cookeville
	Dickson	NHC HomeCare of Dickson
	Franklin	NHC HomeCare of Franklin
	Hendersonville	NHC HomeCare of Hendersonville
	Johnson City	NHC HomeCare of Johnson City
	Knoxville	NHC HomeCare of Knoxville
	Lawrenceburg	NHC HomeCare of Lawrenceburg
	Lewisburg	NHC HomeCare of Lewisburg
	McMinnville	NHC HomeCare of McMinnville
	Milan	NHC HomeCare of Milan
	Murfreesboro	NHC HomeCare of Murfreesboro
	Pulaski	NHC HomeCare of Pulaski
	Somerville	NHC HomeCare of Somerville
	Sparta	NHC HomeCare of Sparta
	Springfield	NHC HomeCare of Springfield

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Hospice Programs

State	City	Hospice Programs	Affiliation
Georgia	Rossville	Caris Healthcare – Rossville	Partnership
Missouri	St. Louis	Caris Healthcare – St. Louis	Partnership
	Kansas City	Caris Healthcare – Kansas City	Partnership
South Carolina	Anderson	Caris Healthcare – Anderson	Partnership
	Bluffton	Caris Healthcare – Bluffton	Partnership
	Charleston	Caris Healthcare – Charleston	Partnership
	Columbia	Caris Healthcare – Columbia	Partnership
	Greenville	Caris Healthcare – Greenville	Partnership
	Greenwood	Caris Healthcare – Greenwood	Partnership
	Myrtle Beach	Caris Healthcare – Myrtle Beach	Partnership
	Sumter	Caris Healthcare – Sumter	Partnership
Tennessee	Athens	Caris Healthcare – Athens	Partnership
	Chattanooga	Caris Healthcare – Chattanooga	Partnership
	Columbia	Caris Healthcare – Columbia	Partnership
	Cookeville	Caris Healthcare – Cookeville	Partnership
	Crossville	Caris Healthcare – Crossville	Partnership
	Dickson	Caris Healthcare – Dickson	Partnership
	Greenville	Caris Healthcare – Greeneville	Partnership
	Johnson City	Caris Healthcare – Johnson City	Partnership
	Knoxville	Caris Healthcare – Knoxville	Partnership
	Lenoir City	Caris Healthcare – Lenoir City	Partnership
	Milan	Caris Healthcare – Milan	Partnership
	Murfreesboro	Caris Healthcare – Murfreesboro	Partnership
	Nashville	Caris Healthcare – Nashville	Partnership
	Sevierville	Caris Healthcare – Sevierville	Partnership
	Somerville	Caris Healthcare – Somerville	Partnership
	Springfield	Caris Healthcare – Springfield	Partnership
Virginia	Bristol	Caris Healthcare – Bristol	Partnership

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
Skilled Nursing Facilities		
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

Assisted Living		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

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ITEM 3. LEGAL PROCEEDINGS

General and Professional Liability Insurance and Lawsuits

The senior care industry has experienced increases in both the number of personal injury/wrongful death claims and in the severity of awards based upon alleged negligence by nursing facilities and their employees in providing care to residents. As of December 31, 2018, we and/or our managed healthcare facilities are currently defendants in 59 such claims.

Insurance coverage for all periods includes primary policies and excess policies. 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. For 2017 and 2018, the excess coverage is $9.0 million per occurrence. 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

Caris HealthCare, L.P. Investigation and Related Litigation

On December 9, 2014, Caris Healthcare, L.P., a business that specializes in hospice care services in Company–owned health care centers and in other settings, received notice from the U.S. Attorney's Office for the Eastern District of Tennessee and the Attorney Generals' 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 precipitated by a *qui tam* lawsuit. We have a 75.1% non–controlling ownership interest in Caris.

A *qui tam* lawsuit was filed on May 22, 2014, in the U.S. District Court for the Eastern District of Tennessee by a former Caris employee, Barbara Hinkle, and is captioned *United States of America, State of Tennessee, and State of Virginia ex rel. Barbara Hinkle v. Caris Healthcare, L.P.*, No. 3:14–cv–212 (E.D. Tenn.).

On June 16, 2016, the State of Tennessee and the State of Virginia declined to intervene in the *qui tam* lawsuit. On June 20, 2016, the Court ordered that the complaint be unsealed. On October 11, 2016, the United States filed a Complaint in Intervention against Caris Healthcare, L.P. and Caris Healthcare, LLC, a wholly owned subsidiary of Caris Healthcare, L.P. The United States' complaint alleged that Caris billed the government for ineligible hospice patients between June 2013 and December 2013 and retained overpayments regarding ineligible hospice patients from April 2010 through June 2013.

On March 9, 2018, Caris and the United States jointly moved for a partial 90-day stay of the case to allow the parties to finalize a settlement in principle of the action. That settlement was finalized on June 25, 2018, in which Caris agreed to pay $8.5 million plus interest for a full release associated with the alleged submission of false claims and alleged retention of overpayments from Medicare for hospice services provided between April 1, 2010, and December 31, 2013. On June 28, 2018, the District Court entered an Order in connection with the parties' Joint Stipulation of Dismissal, which dismissed the action with prejudice as to the Hinkle and Hinkle's bankruptcy trustee, with prejudice to the United States with respect to the conduct released by the settlement, and without prejudice to the United States with respect to all remaining claims. The District Court's Order concludes this litigation.

Nutritional Support Services, L.P., Qui Tam Litigation

On June 19, 2018, a First Amended Complaint was filed naming Nutritional Support Services, L.P. ("NSS"), a wholly-owned subsidiary of the Company, as a defendant in the action captioned *U.S. ex rel. McClain v. Nutritional Support Services, L.P.,* No. 6:17-cv-2608-AMQ (D.S.C.), which was filed in the United States District Court for the District of South Carolina. The action alleges that NSS violated the False Claims Act by reporting a National Drug Code ("NDC") number that did not correspond to the NDC for dispensed prescriptions. The plaintiffs are seeking unspecified damages. On April 16, 2018, the United States filed a Notice of Election to Decline Intervention with respect to the allegations asserted in this action. NSS intends to vigorously defend itself with respect to this action.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

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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-American exchange under the symbol NHC. On December 31, 2018, NHC had approximately 6,700 stockholders, comprised of approximately 2,000 stockholders of record and an additional 4,700 stockholders indicated by security position listings. 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.

