NHC

NATIONAL HEALTHCARE CORPORATION

2019 ANNUAL REPORT

My Favorite Promise

My favorite is to put my heart in everything I do.

JESSICA

My favorite is [to] use compassion as my second language.

BROOKE

My favorite promise is there in no “I” in team.

ASHLEY

My favorite is we promise to give you options. I think that’s important to our patients because it helps to increase their quality of life. It personalizes their care.

HOLLY

I think my favorite promise is promise number 20, which is maintain a positive attitude. Since the day I started with NHC, I’ve seen it from our senior leadership all the way down to the frontline level.

BRANDON

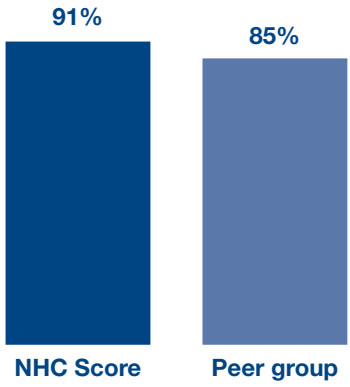
What our patients say about us:

Family/Resident *For Jan 2019 to Dec 2019*

RECOMMENDATION TO OTHERS

OVERALL SATISFACTION

Quality of Life Domain



2019 NRC Health Excellence Award

Founded in 1981, NRC Health is one of the nation's largest, and most widely utilized, companies that measure patient satisfaction in a variety of health care settings. The purpose of NRC Health is "Human Understanding – helping healthcare organizations to understand what matters most to each person they serve." Through its "My Innerview" product, NRC Health has assisted NHC in measuring all aspects of customer satisfaction for several years.

At their 25th annual National Health Symposium in August 2019, NRC awarded NHC its Health Excellence Award. For the preceding year, NHC had the second highest overall Customer Satisfaction scores among all skilled nursing companies utilizing My Innerview.

Investing in Partners

We are committed to being America's premier senior care provider and we can only achieve that goal through our partners. At the close of 2019, The Foundation for Geriatric Education supported approximately 200 partners in 52 communities with tuition reimbursement and textbook reimbursement to help them further their education in the field of geriatric healthcare.

In 2019 through the National Health Foundation, NHC partners facing hardship through unexpected life events received grants.

Investing in Communities

We continue to give back to our community with charitable contributions through National Health Foundation and The Foundation for Geriatric Education. We are proud to be recognized as a Gold Level National team with the Alzheimers' Association. NHC Partners across the country participated in the Walk to Prevent Alzheimer's and raised more than $200,000 collectively.

We provide funding through TFGE for learning tools to high schools, technical schools, and universities across the country to help increase the quality of education in the field of geriatrics. Students across the country can participate in the NHC Dietetic Internship Program and NHC certified nursing assistant programs supported by TFGE.

LETTER TO SHAREHOLDERS

Stephen F. Flatt
Chief Executive Officer

Robert G. Adams
Chairman of the Board

Dear Shareholder,

At the time of the composition of this letter, the entire world was experiencing the rapid spread of the coronavirus. In America, the coronavirus has had repercussions on daily life that we have never seen before.

While it poses a threat to all our citizens, no group is more at risk than the population served in skilled nursing facilities and assisted living communities. NHC is making every effort to prevent the spread of this dreaded virus to the patients that we serve and the partners who serve them.

In light of the current pandemic, 2019 seems like a long time ago. However, it was, in many respects, an excellent year for NHC. Here are some of the year's highlights:

Quality Care – as of December 31, 2019:

- NHC's 75 skilled nursing facilities had an average CMS 5-star rating of 3.97. By contract, the industry average was 3.12.
- Seventy-two percent (72%) of NHC's skilled nursing centers were rated 4 or 5-star. Nationally, only 45% of skilled nursing centers were rated 4 or 5-star.
- In 2019, NHC successfully rolled out a new Electronic Health Record ("EHR") system to all 75 skilled nursing facilities.
- In August 2019, the NRC Health Excellence Award was presented to NHC for outstanding Customer Satisfaction scores.

Financial Performance – 2019 highlights include:

- Net operating revenues for the year totaled $996,383,000 compared to $980,349,000 for the year ended December 31, 2018, an increase of 1.6%.
- Net income available to common shareholders was $68,211,000 compared to $58,964,000 for the year ended December 21, 2018, an increase of 15.7%.
- As of December 31, 2019, NHC shareholder equity was $778,593,000 compared to $733,278,000 at the end of 2018, an increase of 6.2%.
- During 2019, NHC reduced its long-term debt from $55,000,000 to $10,000,000.

Dividends

The dividend for calendar year 2019 was $2.06 per common share compared to $1.98 per share in 2018, an increase of 4.0%. Over the past seven years, we have increased our dividend an average of 8.1% annually.

Growth and Development

- In January 2019, we expanded NHC Advantage, an Institutional Special Needs Plan ("ISNP"), owned 75% by NHC and 25% by AllyAlign, into the state of Tennessee. On December 31, 2019, the plan had over 1,000 participants.
- Also, in January 2019, NHC opened Cavette Hill Memory Care, a 60-bed memory care facility in Farragut, Tennessee.
- In April 2019, NHC began providing management services to Westminster Memory Care, a 52-bed facility in Aiken, South Carolina.
- In June 2019, we acquired the remaining 75% interest in a 60-bed memory care facility in St. Peters, Missouri.

In addition to the above, NHC currently has two facility additions under construction – a 20-unit addition to the NHC Place Sumner assisted living community in Gallatin, Tennessee and a 30-bed addition to NHC HealthCare, Kingsport in Kingsport, Tennessee.

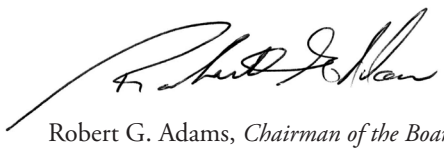
Conclusion

For almost half a century, NHC has been deeply committed to being the senior care leader in customer and investor satisfaction. We continually strive to achieve that aim by providing exceptional person-centered care through engaged partners and to have prudent and disciplined growth.

Thank you for your investment in our efforts.

Sincerely,

Stephen F. Flatt, *Chief Executive Officer*



Robert G. Adams, *Chairman of the Board*

Quality Ratings

The table below summarize NHC's overall performance in these Five-Star ratings versus the skilled nursing industry as of December 31, 2019:

	NHC Ratings	Industry Ratings
Total number of skilled nursing facilities, end of period	**75**	—
Number of 4 and 5-star rated skilled nursing facilities	**54**	—
Percentage of 4 and 5-star rated skilled nursing facilities	**72%**	45%
Average rating for all skilled nursing facilities, end of period	**3.97**	3.12

FINANCIAL HIGHLIGHTS

	As of and for the Year Ended December 31,				
(in thousands, except per share data)	**2019**	2018	2017	2016	2015
Operating Data					
Net operating revenues	**$996,383**	$980,349	$963,895	$923,580	$903,167
Total costs and expenses	**(947,345)**	(924,273)	(909,785)	(863,038)	(836,041)
Income from operations	**49,038**	56,076	54,110	60,542	67,126
Non-operating income	**26,747**	17,670	20,439	19,665	18,148
Unrealized gains on marketable equity securities	**12,230**	1,138	-	-	-
Income before income taxes	**88,015**	74,884	74,549	80,207	85,274
Income tax provision	**(20,039)**	(16,185)	(18,867)	(29,669)	(32,131)
Net income	**67,976**	58,699	55,682	50,538	53,143
Net income attributable to noncontrolling interest	**235**	265	523	-	-
Dividends to preferred stockholders	**-**	-	-	-	(6,819)
Net income attributable to common stockholders of NHC	**$68,211**	$58,964	$56,205	$50,538	$46,324
Earnings per common share:					
Basic	**$4.47**	$3.87	$3.70	$3.34	$3.34
Diluted	**4.44**	3.87	3.69	3.32	3.20
Cash dividends declared:					
Per common share	**$2.06**	$1.98	$1.89	$1.75	$1.54
Per preferred share	**-**	-	-	-	0.64
Balance Sheet Data					
Cash and restricted cash	**$61,010**	$54,920	$67,421	$31,589	$49,314
Marketable equity securities	**152,453**	140,223	139,085	138,013	116,168
Restricted marketable debt securities	**147,406**	172,593	166,395	188,704	169,866
Total assets	**1,286,648**	1,080,948	1,096,526	1,087,447	1,045,329
Accrued risk reserves	**96,011**	96,024	93,275	91,162	98,508
Long-term debt	**-**	55,000	100,000	120,000	120,000
NHC stockholders' equity	**778,593**	733,278	702,738	669,611	630,996

HEALTHCARE HIGHLIGHTS

	As of and for the Year Ended December 31,				
	2019	2018	2017	2016	2015
Skilled Nursing Facilities					
Total operating centers	**75**	76	76	74	74
Owned or leased centers	**67**	68	68	68	67
Centers managed for others	**8**	8	8	6	7
Total licensed beds	**9,513**	9,597	9,597	9,398	9,403
Beds owned or leased	**8,598**	8,682	8,682	8,662	8,520
Beds managed for others	**915**	915	915	736	883
Assisted Living Facilities					
Total assisted living facilities	**25**	24	24	21	20
Assisted living units	**1,238**	1,132	1,132	1,015	935
Behavioral Health Hospital					
Total beds	**14**	-	-	-	-
Independent Living Facilities					
Retirement centers	**5**	5	5	5	5
Retirement apartments	**475**	475	475	475	475
Homecare					
Homecare programs	**35**	35	36	36	36

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

FORM 10–K

(Mark One)

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

For the fiscal year ended December 31, 2019

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 Identification No.)