Stock Repurchase Programs

In August 2018, the Board of Directors authorized a new common stock repurchase program. The program will allow for repurchase of up to $25 million of its common stock. The stock repurchase plan began on September 1, 2018 and will expire on August 31, 2019. No repurchases of common stock have been executed under this current program. This stock repurchase plan replaced the stock repurchase plan previously approved by the Board of Directors on August 3, 2017.

During the first quarter of 2018 and under a previous plan which expired on August 31, 2018, the Company repurchased 14,506 shares of its common stock for a total cost of $867,000. The shares were funded from cash on hand and were cancelled and returned to the status of authorized but unissued.

On August 5, 2016 and under a previous plan which expired on August 31, 2017, the Company repurchased 130,000 shares of its common stock for a total cost of $8,195,000. The shares 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	Weighted–average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(a)	(b)	(c)
Equity compensation plans approved by security holders	1,163,381	$71.16	601,244
Equity compensation plans not approved by security holders	–	–	–
Total	1,163,381	$71.16	601,244

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The following graph and chart compare the cumulative total stockholder return for the period from December 31, 2013 through December 31, 2018 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.

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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 *(in thousands, except per share amounts).*

	2018	2017 *(as adjusted)*	2016 *(as adjusted)*	2015 *(as adjusted)*	2014 *(as adjusted)*
Operating Data:					
Net operating revenues	$980,349	$963,895	$923,580	$903,167	$868,677
Total costs and expenses	(924,273)	(909,785)	(863,038)	(836,041)	(800,666)
Non–operating income	17,670	20,439	19,665	18,148	17,182
Unrealized gains on marketable securities	1,138	-	-	-	-
Income before income taxes	74,884	74,549	80,207	85,274	85,193
Income tax provision	(16,185)	(18,867)	(29,669)	(32,131)	(31,824)
Net income	58,699	55,682	50,538	53,143	53,369
Net loss attributable to noncontrolling interest	265	523	–	–	–
Dividends to preferred stockholders	-	–	–	(6,819)	(8,670)
Net income attributable to common stockholders of NHC	$58,964	$56,205	$50,538	$46,324	$44,699
Earnings per common share:					
Basic	$3.87	$3.70	$3.34	$3.34	$3.24
Diluted	3.87	3.69	3.32	3.20	3.14
Cash dividends declared:					
Per common share	$1.98	$1.89	$1.75	$1.54	$1.34
Per preferred share	$-	$–	$–	$.64	$.80
Balance Sheet Data:					
Total assets	$1,080,948	$1,096,526	$1,087,447	$1,045,329	$1,074,123
Accrued risk reserves	96,024	93,275	91,162	98,508	106,218
Long–term debt	55,000	100,000	120,000	120,000	10,000
NHC stockholders' equity	733,278	702,738	669,611	630,996	734,148

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, 2018, we operate or manage 75 skilled nursing facilities with 9,510 licensed beds, 24 assisted living facilities, five independent living facilities, one behavioral health hospital, and 35 homecare programs located in 10 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 13 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 2018 was 89.8% compared to 90.2% in 2017 and 89.5% in 2016. With the average length of stay decreasing for a skilled nursing patient, as well as the increased availability of assisted living facilities and home and community-based services, the challenge of maintaining desirable patient census levels has been amplified. 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.

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Quality of Patient Care

CMS introduced the Five-Star Quality Rating System to help consumers, their families and caregivers compare skilled nursing facilities more easily. The Five-Star Quality Rating System gives each skilled nursing operation a rating of between one and five stars in various categories (five stars being the best). The Company has always strived for patient-centered care and quality outcomes as precursors to outstanding financial performance. The average Five-Star rating for all of our skilled nursing facilities was 4.32 for 2018. The table below summarizes our performance in these quality ratings for the most recent three years:

	As of December 31,		
	2018	2017	2016
Total number of skilled nursing facilities, end of year	75	76	74
Number of 4 and 5-star rated skilled nursing facilities	63	62	54
Percentage of 4 and 5-star rated skilled nursing facilities	84%	82 %	73 %

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	Bed Addition	44 beds	Charleston, SC	May, 2016
SNF/ALF	New Facility	90 beds / 80 units	Nashville, TN	June, 2016
SNF	Bed Addition	8 beds	Kingsport, TN	September, 2016
SNF	New Facility	112 beds	Columbia, TN	January, 2017
ALF	New Facility	78 units	Bluffton, SC	March, 2017
ALF	New Facility	80 units	Garden City, SC	June, 2017
Memory Care	Bed Addition	23 beds	Murfreesboro, TN	July, 2017
SNF	Bed Addition	30 beds	Springfield, MO	April, 2018
Behavioral Health Hospital	Acquisition	14 beds	Osage Beach, MO	August 2018
Memory Care	New Facility	60 beds	Farragut, TN	January 2019

Impact of U.S. Tax Reform

The enactment of The U.S. Tax Cuts and Jobs Act (the “Tax Act”) in December 2017 has had a favorable impact on our 2018 net income, earnings per share, and operating cash flow. In 2018 and in future years, we estimate that our

effective tax rate should be between 22% to 26%. Our effective tax rate in 2017 and in previous years was 36% to 39%.

For the year ended December 31, 2017 and in connection with the Tax Act, we recorded a tax benefit of $8,488,000 during the fourth quarter of 2017. This estimated benefit was due from the revaluation of our net deferred tax liability based on the new lower corporate income tax rate.

Accrued Risk Reserves

Our accrued professional liability and workers' compensation reserves totaled $96,024,000 and $93,275,000 at December 31, 2018 and 2017, 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 performance measures to 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.

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Government Program Financial Changes

Medicare – Skilled Nursing Facilities

On August 8, 2018, CMS issued a final rule outlining fiscal year 2019 Medicare payments and quality changes for skilled nursing facilities. The 2019 final rule, which began October 1, 2018, provided for an approximate 2.4% market basket update that was spelled out in the Bipartisan Budget Act of 2018. The market basket increase is expected to increase overall payments to skilled nursing facilities in fiscal year 2019 by $820 million compared to fiscal year 2018 levels. For 2018, our average Medicare per diem rate for skilled nursing facilities increased 0.3% compared to the same period in 2017.