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

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

Title of Each Class	Trading Symbol(s)	Name of Each Exchange on which Registered
Shares of Common Stock	**NHC**	**NYSE-American**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically 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 ☒ No ☐

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 ☒ 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 ☒

The aggregate market value of Common Stock held by non–affiliates on June 30, 2019 (based on the closing price of such shares on the NYSE American) was approximately $858 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 13, 2020 was 15,333,145.

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 2020 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

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.

Description of the Business

The following table summarizes our operations by ownership status as of December 31, 2019:

	Owned	Leased	Managed	Total
Skilled Nursing Facilities				
Number of facilities	28	39	8	75
Percentage of total	37.3%	52.0%	10.7%	100.0%
Licensed beds	3,630	4,968	915	9,513
Percentage of total	38.2%	52.2%	9.6%	100.0%
Assisted Living Facilities				
Number of facilities	13	8	4	25
Percentage of total	52.0%	32.0%	16.0%	100.0%
Units	944	203	91	1,238
Percentage of total	76.3%	16.4%	7.3%	100.0%
Independent Living Facilities				
Number of facilities	1	3	1	5
Percentage of total	20.0%	60.0%	20.0%	100.0%
Retirement apartments	93	245	137	475
Percentage of total	19.6%	51.6%	28.8%	100.0%
Homecare locations	35	—	—	35

We also own a controlling ownership interest in a 14-bed behavioral health hospital. This hospital specializes in geriatric behavioral health and is the only behavioral health hospital we operate.

We have 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 2019, 95.1% of our net operating revenues were derived from such health care services. Highlights of health care services activities during 2019 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,		
	2019	2018	2017
Overall census	90.3%	89.8%	90.2%

Rehabilitative Services. We provide therapy services through Professional Health Services, a subsidiary of NHC. Our licensed therapists provide physical, speech, respiratory and occupational therapy for patients recovering from strokes, heart attacks, orthopedic conditions, neurological illnesses, or other illnesses, injuries or disabilities. We maintained a rehabilitation staff of over 1,700 highly trained, professional therapists in 2019. 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.

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 2019, the rate of occupancy was 81.4% compared to 78.7% in 2018. 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. Beginning January 1, 2020,

Medicare will make payments for home health services based upon 30-day payment periods. Under our managed care contracts, we may receive an episode payment or be paid by a per-visit payment model. Medicare episodes in 2019 were 13,956. In 2019, we served an average census of 2,994 patients and provided 371,894 visits.

Pharmacy Operations. At December 31, 2019, 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.

Institutional Special Needs Plan ("I-SNP"). Our I-SNP, which is called NHC Advantage, is a managed care insurance company that restricts enrollment to Medicare Advantage eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility. We believe the I-SNP benefits our patients by providing nurse practitioners and care-coordination teams that continue to enhance the patient-centered experience and our quality of patient care. The I-SNP receives a per member, per month premium from Medicare which covers the members same health care benefits as original Medicare, as well as additional benefits including preventive screenings and routine vision coverage. At December 31, 2019, the I-SNP operated in the states of Tennessee and Missouri with approximately 1,000 members enrolled in the plan.

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 2019, 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. As of December 31, 2019, we perform management services for thirteen healthcare facilities and accounting and financial services for 20 healthcare facilities.

B. **Insurance Services.** NHC owns a Tennessee domiciled insurance company that provides workers' compensation coverage to substantially all of NHC's owned and 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).

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.

On April 24, 2019, CMS announced several changes to the Five-Star Quality Rating System which included updating thresholds for both the staffing and quality components of the system. CMS estimated the changes will cause 47% of all nursing centers to lose stars in their ''Quality'' ratings and 33% are expected to lose stars in their ''Staffing'' ratings. Therefore, approximately 36% of all nursing centers are expected to lose stars in their ''Overall'' ratings. As anticipated, the implementation of these changes impacted our overall ratings, as well as everyone in the industry.

The tables below summarize NHC's overall performance in these Five-Star ratings versus the skilled nursing industry as of December 31, 2019:

	NHC Ratings	Industry Ratings
Total number of skilled nursing facilities, end of period	75	
Number of 4 and 5-star rated skilled nursing facilities	54	
Percentage of 4 and 5-star rated skilled nursing facilities	72%	45%
Average rating for all skilled nursing facilities, end of period	3.97	3.12

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
Skilled Nursing	New Facility	112 beds	Columbia, TN	January 2017
Assisted Living	New Facility	78 units	Bluffton, SC	March 2017
Assisted Living	New Facility	80 units	Garden City, SC	June 2017
Memory Care	Bed Addition	23 beds	Murfreesboro, TN	July 2017
Skilled Nursing	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
Memory Care	Acquisition	60 beds	St. Peters, MO	June 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 to our Company.

The following table sets forth sources of net patient revenues for the periods indicated:

	Year Ended December 31,		
Source	2019	2018	2017
Medicare	34%	35%	35%
Managed Care	12%	12%	13%
Medicaid	27%	26%	26%
Private Pay and Other	27%	27%	26%
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 discharge from an acute care hospital. 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 primarily use a cost–based reimbursement system. 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. Seniors who enter skilled nursing facilities as private pay patients can become eligible for Medicaid once they have substantially depleted their assets. Medicaid is generally the largest source of funding for most skilled nursing facilities.

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.

Government Regulation

General

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 and other health care businesses. 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.

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.

Health Care Reform

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.

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.

Patient Confidentiality

We are also subject to laws and regulations enacted to protect the confidentiality of patient health information. The U.S. Department of Health and Human Services (''HHS'') has issued rules that govern our use and disclosure of protected health information. We have established policies and procedures to comply with HIPAA privacy and security requirements. We maintain a company-wide HIPAA compliance plan, that we believe complies with the HIPAA privacy and security regulations. The HIPAA privacy and security regulations have and will continue to impose significant costs to the Company in order to comply with these standards. Our operations are also subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties for privacy and security breaches.

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 our homecare agencies 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. There have not been any adjustments that have had a material adverse effect on the Company within the last three years.

Medicare Legislation and Regulations

Skilled Nursing Facilities

Medicare is uniform nationwide and reimburses skilled nursing facilities under a fixed payment methodology called 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.

Effective October 1, 2019, CMS issued a new case-mix model under the SNF PPS, 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. 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 and non-therapy ancillary services (''NTA''). It also uses a sixth non-case mix component to cover utilization of skilled nursing facility (''SNF'') resources that do not vary depending on resident characteristics.

PDPM replaces 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 PDPM, the payment to skilled nursing facilities is based heavily on the patient's condition rather than the specific services provided by each skilled nursing facility.

In August 2019, CMS released its final rule outlining fiscal year 2020 Medicare payment rates and policy changes for skilled nursing facilities, which began October 1, 2019. The fiscal year 2020 final rule provided for an approximate net 2.4% increase, or $851 million, compared to fiscal year 2019 levels. This included a 2.8% market-basket update, offset by a statutorily required 0.4% productivity reduction.

Homecares (HHAs)

Medicare is uniform nationwide and reimburses homecare agencies 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 standardized episodic payment, which is adjusted for case mix and geographical wage index. Payment rates are updated at the beginning of each calendar year.

In November 2019, CMS released a final rule that sets forth the implementation of the Patient-Driven Groupings Model (''PDGM'') and a 30-day unit of payment as mandated by the Bipartisan Budget Act of 2018 (''BBA''). The new rule ends request for anticipated payments (''RAP''), or prepayments, and these will be completely phased out by 2021. CMS projects payments to home health agencies in fiscal year 2020 will increase in aggregate by 1.3%, or $250 million, based on proposed policies. The increase reflects the effects of the 1.5% home health payment update percentage as mandated by the BBA and a 0.2% decrease in aggregate payments due to reductions made by the new rural add-on policy, also mandated by the BBA.

Under PDGM, the initial certification of patient eligibility, plan of care, and comprehensive assessment will remain valid for 60-day episodes of care, but payments for home health services will be made based upon 30-day payment periods. These changes focus on providing value over volume of services to patients. 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.

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. 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, 2019 and for the fiscal year 2020, the state of Tennessee implemented specific individual nursing facility rate increases. We estimate the resulting increase in revenue for the 2020 fiscal year will be approximately $1,280,000 annually, or $320,000 per quarter.

Effective October 1, 2019 and for the fiscal year 2020, South Carolina implemented specific individual nursing facility rate changes. We estimate the resulting increase in revenue for the 2020 fiscal year will be approximately $2,012,000 annually, or $503,000 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 and senior living communities, we monitor proposed or existing competing senior living communities. Our development goal is to link our skilled nursing facilities with our assisted living facilities, 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 five full–time individuals in this program. Two of our three regional senior vice presidents, four regional vice presidents, and 52 of our 75 health care center administrators are graduates of this program.

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.

Sustainability

Environmental – We are working diligently to minimize our effect on the environment by conserving energy and protecting our natural resources. We are focusing on being more energy efficient and reducing our water use and

wastewater discharges while continuing to provide a healthy environment for our patients, partners and visitors. We are committed to adhering to applicable federal, state and local environmental regulations. Our goal is to minimize environmental risks to our patients and in the communities which we operate.

Through recycling programs, we are working to reduce the amount of waste sent to landfills. Our electronic waste is recycled through a zero-landfill recycling company.

Community Involvement – We continue to give back to our community with charitable contributions through National Health Foundation and The Foundation for Geriatric Education. We donate to charitable initiatives related to health care, geriatric education and community development. We are an active participate in fundraising for the Alzheimer's Association. Our partners in our centers, as well as our home office partners, participate annually in the Walk to Prevent Alzheimer's and we are proud to be recognized as a Gold Level National team, raising more than $200,000 in 2019. We supported disaster relief efforts for our partners and their communities.

Social – We are committed to investing in continuous learning and improvement of our partners. We invest in the future of our partners by assisting with tuition reimbursement to further their health care education. We also assist with continuing education programs and licensing expenses. We offer an Administrator in Training Program, a Dietetic Internship Program, a Geriatric Clinical Residency Program and CNA training programs.

Employees

As of December 31, 2019, our Administrative Services Contractor (National Health Corporation) had 14,881 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.

Available Information

The Company's Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, are available free of charge at *www.nhccare.com*, as soon as reasonably practicable after the reports are electronically filed or furnished with the U.S. Securities and Exchange Commission (''SEC''). The SEC maintains a website that contains these reports as well as proxy statements and other information regarding issuers that file electronically. The SEC's website is at *www.sec.gov*. NHC's website and its content are not deemed incorporated by reference into this report.

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.

On March 26, 2019, a federal judge struck down the Trump administration's rule which allows small businesses to band together and set up health insurance plans and overlook the requirements of the ACA, undermining the hurdles implemented by the Trump administration. There is a lot of uncertainty around the status of the ACA and how it will be changed in the near future. Furthermore, the uncertainty regarding the constitutionality of the ACA, or specific provisions therein, may negatively affect our business. In addition, on July 19, 2019, a federal judge ruled that the Trump administration can expand the sale of short-term health insurance policies that do not meet the standards of the ACA, which limits the ACA. As some decisions expand the ACA, while others limit the ACA, the impact of the ACA on our business is difficult to predict.

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 of our facilities as a result of regulatory action or otherwise, we could be deemed in default under some of our agreements, including agreements governing outstanding indebtedness.

We 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 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.

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 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.

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, 2019, we perform management services (which include financial services) for 13 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 operations, our financial condition and cash flows.

We provide management services to skilled nursing facilities and other healthcare facilities under terms whereby the payments for our services are subject to subordination to other expenditures of the healthcare facility. Furthermore, there are certain third parties with whom we have contracted to provide services and which we have determined, based on insufficient historical collections and the lack of expected future collections, that the service revenue realization is uncertain. We may, therefore, make expenditures related to the provision of services for which we are not paid.

The cost to replace or retain qualified nurses, health care professionals and other key personnel may adversely affect our financial performance, and we may not be able to comply with certain states' staffing requirements. We could experience significant increases in our operating costs due to shortages in qualified nurses, health care professionals and other key personnel. The market for these key personnel is highly competitive. We, like other health care providers, have experienced difficulties in attracting and retaining qualified personnel, especially facility administrators, nurses, certified nurses' aides and other important health care providers. There is currently a shortage of nurses, and trends indicate this shortage will continue or worsen in the future. The difficulty our skilled nursing facilities are experiencing in hiring and retaining qualified personnel has increased our average wage rate. We may continue to experience increases in our labor costs due to higher wages and greater benefits required to attract and retain qualified health care personnel. Our ability to control labor costs will significantly affect our future operating results.

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

Additionally, in 2019, the staffing rating thresholds in the CMS Nursing Home Five Star Quality Rating System were changed, with the staffing level required to receive a 5-star rating determined based on analysis of the relationship between staffing levels and measures of nursing home quality. CMS placed a strong emphasis on registered nurse ''RN'' staffing; accordingly, the method by which the RN staffing rating and the total nurse staffing rating are combined to generate the overall staffing rating is changing to provide more emphasis on RN staffing. The overall and RN staffing ratings are set to one star for nursing homes that report four or more days in the quarter with no RN on-site. Finally, staffing ratings are no longer being suppressed for nursing homes that have five or more days with residents and no nurse staffing hours reported.

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, 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, 2019, 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 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 our cost of doing business while failure to do so could subject us to significant back pay awards, fines and lawsuits 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.

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 from 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 losses 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.

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 $60,000,000 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 $10,000,000 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 waivered, 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. Uncertain tax positions may arise where tax laws may allow for alternative interpretations or where the timing of recognition of income is subject to judgment. We believe we have adequate provisions for unrecognized tax benefits related to uncertain tax positions. However, because of uncertainty of interpretation by various tax authorities and the possibility that there are issues that have not been recognized by management, we cannot guarantee we have accurately estimated our tax liabilities. We believe that our liabilities reflect the anticipated outcome of known uncertain tax positions in conformity with ASC Topic 740 *Income Taxes*.

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.

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 expend 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 National Health Investors ‘‘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.

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
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

Skilled Nursing Facilities (continued)

State	City	Center Name	Affiliation	Licensed Beds
Tennessee	Athens	NHC HealthCare, Athens	Leased[1]	86
	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]	167
	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	127
	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

Behavioral Health Hospital

State	City	Name	Affiliation	Licensed Beds
Missouri	Osage Beach	Osage Beach Center for Cognitive Disorders	Owned[3]	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	60
New Hampshire	Manchester	Villa Crest Assisted Living	Leased[(1)]	29
South Carolina	Aiken	Westminster Memory Care	Managed	48
	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 Managed	80
Tennessee	Dickson	NHC HealthCare, Dickson	Leased[(1)]	20
	Farragut	NHC Place, Farragut	Owned	84
	Farragut	NHC Place, Cavette Hill	Owned	60
	Franklin	NHC Place, Cool Springs	Owned	89
	Gallatin	NHC Place, Sumner	Owned	60
	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

Homecare Programs

State	City	Homecare Programs
Florida	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

State	City	Homecare Programs
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
	Nashville	Ascension at Home St. Thomas[4]
	Pulaski	NHC HomeCare of Pulaski
	Somerville	NHC HomeCare of Somerville
	Sparta	NHC HomeCare of Sparta
	Springfield	NHC HomeCare of Springfield

Hospice Programs

State	City	Hospice Programs	Affiliation
Georgia	Rossville	Caris Healthcare – Rossville	Partnership
Missouri	St. Louis	Caris Healthcare – St. Louis	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
	Greeneville	Caris Healthcare – Greeneville	Partnership

State	City	Hospice Programs	Affiliation
	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

(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) Osage Beach Center for Cognitive Disorders is owned by a separate limited liability company. The Company owns 90% of the partnership interest.

(4) Ascension at Home St. Thomas is owned by a separate limited liability company. The Company owns 50% of the limited liability company.

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. The Company has been, and continues to be, subject to claims and legal actions that arise in the ordinary course of business, including potential claims related to patient care and treatment. The defense of these lawsuits may result in significant legal costs, regardless of the outcome, and can result in large settlement amounts or damage awards.

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. Additional insurance is purchased through third party providers that serve to supplement the coverage provided through our wholly-owned

captive insurance company. 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

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.

PART II

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

Market Information

Our common stock is listed and traded on the NYSE-American exchange under the symbol ''NHC''. On December 31, 2019, NHC had approximately 7,900 stockholders, comprised of approximately 1,900 stockholders of record and an additional 6,000 stockholders indicated by security position listings.

Dividend Policy

We do not have a formal dividend policy, but we currently intend to continue to pay regular quarterly dividends to the holders of our common stock. The Company has paid a common dividend since 2004, although there can be no assurances that our quarterly dividends will be declared, paid or increased in the future.