As part of the final rule and effective October 1, 2019, CMS plans to start using a new case-mix model, called the Patient-Driven Payment Model (“PDPM”), which focuses on a resident’s condition and care needs, rather than the amount of care provided, to determine reimbursement levels. The PDPM utilizes clinically relevant factors for determining Medicare payment by using ICD-10 diagnosis codes and other patient characteristics as the basis for patient classification. PDPM utilizes five case-mix adjusted payment components: physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), nursing and social services (nursing) and non-therapy ancillary services (NTA). It also uses a sixth non-case mix component to cover utilization of SNF resources that do not vary depending on resident characteristics.

PDPM will replace the existing case-mix classification methodology, Resource Utilization Groups, Version IV. The structure of the PDPM moves Medicare towards a more value-based, unified post-acute care payment system. PDPM also removes therapy minutes as the basis for therapy payment and adjusts the SNF per diem payments to reflect varying costs throughout the stay, through the PT, OT and NTA components. In addition, PDPM is intended to reduce paperwork requirements for performing patient assessments. Under the new PDPM system, the payment to skilled nursing facilities will be based heavily on the patient’s condition rather than the specific services provided by each skilled nursing facility.

Medicaid – Skilled Nursing Facilities

Effective July 1, 2018 and for the fiscal year 2019, the state of Tennessee implemented specific individual nursing facility rate increases. We estimate the resulting increase in revenue for the 2019 fiscal year will be approximately $2,100,000 annually, or $525,000 per quarter.

Effective October 1, 2018 and for the fiscal year 2019, South Carolina implemented specific individual nursing facility rate changes. The resulting increase in revenue beginning October 1, 2018 will be approximately $2,200,000 annually, or $550,000 per quarter.

Effective July 1, 2018 and for the fiscal year 2019, the state of Missouri approved a Medicaid rate increase of $7.76 per patient day to Missouri skilled nursing providers. We estimate the resulting increase in revenue for the 2019 fiscal year will be approximately $2,000,000 annually, or $500,000 per quarter.

Overall our average Medicaid per diem increased 2.9% compared to the same period in 2017. 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. There are several pieces of legislation that include 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.

Medicare – Homecare Programs

On November 13, 2018, CMS published a final rule which updates the Medicare HH PPS rates, including the conversion factor and case-mix weights for calendar years 2019 and 2020. Effective January 1, 2019, CMS estimates the net impact of the PPS rule results in a 2.2% increase ($420 million) in Medicare payments for agencies in 2019. The increase reflects the effects of a 2.2% home health payment update percentage; a 0.1% increase in payments due to decreasing the fixed-dollar-loss ratio in order to pay no more than 2.5% of total payments as outlier payments; and a 0.1% decrease in payments due to the new rural add-on policy mandated by the Bipartisan Budget Act of 2018.

Also published in the final rule and effective January 1, 2020, there will be an elimination of therapy thresholds for payment, implementation of the Patient-Driven Group Model ("PDGM") case-mix methodology refinements and a change in the unit of payment from a sixty (60) day episode to a thirty (30) day episode period. These changes focus on providing value over volume of services to patients. Once the changes are implemented, home health payments will no longer be based on the number of visits provided, but rather the patient's medical condition and care needs.

Segment Reporting

The Company has two reportable operating segments: (1) inpatient services, which includes the operation of skilled nursing facilities, assisted and independent living facilities, and one behavioral health hospital, and (2) homecare services. These reportable operating segments are consistent with information used by the Company's Chief Executive

Officer, as Chief Operating Decision Maker ("CODM"), to assess performance and allocate resources.

The Company also reports an "all other" category that includes revenues from rental income, management and accounting services fees, insurance services, and costs of the corporate office. For additional information on these reportable segments see Note 1 - "*Summary of Significant Accounting Policies"*.

The Company's CODM evaluates performance and allocates capital resources to each segment based on an operating model that is designed to improve the quality of patient care and profitability of the Company while enhancing long-term shareholder value. The CODM does not review assets by segment in his resource allocation and therefore, assets by segment are not disclosed below.

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The following table sets forth the Company's condensed consolidated statements of operations by business segment *(in thousands*):

	Year Ended December 31, 2018			
	Inpatient Services	Homecare	All Other	Total
Revenues:				
Net patient revenues	$872,912	$ 59,862	$-	$932,774
Other revenues	2,494	-	45,081	47,575
Net operating revenues	875,406	59,862	45,081	980,349
Costs and Expenses:				
Salaries, wages and benefits	513,647	33,339	35,735	582,721
Other operating	225,133	19,566	9,339	254,038
Facility rent	33,052	1,945	5,926	40,923
Depreciation and amortization	38,372	229	3,293	41,894
Interest	1,504	-	3,193	4,697
Total costs and expenses	811,708	55,079	57,486	924,273
Income (loss) before non-operating income	63,698	4,783	(12,405)	56,076
Non-operating income	-	-	17,670	17,670
Unrealized gains on marketable securities	-	-	1,138	1,138
Income before income taxes	$63,698	$ 4,783	$6,403	$74,884

	Year Ended December 31, 2017			
(As adjusted)	Inpatient Services	Homecare	All Other	Total
Revenues:				
Net patient revenues	$853,662	$ 63,080	$-	$916,742
Other revenues	663	-	46,490	47,153
Net operating revenues	854,325	63,080	46,490	963,895
Costs and Expenses:				
Salaries, wages and benefits	501,510	33,059	37,474	572,043
Other operating	221,414	20,855	7,564	249,833
Facility rent	32,744	1,980	5,643	40,367
Depreciation and amortization	38,246	177	4,229	42,652
Interest	1,719	-	3,171	4,890
Total costs and expenses	795,633	56,071	58,081	909,785
Income (loss) before non-operating income	58,692	7,009	(11,591)	54,110

Non-operating income	-	-	20,439	20,439
Income before income taxes	$58,692	$ 7,009	$8,848	$74,549