Stock Repurchase Programs

In August 2019, the Board of Directors authorized a common stock purchase program. The program will allow for repurchases of up to $25 million of its common stock. The stock repurchase plan began on September 1, 2019 and will expire on August 31, 2020. No repurchases have been made under this plan at December 31, 2019.

During the first quarter of 2019 and under a previous stock repurchase plan, the Company purchased 10,396 shares of its common stock for a total cost of $872,000. During the first quarter of 2018 and under a previous plan, 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.

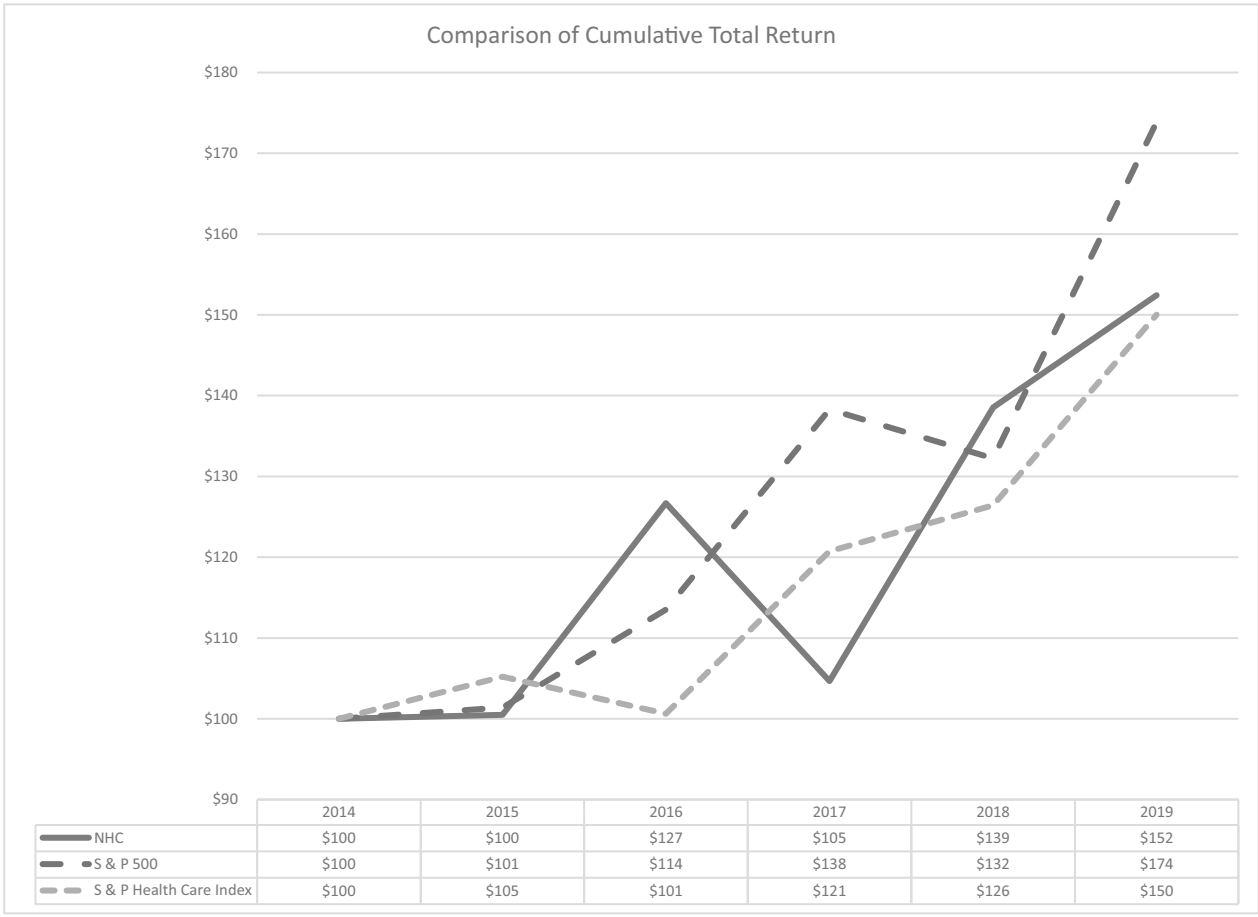
Under the common stock repurchase program, the Company may repurchase its common stock from time to time, in amounts and at prices the Company deems appropriate, subject to market conditions and other considerations. The Company's repurchases may be executed using open market purchases, privately negotiated 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	785,529	$71.24	632,142
Equity compensation plans not approved by security holders	—	—	—
Total	785,529	$71.24	632,142

The following graph and chart compare the cumulative total stockholder return for the period from December 31, 2014 through December 31, 2019 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.



	2014	2015	2016	2017	2018	2019
NHC	$100	$100	$127	$105	$139	$152
S & P 500	$100	$101	$114	$138	$132	$174
S & P Health Care Index	$100	$105	$101	$121	$126	$150

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)*.

	2019	2018	2017	2016	2015
Operating Data:					
Net operating revenues	$ 996,383	$ 980,349	$ 963,895	$ 923,580	$ 903,167
Total costs and expenses	(947,345)	(924,273)	(909,785)	(863,038)	(836,041)
Income from operations	49,038	56,076	54,110	60,542	67,126
Non–operating income	26,747	17,670	20,439	19,665	18,148
Unrealized gains on marketable equity securities	12,230	1,138	—	—	—
Income before income taxes	88,015	74,884	74,549	80,207	85,274
Income tax provision	(20,039)	(16,185)	(18,867)	(29,669)	(32,131)
Net income	67,976	58,699	55,682	50,538	53,143
Net loss attributable to noncontrolling interest	235	265	523	—	—
Dividends to preferred stockholders	—	—	—	—	(6,819)
Net income attributable to common stockholders of NHC	$ 68,211	$ 58,964	$ 56,205	$ 50,538	$ 46,324
Earnings per common share:					
Basic	$ 4.47	$ 3.87	$ 3.70	$ 3.34	$ 3.34
Diluted	4.44	3.87	3.69	3.32	3.20
Cash dividends declared:					
Per common share	$ 2.06	$ 1.98	$ 1.89	$ 1.75	$ 1.54
Per preferred share	$ —	$ —	$ —	$ —	$ .64
Balance Sheet Data:					
Cash and restricted cash	$ 61,010	$ 54,920	$ 67,421	$ 31,589	$ 49,314
Marketable equity securities	152,453	140,223	139,085	138,013	116,168
Restricted marketable debt securities	147,406	172,593	166,395	188,704	169,866
Total assets	1,286,648	1,080,948	1,096,526	1,087,447	1,045,329
Accrued risk reserves	96,011	96,024	93,275	91,162	98,508
Long–term debt	—	55,000	100,000	120,000	120,000
NHC stockholders' equity	778,593	733,278	702,738	669,611	630,996

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, 2019, we operate or manage 75 skilled nursing facilities with 9,513 1icensed beds, 25 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 2019 was 90.3% compared to 89.8% in 2018 and 90.2% in 2017. 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 us to be an active participant in the health delivery systems as they develop.

Patient-Driven Payment Model

On October 1, 2019, the new case-mix reimbursement model of PDPM became effective. Under PDPM, the payment to skilled nursing facilities is based heavily on the patient's condition rather than the specific services provided by each skilled nursing facility.

CMS' fiscal year 2020 final rule provided for an approximate net 2.4% increase, or $851 million, compared to fiscal year 2019 levels, which was effective October 1, 2019. For the quarter ended December 31, 2019, our average Medicare per diem increased 7.6% compared to the same period in 2018.

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.

On April 24, 2019, CMS announced several changes to the Five-Star Quality Rating System which included updating thresholds for both the staffing and quality components of the system. CMS estimated the changes will cause 47% of all nursing centers to lose stars in their ''Quality'' ratings and 33% are expected to lose stars in their ''Staffing'' ratings. Therefore, approximately 36% of all nursing centers are expected to lose stars in their ''Overall'' ratings. As anticipated, the implementation of these changes impacted our overall ratings, as well as everyone in the industry.

The tables below summarize NHC's overall performance in these Five-Star ratings versus the skilled nursing industry as of December 31, 2019:

	NHC Ratings	Industry Ratings
Total number of skilled nursing facilities, end of period	75	
Number of 4 and 5-star rated skilled nursing facilities	54	
Percentage of 4 and 5-star rated skilled nursing facilities	72%	45%
Average rating for all skilled nursing facilities, end of period	3.97	3.12

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
Skilled Nursing	New Facility	112 beds	Columbia, TN	January 2017
Assisted Living	New Facility	78 units	Bluffton, SC	March 2017
Assisted Living	New Facility	80 units	Garden City, SC	June 2017
Memory Care	Bed Addition	23 beds	Murfreesboro, TN	July 2017
Skilled Nursing	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
Memory Care	Acquisition	60 beds	St. Peters, MO	June 2019

Accrued Risk Reserves

Our accrued professional liability and workers' compensation reserves totaled $96,011,000 and $96,024,000 at December 31, 2019 and 2018, 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.