	Year Ended December 31, 2016			
(As adjusted)	Inpatient Services	Homecare	All Other	Total
Revenues:				
Net patient revenues	$814,010	$ 63,656	$-	$877,666
Other revenues	651	-	45,263	45,914
Net operating revenues	814,661	63,656	45,263	923,580
Costs and Expenses:				
Salaries, wages and benefits	480,058	32,597	35,352	548,007
Other operating	202,827	20,705	7,243	230,775
Facility rent	33,129	1,932	6,231	41,292
Depreciation and amortization	34,423	190	4,410	39,023
Interest	1,921	-	2,020	3,941
Total costs and expenses	752,358	55,424	55,256	863,038
Income (loss) before non-operating income	62,303	8,232	(9,993)	60,542
Non-operating income	-	-	19,665	19,665
Income before income taxes	$62,303	$ 8,232	$9,672	$80,207

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Non-GAAP Financial Presentation

The Company is providing certain non-GAAP financial measures as the Company believes that these figures are helpful in allowing investors to more accurately assess the ongoing nature of the Company's operations and measure the Company's performance more consistently across periods. Therefore, the Company believes this information is meaningful in addition to the information contained in the GAAP presentation of financial information. The presentation of this additional non-GAAP financial information is not intended to be considered in isolation or as a substitute for the financial information prepared and presented in accordance with GAAP.

Specifically, the Company believes the presentation of non-GAAP financial information should exclude the following items: the unrealized gains or losses on our marketable equity securities, legal costs and charges related to the settlement of a Qui Tam investigation within our Caris hospice partnership, operating results for the newly constructed healthcare facilities not at full capacity, a gain on the acquisition of an equity method investment (behavioral health hospital), gains on the sale of healthcare facilities, share-based compensation expense, and tax adjustments with the U.S. Tax Cuts and Jobs Act.

The operating results for the newly constructed healthcare facilities not at full capacity include the following: for the year ended December 31, 2018, included are facilities that began operations from 2016 to 2018 (two skilled nursing facilities and three assisted living facilities). For the year ended December 31, 2017, included are facilities that began operations from 2015 to 2017 (three skilled nursing facilities and four assisted living facilities). For the year ended December 31, 2016, included are facilities that began operations from 2014 to 2016 (three skilled nursing facilities and two assisted living facilities).

The table below provides reconciliations of GAAP to non-GAAP items (*dollars in thousands, except per share data*):

	Year Ended December 31,		
	2018	2017	2016
Net income attributable to National HealthCare Corporation	$58,964	$56,205	$50,538
Non-GAAP adjustments:			
Unrealized gains on marketable equity securities	(1,138)	-	-
Legal costs and charges related to Caris' legal investigation	8,364	2,889	638
Operating results for newly opened facilities not at full capacity	3,562	7,332	8,501
Gain on acquisition of equity method investment	(2,050)	-	-
Gain on sale of real estate/healthcare facilities	(1,669)	(1,305)	-
Stock-based compensation expense	1,778	1,678	509
Tax adjustments with the U.S. Tax Cuts and Jobs Act	(1,434)	(8,488)	-
Provision of income taxes on non-GAAP adjustments	(2,005)	(3,503)	(2,128)
Non-GAAP Net Income	$64,372	$54,179	$56,423

GAAP diluted earnings per share	$3.87	$3.69	$3.32
Non-GAAP adjustments:			
Unrealized gains on marketable equity securities	(0.06)	-	-
Legal costs and charges related to Caris' legal investigation	0.46	0.12	0.03
Operating results for newly opened facilities not at full capacity	0.17	0.29	0.34
Gain on acquisition of equity method investment	(0.13)	-	-
Gain on sale of real estate/healthcare facilities	(0.08)	(0.05)	-
Stock-based compensation expense	0.08	0.07	0.02
Tax adjustments with the U.S. Tax Cuts and Jobs Act	(0.09)	(0.56)	-
Non-GAAP diluted earnings per share	$4.22	$3.56	$3.71

Results of Operations

The following table and discussion sets forth items from the consolidated statements of operations as a percentage of net operating revenues for the years ended December 31, 2018, 2017 and 2016.

Percentage of Net Operating Revenues

	Year Ended December 31,		
	2018	2017	2016
Revenues:		*(as adjusted)*	*(as adjusted)*
Net patient revenues	95.1 %	95.1 %	95.0 %
Other revenues	4.9	4.9	5.0
Net operating revenues	100.0	100.0	100.0
Costs and Expenses:			
Salaries, wages and benefits	59.4	59.4	59.3
Other operating	25.9	25.9	25.0
Facility rent	4.2	4.2	4.5
Depreciation and amortization	4.3	4.4	4.2
Interest	0.5	0.5	0.4
Total costs and expenses	94.3	94.4	93.4
Income before non–operating income	5.7	5.6	6.6
Non–operating income	1.9	2.1	2.1
Income before income taxes	7.6	7.7	8.7
Income tax provision	(1.6)	(1.9)	(3.2)
Net income	6.0	5.8	5.5
Net loss attributable to noncontrolling interest	0.0	0.0	0.0
Net income attributable to common stockholders of NHC	6.0 %	5.8 %	5.5 %

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

Period to Period Increase (Decrease)

	2018 vs. 2017		2017 vs. 2016	
(dollars in thousands)	Amount	Percent	Amount	Percent
Revenues:				
Net patient revenues	$16,032	1.7	$39,076	4.5
Other revenues	422	0.9	1,239	2.7
Net operating revenues	16,454	1.7	40,315	4.4
Costs and Expenses:				
Salaries, wages and benefits	10,678	1.9	24,036	4.4
Other operating	4,205	1.7	19,058	8.3
Facility rent	556	1.4	(925)	(2.2)
Depreciation and amortization	(758)	(1.8)	3,629	9.3
Interest	(193)	(3.9)	949	24.1
Total costs and expenses	14,488	1.6	46,747	5.4
Income before non–operating income	1,966	3.6	(6,432)	(10.6)
Non–operating income	(2,769)	(13.5)	774	3.9
Unrealized gains on marketable securities	1,138	-	-	-
Income before income taxes	335	0.4	(5,658)	(7.1)
Income tax provision	(2,682)	(14.2)	(10,802)	(36.4)
Net income	3,017	5.4	5,144	10.2
Net loss attributable to noncontrolling interest	(258)	(49.3)	523	-
Net income attributable to common stockholders of NHC	$2,759	4.9	$5,667	11.2

2018 Compared to 2017

Results for the year ended December 31, 2018 compared to 2017 include a 1.7% increase in net operating revenues and a 4.9% increase in net income attributable to NHC. Excluding the unrealized gains in our marketable equity securities portfolio and the other non-GAAP adjustments, non-GAAP net income for the year ended December 31, 2018 was $64,372,000 compared to $54,179,000 for the 2017 year, which is an increase of 18.8%.