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.

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

	Year Ended December 31, 2019			
	Inpatient Services	Homecare	All Other	Total
Revenues:				
Net patient revenues	$893,201	$54,671	$ —	$947,872
Other revenues	910	—	47,601	48,511
Net operating revenues	894,111	54,671	47,601	996,383
Costs and Expenses:				
Salaries, wages and benefits	526,430	33,037	33,364	592,831
Other operating	242,435	17,003	9,004	268,442
Facility rent	32,748	1,854	5,916	40,518
Depreciation and amortization	38,731	250	3,438	42,419
Interest	1,578	—	1,557	3,135
Total costs and expenses	841,922	52,144	53,279	947,345
Income (loss) from operations	52,189	2,527	(5,678)	49,038
Non-operating income	—	—	26,747	26,747
Unrealized gains on marketable equity securities	—	—	12,230	12,230
Income before income taxes	$ 52,189	$ 2,527	$33,299	$ 88,015

	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) from operations	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			
	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) from operations	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

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, operating results for the newly constructed healthcare facilities not at full capacity, legal costs and charges related to the settlement of a Qui Tam investigation within our Caris hospice partnership, any gains on the acquisition of equity method investments, gains on the sale of healthcare facilities, share-based compensation expense, and tax adjustments with the 2017 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, 2019, included are facilities that began operations from 2017 to 2019 (one skilled nursing facility, two assisted living facilities, and one memory care facility).

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).

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

	Year Ended December 31,		
	2019	2018	2017
Net income attributable to National HealthCare Corporation	$ 68,211	$58,964	$56,205
Non-GAAP adjustments:			
Unrealized gains on marketable equity securities	(12,230)	(1,138)	—
Legal costs and charges related to Caris' legal investigation	—	8,364	2,889
Operating results for newly opened facilities not at full capacity	712	3,562	7,332
Gain on acquisition of equity method investment	(1,975)	(2,050)	—
Gain on sale of real estate/healthcare facilities	—	(1,668)	(1,305)
Stock-based compensation expense	1,878	1,778	1,678
U.S. Tax Cuts and Jobs Act of 2017 adjustment	—	(1,434)	(8,488)
Provision (benefit) of income taxes on non-GAAP adjustments	3,020	(2,005)	(4,132)
Non-GAAP Net Income	$ 59,616	$64,373	$54,179
GAAP diluted earnings per share	$ 4.44	$ 3.87	$ 3.69
Non-GAAP adjustments:			
Unrealized gains on marketable equity securities	(0.59)	(0.06)	—
Legal costs and charges related to Caris' legal investigation	—	0.46	0.12
Operating results for newly opened facilities not at full capacity	0.03	0.17	0.29
Gain on acquisition of equity method investment	(0.09)	(0.13)	—
Gain on sale of real estate/healthcare facilities	—	(0.08)	(0.05)
Stock-based compensation expense	0.09	0.08	0.07
U.S. Tax Cuts and Jobs Act of 2017 adjustment	—	(0.09)	(0.56)
Non-GAAP diluted earnings per share	$ 3.88	$ 4.22	$ 3.56

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, 2019, 2018 and 2017.

Percentage of Net Operating Revenues

	Year Ended December 31,		
	2019	2018	2017
Revenues:			
Net patient revenues	95.1%	95.1%	95.1%
Other revenues	4.9	4.9	4.9
Net operating revenues	100.0	100.0	100.0
Costs and Expenses:			
Salaries, wages and benefits	59.5	59.4	59.4
Other operating	26.9	25.9	25.9
Facility rent	4.1	4.2	4.2
Depreciation and amortization	4.3	4.3	4.4
Interest	0.3	0.5	0.5
Total costs and expenses	95.1	94.3	94.4
Income from operations	4.9	5.7	5.6
Non–operating income	2.7	1.8	2.1
Unrealized gains on marketable equity securities	1.2	0.1	—
Income before income taxes	8.8	7.6	7.7
Income tax provision	(2.0)	(1.6)	(1.9)
Net income	6.8	6.0	5.8
Net loss attributable to noncontrolling interest	0.0	0.0	0.0
Net income attributable to common stockholders of NHC	6.8%	6.0%	5.8%

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)

(dollars in thousands)	2019 vs. 2018 Amount	2019 vs. 2018 Percent	2018 vs. 2017 Amount	2018 vs. 2017 Percent
Revenues:				
Net patient revenues	$15,098	1.6	$16,032	1.7
Other revenues	936	2.0	422	0.9
Net operating revenues	16,034	1.6	16,454	1.7
Costs and Expenses:				
Salaries, wages and benefits	10,110	1.7	10,678	1.9
Other operating	14,404	5.7	4,205	1.7
Facility rent	(405)	(1.0)	556	1.4
Depreciation and amortization	525	1.3	(758)	(1.8)
Interest	(1,562)	(33.3)	(193)	(3.9)
Total costs and expenses	23,072	2.5	14,488	1.6
Income from operations	(7,038)	(12.6)	1,966	3.6
Non–operating income	9,077	51.4	(2,769)	(13.5)
Unrealized gains on marketable equity securities	11,092	974.7	1,138	—
Income before income taxes	13,131	17.5	335	0.4
Income tax provision	(3,854)	23.8	(2,682)	(14.2)
Net income	9,277	15.8	3,017	5.4
Net loss attributable to noncontrolling interest	(30)	(11.3)	(258)	(49.3)
Net income attributable to common stockholders of NHC	$ 9,247	15.7	$ 2,759	4.9

2019 Compared to 2018

Results for the year ended December 31, 2019 compared to 2018 include a 1.6% increase in net operating revenues and a 15.7% 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, 2019 was $59,616,000 compared to $64,373,000 for the 2018 year.

The overall average census in our owned and leased skilled nursing facilities for 2019 was 90.3% compared to 89.8% in 2018. Although our census increased in 2019, we had a decline in Medicare patients (offset by Managed Care and Medicaid patients), which decreased our operating margins in our skilled nursing facilities. The composite skilled nursing facility per diem increased 0.3% in 2019 compared to 2018. Medicare per diem rates increased 1.8% in 2019 compared to 2018 and Managed Care per diem rates decreased 0.4% in 2019 compared to 2018. Medicaid and private pay per diem rates increased 3.0% and 1.9%, respectively, in 2019 compared to 2018.

Net patient revenues totaled $947,872,000, an increase of $15,098,000, or 1.6%, compared to the prior year. The largest driver of the net patient revenue increase in 2019 was the Company's Institutional Special Needs Plan ''(I-SNP''). Beginning January 1, 2019, the I-SNP began offering and providing insurance and healthcare services in the state of Tennessee. Our I-SNP, which is called NHC Advantage, is a managed care insurance company that enrolls Medicare Advantage eligible individuals who are patients in our skilled nursing facilities. We believe the I-SNP benefits our patients by providing nurse practitioners and care-coordination teams that continue to enhance the patient-centered experience and our quality of care. We also believe our progressive improvement to patient care will continue to drive positive financial results for the Company. For the year ended December 31, 2019, the I-SNP increased net patient revenues approximately $10,867,000 compared to 2018.

The Company has opened one skilled nursing facility, two assisted living facilities, and a memory care facility from the years 2017 to 2019. These facilities continue to stabilize and increased net patient revenues approximately $3,891,000 compared to the same period a year ago. In August 2018, the Company acquired a controlling ownership interest in a 14-bed behavioral health hospital. For the 2019 year, the hospital increased net patient revenues by

approximately $3,017,000 compared to 2018. The remaining increase in our net patient revenues is primarily due to the per diem increases in our existing skilled nursing facility and assisted living operations. Our homecare operations had a decline in net patient revenues of approximately $5,190,000 compared to the same period a year ago. Our homecare net patient revenue decline was primarily due to volume declines, as well as an unfavorable payor mix change with less Medicare patients and an increase of managed care patients. In October 2018, we sold a skilled nursing facility in Madisonville, Kentucky. The sale of this facility decreased net patient revenues $5,098,000 compared to the same period a year ago.

Other revenues in 2019 were $48,511,000, an increase of $936,000, or 2.0%, as further detailed in Note 3 of the consolidated financial statements. Other revenues in 2019 include rental revenues of $22,641,000 ($22,262,000 in 2018), management and accounting service fees of $18,533,000 ($15,175,000 in 2018), and insurance services revenue of $6,209,000 ($7,084,000 in 2018). In October 2018, we sold a skilled nursing facility in Madisonville, Kentucky and recorded a gain on the sale of the transaction of $1,668,000.

Total costs and expenses for 2019 increased $23,072,000, or 2.5%, to $947,345,000 from $924,273,000 in 2018.

Salaries, wages and benefits, the largest operating costs of the company, increased $10,110,000, or 1.7%, to $592,831,000 from $582,721,000. Our salaries and wages were 59.5% and 59.4% of net operating revenues for 2019 and 2018, respectively. The primary reason for salaries, wages and benefits increasing is due to our existing skilled nursing facilities and the continued wage pressure in most of the markets in which we operate. The newly opened operations (one skilled nursing facility, two assisted living facilities, and one memory care facility) increased salaries, wages and benefits by approximately $2,129,000 compared to a year ago. The behavioral health hospital that we acquired in August 2018 increased salaries and wages expense of $1,695,000 in 2019 compared to the same period a year ago. These salaries and wage increases in 2019 were offset by the October 2018 disposition of the Madisonville, Kentucky skilled nursing facility ($3,040,000).

Other operating expenses increased $14,404,000, or 5.7%, to $268,442,000 for 2019 compared to $254,038,000 in 2018. These costs were 26.9% and 25.9% of net operating revenues for 2019 and 2018, respectively. The majority of the increase in other operating expenses in 2019 compared to a year ago is due to the January 1, 2019 start of our I-SNP insurance plan, NHC Advantage. For the year ending December 31, 2019, the I-SNP increased other operating expenses approximately $11,612,000 compared to the same period a year ago. The behavioral health hospital that we acquired in August 2018 increased other operating expenses $1,404,000 in 2019 compared to the same period a year ago. The October 2018 disposition of the Madisonville, Kentucky skilled nursing facility decreased other operating expenses in the amount of $2,974,000 in 2019 compared to 2018.

Facility rent expense decreased $405,000, or 1.0%, to $40,518,000. Depreciation and amortization increased 1.3% to $42,419,000.

Interest expense decreased $1,562,000 to $3,135,000 in 2019 from $4,697,000 in 2018. The decrease in interest expense is due from our long-term debt being paid down during 2019. At December 31, 2019, we had $10,000,000 outstanding on our credit facility.

Non–operating income in 2019 increased $9,077,000, or 51.4% to $26,747,000, as further detailed in Note 4 of the consolidated financial statements. The increase 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' 2018 earnings negatively impacted NHC's non-operating income by $8,364,000. There were no such charges or legal expenses in Caris for 2019.

There were also gains on acquisitions of equity method investments in both the 2019 and 2018 years. In June 2019, a gain of $1,975,000 was recorded on the acquisition of the remaining ownership interest of a 60-bed memory care facility in St. Peters, Missouri. We previously held a noncontrolling interest in the facility. Upon acquiring the remaining ownership interest, we valued the business and our previously held equity position based upon the facility's fair value. 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. Upon acquiring the controlling ownership interest, we valued the business and our previously held equity position based upon the hospital's fair value.

We recorded unrealized gains in the amount of $12,230,000 for the increase in fair value of our marketable equity securities portfolio for the year ended December 31, 2019. The marketable equity securities portfolio consists of publicly traded healthcare REIT's, with NHI comprising approximately 87% of the market value of the portfolio at December 31, 2019.

The income tax provision for 2019 is $20,039,000 (an effective income tax rate of 22.8%). The income tax provision and effective tax rate for 2019 were also favorably impacted by statute of limitation expirations resulting in a benefit to the provision of $2,064,000 or 2.3% of income before taxes in 2019.

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.

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 $64,373,000 compared to $54,179,000 for the 2017 year.

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.

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.

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	
	12/31/19	12/31/18	$	%	12/31/18	12/31/17	$	%
Cash, cash equivalents, restricted cash, and restricted cash equivalents at beginning of period	$ 54,920	$ 67,421	$(12,501)	(18.5)	$ 67,421	$ 31,589	$ 35,832	113.4
Cash provided by operating activities	100,103	98,435	1,668	1.7	98,435	94,466	3,969	4.2
Cash used in investing activities	(14,265)	(33,662)	19,397	57.6	(33,662)	(9,560)	(24,102)	(252.1)
Cash used in financing activities	(79,748)	(77,274)	(2,474)	(3.2)	(77,274)	(49,074)	(28,200)	(57.5)
Cash, cash equivalents, restricted cash, and restricted cash equivalents at end of period	$ 61,010	$ 54,920	$ 6,090	11.1	$ 54,920	$ 67,421	$(12,501)	(18.5)

Operating Activities

Net cash provided by operating activities for the year ended December 31, 2019 was $100,103,000 as compared to $98,435,000 and $94,466,000 for the years ended December 31, 2018 and 2017, respectively. Cash provided by operating activities consisted of net income of $67,976,000 and adjustments for non–cash items of $24,400,000. There was cash provided by working capital in the amount of $3,952,000 for the year ended December 31, 2019 compared to cash used for working capital needs of $4,001,000 in 2018. We also received cash distributions from our unconsolidated investments of $3,902,000 for the year ended December 31, 2019 compared to $5,241,000 for 2018. There were also gains on sales of restricted marketable debt securities of $127,000 for the year ended December 31, 2019 compared to $18,000 for the same period in 2018.

Included in the adjustments for non-cash items are depreciation expense, equity in earnings of unconsolidated investments, unrealized gains on our marketable equity securities, deferred taxes, stock compensation, and a gain on the acquisition of a 60-bed memory care facility in St. Peters, Missouri in which we previously held a noncontrolling ownership interest.

Investing Activities

Cash used in investing activities totaled $14,265,000 for the year ended December 31, 2019, as compared to $33,662,000 and $9,560,000 for the years ended December 31, 2018 and 2017, respectively. Cash used for property and equipment additions was $26,400,000, $29,772,000, and $32,347,000 for the years ended December 31, 2019, 2018 and 2017, respectively. Sales of restricted marketable debt securities, net of purchases, resulted in positive cash flow of $32,029,000 in 2019; compared to purchases of restricted marketable debt securities, net of sales, resulting in a net use of cash of $8,772,000 in 2018. Additionally, in 2019, we had investments in notes receivable of $5,462,000 and cash used for the acquisition of a 60-bed memory care facility in St. Peters, Missouri, of $15,589,000. In 2018, we had cash proceeds from the sale of a skilled nursing facility in Madisonville, Kentucky of $4,300,000.

Financing Activities

Net cash used in financing activities totaled $79,748,000, $77,274,000 and $49,074,000 for the years ended December 31, 2019, 2018, and 2017, respectively. During 2019 and 2018, $45,000,000 of cash was used for principal payments on long-term debt compared to $20,000,000 in 2017. Dividends paid to common stockholders were $31,208,000, $29,827,000, and $28,237,000 for the years ended December 31, 2019, 2018 and 2017, respectively. Proceeds from the issuance of common stock totaled $2,346,000 in 2019 compared to $2,865,000 and $2,524,000 for 2018 and 2017, respectively. The Company repurchased 10,396 shares of its common stock for a total cost of $872,000 in 2019 and 14,506 shares of its common stock for a total cost of $867,000 in 2018.

Table of Contractual Cash Obligations

Our contractual cash obligations for periods subsequent to December 31, 2019 are as follows (*in thousands)*:

Contractual Obligations	Total	Less than 1 year	1–3 Years	3–5 Years	More than 5 Years
Current maturities of long-term debt	$ 10,000	$10,000	$ —	$ —	$ —
Construction obligations	1,556	1,556	—	—	—
Operating and finance leases	270,285	40,769	80,505	74,861	74,150
Total contractual cash obligations	$281,841	$52,325	$80,505	$74,861	$74,150

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 $50,334,000, marketable securities of $152,453,000 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 $50,334,000, marketable securities of $152,453,000, and our borrowing capacity on the

credit facility. At December 31, 2019, the outstanding balance on the credit facility is $10,000,000; therefore, leaving $50,000,000 available for future borrowings. The maturity date on the credit facility is October 7, 2020. The credit facility is available for general corporate purposes, including working capital and acquisitions.

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

Contingencies

Impact of Inflation

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

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

Guarantees

At December 31, 2019, 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, 2019, 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.

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 based on the acuity level of the patient to determine the amount that is paid to us for patient services. The assignment of patients to the various categories is subject to post–payment review by Medicare and Managed Care 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. Significant estimation is required in determining the reserves, particularly the assumptions of the severity of asserted claims and the quantity and severity of unknown 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. 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 current maturities of our 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, 2019, we have available for sale marketable debt securities in the amount of $147,406,000. 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, 2019, our available for sale marketable debt securities had gross realized gains of $3,407,000 and gross unrealized losses of $167,000.

As of December 31, 2019, our credit facility bears interest at a variable interest rate. Currently, we have an outstanding balance of $10.0 million on the credit facility, all due within a year. Based on our outstanding balance on the credit facility, a 1% change in interest rates would change our interest cost by approximately $100,000.

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 82% of the fair value of the fixed income portfolio. At December 31, 2019, the credit quality ratings for our fixed income portfolio consisted of the following investment grades (as a percent of fair value): 26% AAA rated, 13% AA rated, 39% A rated, and 22% BBB rated.