The overall average census in owned and leased skilled nursing facilities for 2018 was 89.8% compared to 90.2% in 2017. The composite skilled nursing facility per diem increased 1.2% in 2018 compared to 2017. Medicare per diem rates increased 0.3% in 2018 compared to 2017 and Managed Care per diem rates decreased 2.0% in 2018 compared to 2017. Medicaid and private pay per diem rates increased 2.9% and 3.0%, respectively, in 2018 compared to 2017.

Net patient revenues totaled $932,774,000, an increase of $16,032,000, or 1.7%, compared to the prior year. The newly constructed healthcare facilities placed in service from 2016 to 2018 (which is two skilled nursing facilities and three assisted living facilities) continue to mature and increased net patient revenues $6,457,000 compared to a year ago. In August 2018, the Company acquired a controlling ownership interest in a 14-bed behavioral health hospital. For the five months since the acquisition of this entity, the hospital has generated approximately $2,496,000 in net patient revenue. The remaining increase in our net patient revenues is primarily due to the per diem increases in our existing skilled nursing facility operations.

Other revenues in 2018 were $47,575,000, an increase of $422,000, or 0.9%, as further detailed in Note 3 of the consolidated financial statements. Other revenues in 2018 include rental revenues of $22,262,000 ($21,957,000 in 2017), management and accounting service fees of $15,175,000 ($16,169,000 in 2017), and insurance services revenue of $7,084,000 ($8,003,000 in 2017). In October 2018, we sold a skilled nursing facility in Madisonville, Kentucky and recorded a gain on the sale of the transaction of $1,669,000.

Total costs and expenses for 2018 increased $14,488,000, or 1.6%, to $924,273,000 from $909,785,000 in 2017.

Salaries, wages and benefits, the largest operating costs of the company, increased $10,678,000, or 1.9%, to $582,721,000 from $572,043,000. Our salaries and wages were 59.4% of net operating revenues for both the 2018 and 2017 years. The newly constructed healthcare facilities placed in service during 2016 to 2018 increased salaries, wages and benefits by $1,453,000 compared to a year ago. The newly acquired behavioral health hospital increased in salaries and wages by $1,116,000 in 2018. The remaining increase in salaries, wages and benefits in 2018 is due to the increase in our existing skilled nursing facilities and the continued wage pressure in certain markets in which we operate.

Other operating expenses increased $4,205,000, or 1.7%, to $254,038,000 for 2018 compared to $249,833,000 in 2017. These costs were 25.9% of net operating revenues for both the 2018 and 2017 years. The newly constructed healthcare facilities placed in service during 2016 to 2018 increased other operating expenses by $2,183,000 compared to a year ago. The newly acquired behavioral health hospital increased other operating expenses by $914,000 in 2018.

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Facility rent expense increased $556,000, or 1.4%, to $40,923,000. Depreciation and amortization decreased 1.8% to $41,894,000.

Interest expense decreased $193,000 to $4,697,000 in 2018 from $4,890,000 in 2017. The decrease in interest expense is due from our long-term debt being paid down during 2018. At December 31, 2018, we had $55 million outstanding on our credit facility.

Non–operating income in 2018 decreased $2,769,000, or 13.5% to $17,670,000, as further detailed in Note 4 of the consolidated financial statements. The decrease in non-operating income is primarily due from:

Our equity in earnings investment in our Caris hospice operations. During 2018, Caris recorded a charge to earnings of $8,500,000 for the settlement of a Qui Tam investigation, of which 75.1% is included in the Company's earnings. In total, with the $8.5 million settlement and legal expenses, Caris' earnings negatively impacted NHC's non-operating income by $8,364,000 for the year ended December 31, 2018. For the year ended December 31, 2017, Caris had legal expenses in connection with the Qui Tam investigation that negatively impacted NHC's non-operating income by $2,889,000.

In July 2018, a gain of $2,050,000 was recorded on the acquisition of a controlling financial interest in a 14-bed behavioral health hospital in Osage Beach, Missouri. We previously held a non-controlling ownership interest and equity method investment in this hospital. Upon acquiring the controlling ownership interest, we valued the business and our previously held equity position based upon the hospital's fair value.

Effective January 1, 2018, we adopted new accounting pronouncement ASU No. 2016–01, "Financial Instruments – Recognition and Measurement of Financial Assets and Financial Liabilities (Topic 825)". This guidance requires that the change in the fair value of our marketable equity securities be recognized in net income instead of other comprehensive income. Therefore, we recorded unrealized gains in the amount of $1,138,000 for the increase in fair value of our marketable equity securities portfolio for the year ended December 31, 2018. The marketable equity securities portfolio consists of publicly-traded healthcare REIT's, with NHI comprising approximately 88% of the market value of the portfolio at December 31, 2018.

The income tax provision for 2018 is $16,185,000 (an effective income tax rate of 21.6%). The income tax provision and effective tax rate for 2018 were also favorably impacted by statute of limitation expirations resulting in a benefit to the provision of $2,222,000 or 3.0% of income before taxes in 2018.

The income tax provision for 2017 was $18,867,000 (an effective income tax rate of 25.3%). We recorded a tax benefit of $8,488,000 during the fourth quarter of 2017 due to the U.S. tax reform legislation. This estimated benefit was due from the revaluation of our net deferred tax liabilities based on the new lower federal corporate income tax rate. The income tax provision and effective tax rate for 2017 were also favorably impacted by statute of limitation expirations resulting in a benefit to the provision of $1,753,000 or 2.4% of income before taxes in 2017.