Equity Price and Concentration Risk

Our marketable 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, 2019, the fair value of our marketable equity securities is approximately $152,453,000. Of the $152.5 million marketable equity securities portfolio, our investment in NHI comprises approximately $132.9 million, or 87%, 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 $15.2 million. At December 31, 2019, our marketable equity securities had unrealized gains of $122.3 million. Of the $122.3 million unrealized gains, $108.1 million is related to NHI.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholders and the 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, 2019 and 2018, and the related consolidated statements of operations, comprehensive income, equity and cash flows for each of the three years in the period ended December 31, 2019, 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, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019, 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, 2019, 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 21, 2020 expressed an unqualified opinion thereon.

Adoption of ASU No. 2016-02

As discussed in Note 1 to the consolidated financial statements, the Company changed its method of accounting for leases in the year ended December 31, 2019 due to the adoption of ASU No. 2016-02, *Leases (Topic 842)*, on a modified retrospective basis.

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 years ended December 31, 2018 and 2019 due to the adoption of ASU No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's 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 response 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.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current period audit of the financial statements that was communicated or required to be communicated to the audit committee and that: (1) relates to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective or complex judgments. The communication of the critical audit matter does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the accounts or disclosures to which it relates.

Estimation of Professional Liability Claims Reserves

Description of the Matter

The Company's accrued risk reserves totaled $96,011,000 as of December 31, 2019. As described in Note 16 to the consolidated financial statements, the accrued risk reserves include professional liability claims reserves for unpaid reported professional liability claims and estimates for incurred but unreported claims. The Company's policy with respect to the professional liability claims reserves is to use an actuary to assist management in estimating the exposure for claims obligations (for both asserted and unasserted claims).

Auditing management's professional liability claims reserves was complex and highly judgmental due to the significant estimation required in determining the reserves, particularly the assumptions of the severity of asserted claims and the quantity and severity of unknown claims.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the effectiveness of controls over the Company's professional liability claims reserve determination, including controls over management's review of the significant assumptions described above. For example, we tested controls over management's review of the actuarial analysis, the significant actuarial assumptions and the data inputs provided to the actuary.

To test the professional liability claims reserves, our audit procedures included, among others, testing the completeness and accuracy of the underlying claims data provided to the Company's actuarial specialist, obtaining legal confirmation letters to evaluate the reserves recorded on significant litigated matters, and reviewing the Company's insurance contracts by policy year to assess the Company's self-insured retentions, deductibles, and coverage limits. In addition, we involved our actuarial specialists to assist in our evaluation of the methodologies applied by management's specialist and assessing the accuracy of the Company's reserves. We also compared the reserves recorded to a range developed by our actuarial specialists based on independently selected assumptions.

/s/ Ernst & Young LLP

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

Nashville, Tennessee
February 21, 2020

NATIONAL HEALTHCARE CORPORATION
Consolidated Statements of Operations
(in thousands, except share and per share amounts)

	Year Ended December 31,		
	2019	**2018**	**2017**
Revenues:			
Net patient revenues	$ 947,872	$ 932,774	$ 916,742
Other revenues	48,511	47,575	47,153
Net operating revenues	996,383	980,349	963,895
Costs and expenses:			
Salaries, wages and benefits	592,831	582,721	572,043
Other operating	268,442	254,038	249,833
Facility rent	40,518	40,923	40,367
Depreciation and amortization	42,419	41,894	42,652
Interest	3,135	4,697	4,890
Total costs and expenses	947,345	924,273	909,785
Income from operations	49,038	56,076	54,110
Other income:			
Non-operating income	26,747	17,670	20,439
Unrealized gains on marketable equity securities	12,230	1,138	—
Income before income taxes	88,015	74,884	74,549
Income tax provision	(20,039)	(16,185)	(18,867)
Net income	67,976	58,699	55,682
Net loss attributable to noncontrolling interest	235	265	523
Net income attributable to National HealthCare Corporation	$ 68,211	$ 58,964	$ 56,205
Earnings per share attributable to National HealthCare Corporation stockholders:			
Basic	$ 4.47	$ 3.87	$ 3.70
Diluted	$ 4.44	$ 3.87	$ 3.69
Weighted average common shares outstanding:			
Basic	15,270,154	15,224,886	15,189,920
Diluted	15,360,046	15,236,826	15,218,962
Dividends declared per common share	$ 2.06	$ 1.98	$ 1.89

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

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

	Year Ended December 31,		
	2019	**2018**	**2017**
Net income	$67,976	$58,699	$55,682
Other comprehensive income (loss):			
Unrealized gains (losses) on investments in restricted marketable debt securities	6,842	(2,574)	1,644
Unrealized gains on investments in marketable equity securities	—	—	1,073
Reclassification adjustment for realized gains on sale of securities	(127)	(18)	(262)
Income tax (expense) benefit related to items of other comprehensive income (loss)	(1,410)	544	(1,019)
Other comprehensive income (loss), net of tax	5,305	(2,048)	1,436
Net loss attributable to noncontrolling interest	235	265	523
Comprehensive income attributable to National HealthCare Corporation	$73,516	$56,916	$57,641

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

NATIONAL HEALTHCARE CORPORATION
Consolidated Balance Sheets
(in thousands)

	December 31, 2019	December 31, 2018
Assets		
Current Assets:		
Cash and cash equivalents	$ 50,334	$ 43,247
Restricted cash and cash equivalents, current portion	8,944	9,967
Marketable equity securities	152,453	140,223
Restricted marketable debt securities, current portion	20,576	18,676
Accounts receivable	92,975	97,274
Inventories	7,441	7,470
Prepaid expenses and other assets	4,075	3,863
Notes receivable, current portion	1,695	1,289
Federal income tax receivable	2,560	—
Total current assets	341,053	322,009
Property and Equipment:		
Property and equipment, at cost	1,017,204	979,088
Accumulated depreciation and amortization	(481,774)	(444,438)
Net property and equipment	535,430	534,650
Other Assets:		
Restricted cash and cash equivalents, less current portion	1,732	1,706
Restricted marketable debt securities, less current portion	126,830	153,917
Deposits and other assets	5,124	5,602
Operating lease – right-of-use assets	202,909	—
Goodwill	20,995	20,995
Notes receivable, less current portion	13,384	9,707
Investments in unconsolidated companies	39,191	32,362
Total other assets	410,165	224,289
Total assets	$1,286,648	$1,080,948

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

NATIONAL HEALTHCARE CORPORATION
Consolidated Balance Sheets
(in thousands, except share and per share amounts)

	December 31, 2019	December 31, 2018
Liabilities and Equity		
Current Liabilities:		
Trade accounts payable	$ 18,903	$ 19,759
Finance lease obligations, current portion	4,166	3,924
Operating lease liabilities, current portion	24,243	—
Accrued payroll	69,826	67,618
Amounts due to third party payors	15,108	16,108
Accrued risk reserves, current portion	29,520	28,643
Other current liabilities	15,029	14,249
Dividends payable	7,968	7,623
Current maturities of long-term debt	10,000	—
Total current liabilities	194,763	157,924
Long–term debt	—	55,000
Finance lease obligations, less current portion	14,963	19,128
Operating lease liabilities, less current portion	178,666	—
Accrued risk reserves, less current portion	66,491	67,381
Refundable entrance fees	7,455	8,078
Obligation to provide future services	2,035	2,172
Deferred income taxes	24,012	18,550
Other noncurrent liabilities	16,058	15,204
Deferred revenue	3,136	3,054
Total liabilities	507,579	346,491
Equity:		
Common stock, $.01 par value; 45,000,000 shares authorized; 15,332,206 and 15,255,002 shares, respectively, issued and outstanding	153	153
Capital in excess of par value	222,787	219,435
Retained earnings	553,093	516,435
Accumulated other comprehensive income (loss)	2,560	(2,745)
Total National HealthCare Corporation stockholders' equity	778,593	733,278
Noncontrolling interest	476	1,179
Total equity	779,069	734,457
Total liabilities and equity	$1,286,648	$1,080,948

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

NATIONAL HEALTHCARE CORPORATION
Consolidated Statements of Cash Flows
(in thousands)