2017 Compared to 2016

In order to facilitate the comparison of the 2017 financial performance to the 2016 year, the summary table below highlights the impact of the Tax Act on the Company's 2017 financial performance. During the fourth quarter of 2017, the Company recorded a tax benefit in the amount of $8,488,000 from the revaluation of our net deferred tax liability based on the new lower corporate income tax rate. The two columns in 2017 outline the financial performance including and excluding the tax reform adjustment, which is in comparison to the 2016 financial performance.

(dollars in thousands)	2017 Including tax reform adjustment (GAAP)	Excluding tax reform adjustment	2016
Net operating revenues	$963,895	$963,895	$923,580
Income before income taxes	74,549	74,549	80,207
Provision for income taxes	(18,867)	(27,355)	(29,669)
Net income	55,682	47,194	50,538
Net loss attributable to noncontrolling interest	523	523	-
Net income attributable to NHC	56,205	47,717	50,538
Effective income tax rate	25.3%	36.7%	37.0%
Diluted earnings per share	3.69	3.14	3.32

Results for the year ended December 31, 2017 compared to 2016 include a 4.4% increase in net operating revenues and an 11.2% increase in net income attributable to NHC, which includes the 2017 fourth quarter tax reform adjustment. Excluding the 2017 fourth quarter tax reform adjustment and other non-GAAP adjustments, non-GAAP net income for the year ended December 31, 2017 was $54,179,000 compared to $56,423,000 for the 2016 year.

The overall average census in owned and leased skilled nursing facilities for 2017 was 90.2% compared to 89.5% in 2016. The composite skilled nursing facility per diem increased 2.6% in 2017 compared to 2016. Medicare and Managed Care per diem rates increased 1.8% and 0.2%, respectively, in 2017 compared to 2016. Medicaid and private pay per diem rates increased 2.0% and 3.2%, respectively, in 2017 compared to 2016.

Net patient revenues totaled $916,742,000, an increase of $39,076,000, or 4.5%, compared to the prior year. The newly constructed healthcare facilities placed in service during 2015 to 2017 (which is three skilled nursing facilities and four assisted living facilities) continued to mature and increased net patient revenues $23,888,000 compared to a year ago. The remaining increase in our net patient revenues is primarily due to the census increase and per diem increases in our existing skilled nursing facility operations.

Other revenues in 2017 were $47,153,000, an increase of $1,239,000, or 2.7%, as further detailed in Note 3 of the consolidated financial statements. Other revenues in 2017 include rental revenues of $21,957,000 ($21,835,000 in 2016), management and accounting service fees of $16,169,000 ($15,953,000 in 2016), and insurance services revenue of $8,003,000 ($7,195,000 in 2016).

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Total costs and expenses for 2017 increased $46,747,000, or 5.4%, to $909,785,000 from $863,038,000 in 2016.

Salaries, wages and benefits, the largest operating costs of the company, increased $24,036,000, or 4.4%, to $572,043,000 from $548,007,000. These costs were 59.4% and 59.3% of net operating revenues for the year ended December 31, 2017 and 2016, respectively. The newly constructed healthcare facilities placed in service during 2015 to 2017 increased salaries, wages and benefits by $9,996,000 compared to a year ago. The remaining increase in salaries, wages and benefits in 2017 was due to the increase in our existing skilled nursing facilities and the continued wage pressure in certain markets in which we operate.

Other operating expenses increased $19,058,000, or 8.3%, to $249,833,000 for 2017 compared to $230,775,000 in 2016. These costs were 25.9% and 25.0% of net operating revenues for the year ended December 31, 2017 and 2016, respectively. The increase in other operating expenses for 2017 was primarily due to the operations of the newly constructed healthcare facilities compared to 2016 ($11,409,000). We also had unfavorable results within our self-insurance accrued risk reserve programs in 2017 compared to 2016 ($6,368,000) due to the increase in professional liability lawsuits during 2017. As of December 31, 2017, we and/or our managed facilities were defendants in 60 claims. At December 31, 2016, we and/or our managed facilities were defendants in 43 claims.

Facility rent expense decreased $925,000, or 2.2%, to $40,367,000.

Depreciation and amortization increased 9.3% to $42,652,000. The majority of the increase in depreciation expense is due to the newly constructed healthcare facilities.

Interest expense increased $949,000 to $4,890,000 in 2017 from $3,941,000 in 2016. The increase in interest expense is primarily from the increased interest rate on the line of credit borrowings compared to a year ago. At December 31, 2017, we had $90 million outstanding on our credit facility.

Non–operating income in 2017 increased $774,000, or 3.9% to $20,439,000, as further detailed in Note 4 of the consolidated financial statements. The increase in non-operating income is primarily from the sale of the 83-unit assisted living facility in Evans, Georgia during the third quarter of 2017 in which we had an equity method investment and 10% ownership stake. This sale transaction increased non-operating income $1,310,000 in 2017 in comparison to 2016. We also received approximately $250,000 annually in management services revenue from this entity, in which we no longer provided management services after September 30, 2017.

The noncontrolling interest in a subsidiary is the joint venture operations of a skilled nursing facility in Columbia, Tennessee. This facility opened and began operating in January 2017 in which NHC owns 80% of the operating entity and Maury Regional Medical Center owns 20% of the entity.

The income tax provision for 2017 is $18,867,000 (an effective income tax rate of 25.3%). As stated above, we recorded a tax benefit of $8,488,000 during the fourth quarter of 2017 due to the U.S. tax reform legislation. This estimated benefit was due from the revaluation of our net deferred tax liabilities based on the new lower federal corporate income tax rate. The income tax provision and effective tax rate for 2017 were also favorably impacted by statute of limitation expirations resulting in a benefit to the provision of $1,753,000 or 2.4% of income before taxes in 2017.

The income tax provision for 2016 is $29,669,000 (an effective income tax rate of 37.0%). The income tax provision and effective tax rate for 2016 were favorably impacted by statute of limitation expirations resulting in a benefit to the provision of $1,368,000 or 1.7% of income before taxes in 2016.

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, rental income, management and accounting services and insurance services. Our primary uses of cash include salaries, wages and benefits, operating costs of the healthcare facilities, the cost of additions and improvements to our 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 Ended		One Year Change	
	12/31/18	12/31/17	$	%	12/31/17	12/31/16	$	%
Cash, cash equivalents, restricted cash, and restricted cash equivalents at beginning of period	$67,421	$31,589	$35,832	113.4	$31,589	$49,314	$(17,725)	(35.9)
Cash provided by operating activities	98,435	94,466	3,969	4.2	94,466	90,882	3,584	3.9
Cash used in investing activities	(33,662)	(9,560)	(24,102)	(252.1)	(9,560)	(81,476)	71,916	88.2

Cash used in financing activities	(77,274)	(49,074)	(28,200)	(57.5)	(49,074)	(27,131)	(21,943)	(80.9)
Cash, cash equivalents, restricted cash, and restricted cash equivalents at end of period	$54,920	$67,421	$(12,501)	(18.5)	$67,421	$31,589	$35,832	113.4

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Operating Activities

Net cash provided by operating activities for the year ended December 31, 2018 was $98,435,000 as compared to $94,466,000 and $90,882,000 for the years ended December 31, 2017 and 2016, respectively. In 2018, cash provided by operating activities consisted of net income of $58,699,000, adjustments for non–cash items of $41,202,000, less gains on the sale of restricted marketable securities of $18,000 and the sale of a skilled nursing facility of $1,668,000, plus the addition of cash distributions in excess of earnings from equity method investments of $4,221,000. There was cash used for working capital needs in the amount of $4,001,000 in 2018 compared to $1,467,000 and $4,586,000 in 2017 and 2016, respectively.

Included in the adjustments for non-cash items are depreciation expense, deferred taxes, stock compensation, unrealized gains on our marketable equity securities, and a gain on the acquisition of our controlling financial interest in the 14-bed behavioral health hospital in Osage Beach, Missouri.

Investing Activities

Cash used in investing activities totaled $33,662,000 for the year ended December 31, 2018, as compared to $9,560,000 and $81,476,000 for the years ended December 31, 2017 and 2016, respectively. Cash used for property and equipment additions was $29,772,000, $32,347,000, and $62,601,000 for the years ended December 31, 2018, 2017 and 2016, respectively. Purchases of restricted marketable securities, net of sales, resulted in a net use of cash of $8,772,000 in 2018. Conversely, sales of restricted marketable securities, net of purchases, resulted in positive cash flow in 2017 of $18,953,000. Purchases of restricted marketable securities, net of sales, resulted in a net use of cash of $13,978,000 in 2016. Additionally, we had cash proceeds from the sale of a skilled nursing facility in Madisonville, Kentucky of $4,300,000 in 2018.

In 2018, additions to property and equipment include $2,038,000 for the construction and completion of the 30-bed addition to a skilled nursing facility in Springfield, Missouri that began operations in April 2018. Also, construction costs for the 60-unit memory care facility located in Farragut, Tennessee was $10,264,000 during 2018. The memory care facility began operations in January 2019.

Financing Activities

Net cash used in financing activities totaled $77,274,000, $49,074,000 and $27,131,000 for the years ended December 31, 2018, 2017, and 2016, respectively.

During 2018, $45,000,000 of cash was used for principal payments on long-term debt compared to $20,000,000 in 2017 and $0 in 2016. Dividends paid to common stockholders was $29,827,000, $28,237,000, and $25,795,000 for the years ended December 31, 2018, 2017 and 2016. Proceeds from the issuance of common stock totaled $2,524,000 in 2018 compared to $10,772,000 and $10,634,000 for 2017 and 2016, respectively. During the first quarter of 2018, the Company repurchased 14,506 shares of its common stock for a total cost of $867,000. In 2016, the Company repurchased 130,000 shares of its common stock for a total cost of $8,195,000.

Table of Contractual Cash Obligations

Our contractual cash obligations for periods subsequent to December 31, 2018 are as follows (*in thousands)*:

	Total	Less than 1 year	1–3 Years	3–5 Years	After 5 Years
Long–term debt principal	$55,000	$–	$55,000	$–	$--
Long–term debt – interest	3,812	2,157	1,655	--	--
Construction obligations	774	774	–	–	–
Operating and capital leases	306,217	39,400	78,800	78,800	109,217
Total contractual cash obligations	$365,803	$42,331	$135,455	$78,800	$109,217

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 $43,247,000, marketable securities of $140,223,000 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 $43,247,000, marketable securities of $140,223,000, and our borrowing capacity on the credit facility. At December 31, 2018, the outstanding balance on the credit facility is $55,000,000; therefore, leaving $55,000,000 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.

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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 16 to the consolidated financial statements for additional information on pending litigation and other contingencies.

Guarantees

At December 31, 2018, 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, 2018, 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.

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:

Net Patient Revenues and Accounts Receivable

Net patient revenues are derived from services rendered to patients for skilled and intermediate nursing, rehabilitation therapy, assisted living and independent living, and home health care services. Net patient revenue is reported at the amount that reflects the consideration to which the Company expects to be entitled in exchange for providing patient services. These amounts are due from patients, governmental programs, and other third-party payors, and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations.

The Company recognizes revenue as its performance obligations are completed. Routine services are treated as a single performance obligation satisfied over time as services are rendered. These routine services represent a bundle of services that are not capable of being distinct. The performance obligations are satisfied over time as the patient simultaneously receives and consumes the benefits of the healthcare services provided. Additionally, there may be ancillary services which are not included in the daily rates for routine services, but instead are treated as separate performance obligations satisfied at a point in time when those services are rendered.

The Company determines the transaction price based on established billing rates reduced by contractual adjustments provided to third party payors. Contractual adjustments are based on contractual agreements and historical experience. The Company considers the patient's ability and intent to pay the amount of consideration upon admission. Subsequent changes resulting from a patient’s ability to pay are recorded as bad debt expense, which is included as a component of other operating expenses in the consolidated statements of operations.

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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. 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. Settlements with third-party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Company's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved.

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.

Accrued Risk Reserves

We are self–insured for risks related to health insurance and have wholly–owned limited purpose insurance companies that insure risks related to workers' compensation and general and professional liability insurance claims. The accrued risk reserves include a liability for reported claims and estimates for incurred but unreported claims. Our policy is to engage an external, independent actuary to assist in estimating our exposure for claims obligations (for both asserted and unasserted claims). We reassess our accrued risk reserves on a quarterly basis.

Professional liability remains an area of particular concern to us. The long-term care industry has seen an increase in personal injury/wrongful death claims based on alleged negligence by skilled nursing facilities and their employees in providing care to residents. As of December 31, 2018, we and/or our managed centers are defendants in 59 claims. It remains possible that those pending matters plus potential unasserted claims could exceed our reserves, which could have a material adverse effect on our consolidated 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 are principally self–insured for incidents occurring in all centers owned or leased 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.

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, 2018, we have available for sale debt marketable securities in the amount of $172,593,000. 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, 2018, our available for sale debt marketable securities had gross realized gains of $335,000 and gross unrealized losses of $3,809,000.

As of December 31, 2018, our credit facility bears interest at a variable interest rate. Currently, we have long–term debt outstanding of $55.0 million on the credit facility. Based on our outstanding long–term debt, a 1% change in interest rates would change our interest cost by approximately $550,000.

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 asset–backed securities comprise approximately 75% of the fair value of the fixed income portfolio. At December 31, 2018, the credit quality ratings for our fixed income portfolio consisted of the following investment grades (as a percent of fair value): 28% AAA rated, 13% AA rated, 38% A rated, and 21% 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, 2018, the fair value of our equity marketable securities is approximately $140,223,000. Of the $140.2 million equity securities portfolio, our investment in NHI comprises approximately $123.2 million, or 88%, 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 $14.0 million. At December 31, 2018, our equity marketable securities had unrealized gains of $110.0 million. Of the $110.0 million unrealized gains, $98.4 million is related to NHI.

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ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholders and Board of Directors of National HealthCare Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of National HealthCare Corporation (the Company) as of December 31, 2018 and 2017, and the related consolidated statements of operations, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes and financial statement schedule listed in the Index at Item 15(a) (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2018 and 2017, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, 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 20, 2019 expressed an unqualified opinion thereon.

Adoption of ASU No. 2014-09

As discussed in Note 1 to the consolidated financial statements, the Company changed its method of accounting for revenue from contracts with customers in each of the three years ended December 31, 2018 due to the adoption of ASU No. 2014-09, *Revenue from Contracts with Customers*, as amended.

Adoption of ASU No. 2016-01

As discussed in Note 1 to the consolidated financial statements, the Company changed its method of classification and measurement of investments in certain equity investments and the presentation of fair value changes in the year ended December 31, 2018 due to the adoption of ASU No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*.

Basis for Opinion

These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's consolidated financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2009.

Nashville, Tennessee

February 20, 2019

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NATIONAL HEALTHCARE CORPORATION

Consolidated Statements of Operations

(in thousands, except share and per share amounts)

	Year Ended December 31,		
	2018	2017 *(as adjusted)*	2016 *(as adjusted)*
Revenues:			
Net patient revenues	$*932,774*	$*916,742*	$*877,666*
Other revenues	*47,575*	*47,153*	*45,914*
Net operating revenues	*980,349*	*963,895*	*923,580*
Costs and expenses:			
Salaries, wages and benefits	*582,721*	*572,043*	*548,007*
Other operating	*254,038*	*249,833*	*230,775*
Facility rent	*40,923*	*40,367*	*41,292*
Depreciation and amortization	*41,894*	*42,652*	*39,023*
Interest	*4,697*	*4,890*	*3,941*
Total costs and expenses	*924,273*	*909,785*	*863,038*
Income from operations	*56,076*	*54,110*	*60,542*
Other income:			
Non-operating income	*17,670*	*20,439*	*19,665*
Unrealized gains on marketable equity securities	*1,138*	-	-
Income before income taxes	*74,884*	*74,549*	*80,207*
Income tax provision	*(16,185)*	*(18,867)*	*(29,669)*
Net income	*58,699*	*55,682*	*50,538*
Net loss attributable to noncontrolling interest	*265*	*523*	–
Net income attributable to common stockholders of National HealthCare Corporation	$*58,964*	$*56,205*	$*50,538*
Earnings per share attributable to National HealthCare Corporation stockholders:			
Basic	$*3.87*	$*3.70*	$*3.34*
Diluted	$*3.87*	$*3.69*	$*3.32*
Weighted average common shares outstanding:			

Basic	*15,224,886*	*15,189,920*	*15,134,518*
Diluted	*15,236,826*	*15,218,962*	*15,206,997*
Dividends declared per common share	$*1.98*	$*1.89*	$*1.75*

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

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NATIONAL HEALTHCARE CORPORATION

Consolidated Statements of Comprehensive Income

(in thousands)

	Year Ended December 31,		
	2018	2017 *(as adjusted)*	2016 *(as adjusted)*
Net income	$ *58,699*	$ *55,682*	$ *50,538*
Other comprehensive income (loss):			
Unrealized gains (losses) on investments in restricted marketable debt securities	*(2,574)*	*1,644*	*(140)*
Unrealized gains (losses) on investments in marketable equity securities	-	*1,073*	*21,845*
Reclassification adjustment for realized gains on sale of securities	*(18)*	*(262)*	*(816)*
Income tax (expense) benefit related to items of other comprehensive income (loss)	*544*	*(1,019)*	*(8,185)*
Other comprehensive income (loss), net of tax	*(2,048)*	*1,436*	*12,704*
Net loss attributable to noncontrolling interest	*265*	*523*	–
Comprehensive income attributable to National HealthCare Corporation	$ *56,916*	$ *57,641*	$ *63,242*

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

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NATIONAL HEALTHCARE CORPORATION

Consolidated Balance Sheets

(in thousands)

	December 31,	
	2018	2017
Assets		
Current Assets:		
Cash and cash equivalents	$*43,247*	$*59,118*
Restricted cash and cash equivalents	*9,967*	*6,397*
Marketable securities	*140,223*	*139,085*
Restricted marketable securities	*18,676*	*21,012*
Accounts receivable	*97,274*	*86,767*
Inventories	*7,470*	*7,153*
Prepaid expenses and other assets	*3,863*	*2,864*
Notes receivable, current portion	*1,289*	*1,450*
Federal income tax receivable	-	*5,465*
Total current assets	*322,009*	*329,311*
Property and Equipment:		
Property and equipment, at cost	*979,088*	*958,748*
Accumulated depreciation and amortization	*(444,438)*	*(409,429)*