	Year Ended December 31,		
	2019	2018	2017
Cash Flows From Operating Activities:			
Net income	$ 67,976	$ 58,699	$ 55,682
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	42,419	41,894	42,652
Equity in earnings of unconsolidated investments	(9,744)	(1,020)	(6,932)
Distributions from unconsolidated investments	3,902	5,241	7,829
Unrealized gains on marketable equity securities	(12,230)	(1,138)	—
Gains on sale of restricted marketable debt securities	(127)	(18)	(262)
Gains on acquisitions of equity method investments	(1,975)	(2,050)	—
Gain on sale of skilled nursing facility	—	(1,668)	—
Deferred income taxes	4,052	718	(4,714)
Stock–based compensation	1,878	1,778	1,678
Changes in operating assets and liabilities:			
Accounts receivable	4,299	(9,398)	(4,236)
Federal income tax receivable	(2,560)	5,465	(800)
Inventories	29	(317)	355
Prepaid expenses and other assets	(287)	(1,743)	(796)
Trade accounts payable	(856)	3,467	(2,615)
Accrued payroll	2,208	516	1,190
Amounts due to third party payors	(1,000)	(1,281)	370
Accrued risk reserves	540	2,818	3,070
Other current liabilities	780	(2,050)	2,987
Obligation to provide future services	(137)	(715)	(349)
Other noncurrent liabilities	854	(591)	(507)
Deferred revenue	82	(172)	(136)
Net cash provided by operating activities	100,103	98,435	94,466
Cash Flows From Investing Activities:			
Additions to property and equipment	(26,400)	(29,772)	(32,347)
Proceeds from the sale of skilled nursing facility	—	4,300	—
Investments in unconsolidated companies	(222)	(444)	(246)
Acquisition of equity method investment	(15,589)	(527)	—
Investments in notes receivable	(5,462)	—	(202)
Collections of notes receivable	1,379	1,553	4,282
Purchases of restricted marketable debt securities	(12,471)	(13,311)	(31,244)
Sale of restricted marketable debt securities	44,500	4,539	50,197
Net cash used in investing activities	(14,265)	(33,662)	(9,560)
Cash Flows From Financing Activities:			
Principal payments under line of credit agreement	(45,000)	(45,000)	(20,000)
Principal payments under finance lease obligations	(3,923)	(3,696)	(3,481)
Dividends paid to common stockholders	(31,208)	(29,827)	(28,237)
Issuance of common shares	2,346	2,865	2,524
Repurchase of common shares	(872)	(867)	—
Distributions attributable to noncontrolling interest	(468)	—	—
Equity contributed by noncontrolling interest	—	—	1,217
Entrance fee refunds	(623)	(749)	(1,097)
Net cash used in financing activities	(79,748)	(77,274)	(49,074)
Net Increase (Decrease) in Cash, Cash Equivalents, Restricted Cash, and Restricted Cash Equivalents	6,090	(12,501)	35,832
Cash, Cash Equivalents, Restricted Cash, and Restricted Cash Equivalents, Beginning of Period	54,920	67,421	31,589
Cash, Cash Equivalents, Restricted Cash, and Restricted Cash Equivalents, End of Period	$ 61,010	$ 54,920	$ 67,421
Balance Sheet Classifications:			
Cash and cash equivalents	$ 50,334	$ 43,247	$ 59,118
Restricted cash and cash equivalents	10,676	11,673	8,303
Total Cash, Cash Equivalents, Restricted Cash, and Restricted Cash Equivalents	$ 61,010	$ 54,920	67,421
Supplemental Information:			
Cash payments for interest	$ 3,118	$ 4,899	$ 5,183
Cash payments for income taxes	20,889	9,182	23,550

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

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

	Common Stock		Capital in Excess of	Retained	Accumulated Other Comprehensive	Non-controlling	Total
	Shares	Amount	Par Value	Earnings	Income (Loss)	Interest	Equity
Balance at January 1, 2017	15,162,938	$152	$211,457	$391,934	$ 66,068	$ —	$669,611
Net income attributable to National HealthCare Corporation	—	—	—	56,205	—	—	56,205
Net loss attributable to noncontrolling interest	—	—	—	—	—	(523)	(523)
Equity contributed by noncontrolling interest	—	—	—	—	—	1,217	1,217
Other comprehensive income	—	—	—	—	1,436	—	1,436
Stock–based compensation	—	—	1,678	—	—	—	1,678
Shares sold – options exercised	49,195	—	2,524	—	—	—	2,524
Dividends declared to common stockholders ($1.89 per share)	—	—	—	(28,716)	—	—	(28,716)
Balance at January 1, 2018	15,212,133	$152	$215,659	$419,423	$ 67,504	$ 694	$703,432
Reclassification due to new accounting standards	—	—	—	68,201	(68,201)	—	—
Net income attributable to National HealthCare Corporation	—	—	—	58,964	—	—	58,964
Net loss attributable to noncontrolling interest	—	—	—	—	—	(265)	(265)
Equity contributed by noncontrolling interest	—	—	—	—	—	750	750
Other comprehensive loss	—	—	—	—	(2,048)	—	(2,048)
Stock–based compensation	—	—	1,778	—	—	—	1,778
Shares sold – options exercised	57,375	1	2,865	—	—	—	2,866
Repurchase of common shares	(14,506)	—	(867)	—	—	—	(867)
Dividends declared to common stockholders ($1.98 per share)	—	—	—	(30,153)	—	—	(30,153)
Balance at January 1, 2019	15,255,002	$153	$219,435	$516,435	$ (2,745)	$1,179	$734,457
Net income attributable to National HealthCare Corporation	—	—	—	68,211	—	—	68,211
Net loss attributable to noncontrolling interest	—	—	—	—	—	(235)	(235)
Distributions attributable to noncontrolling interest	—	—	—	—	—	(468)	(468)
Other comprehensive income	—	—	—	—	5,305	—	5,305
Stock–based compensation	—	—	1,878	—	—	—	1,878
Shares sold – options exercised	87,600	—	2,346	—	—	—	2,346
Repurchase of common shares	(10,396)	—	(872)	—	—	—	(872)
Dividends declared to common stockholders ($2.06 per share)	—	—	—	(31,553)	—	—	(31,553)
Balance at December 31, 2019	15,332,206	$153	$222,787	$553,093	$ 2,560	$ 476	$779,069

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

Notes to Consolidated Financial Statements

Note 1 – Summary of Significant Accounting Policies

Nature of Operations

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

Principles of Consolidation and Basis of Presentation

The consolidated financial statements, which are prepared in accordance with U.S. generally accepted accounting principles (''GAAP''), include our wholly owned and controlled subsidiaries and affiliates. All significant intercompany transactions and balances have been eliminated in consolidation. The Company presents noncontrolling interest within the equity section of its consolidated balance sheets. The Company presents the amount of consolidated net income that is attributable to NHC and the noncontrolling interest in its consolidated statements of operations.

Variable interest entities (''VIEs'') in which we have an interest have been consolidated when we have been identified as the primary beneficiary. Investments in ventures in which we have the ability to exercise significant influence but do not have control over are accounted for using the equity method. Equity method investments are initially recorded at cost and subsequently are adjusted for our share of the venture's earnings or losses and cash distributions. Our most significant equity method investment is a 75.1% noncontrolling ownership interest in Caris, a business that specializes in hospice care services. Investments in entities in which we lack the ability to exercise significant influence are included in the consolidated financial statements at cost unless there has been a decline in the market value of our investment that is deemed to be other than temporary.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates and could cause our reported net income to vary significantly from period to period.

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. Bad debt expense was $2,403,000, $1,524,000, and $1,895,000 for years ended December 31, 2019, 2018, and 2017, respectively. As of December 31, 2019, and 2018, the Company has recorded allowance for doubtful accounts of $4,451,000 and $4,610,000, respectively, as our best estimate of probable losses inherent in the accounts receivable balance.

Other Revenues

As discussed in Note 3, other revenues include revenues from the provision of insurance services, management and accounting services to other long–term care providers, and rental income. Our insurance revenues consist of premiums that are generally paid in advance and then amortized into income over the policy period. We charge for management services based on a percentage of net revenues. We charge for accounting services based on a monthly fee or a fixed fee per bed of the long–term care center under contract. We record other revenues as the performance obligations are satisfied based on the terms of our contractual arrangements.

We recognize rental income based on the terms of our operating leases. Under certain of our leases, we receive variable rent, which is based on the increase in revenues of a lessee over a base year. We recognize variable rent annually or monthly, as applicable, when, based on the actual revenue of the lessee is earned.

Segment Reporting

In accordance with the provisions of Accounting Standards Codification (''ASC'') Topic 280, *Segment Reporting*, the Company is required to report financial and descriptive information about its reportable operating 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 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 officers. See Note 5 for further disclosure of the Company's operating segments.

Other Operating Expenses

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

General and Administrative Costs

With the Company being a healthcare provider, the majority of our expenses are ''cost of revenue'' items. Costs that could be classified as ''general and administrative'' by the Company would include its corporate office costs, excluding stock-based compensation, which were $24.8 million, $28.7 million, and $29.8 million for the years ended December 31, 2019, 2018, and 2017, respectively.

Cash and Cash Equivalents

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

Restricted Cash and Cash Equivalents and Restricted Marketable Securities

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

Investments in Marketable Securities and Restricted Marketable Securities

On January 1, 2018, the Company adopted Accounting Standards Update (''ASU'') No. 2016-01 using the modified retrospective method as required in the standard. ASU No. 2016-01 revised the classification and measurement of investments in certain equity investments and required the change in fair value of many equity investments to be recognized in net income. The adoption of ASU No. 2016-01 resulted in a $68,073,000 reclassification of net unrealized gains from accumulated other comprehensive income to the opening balance sheet of retained earnings.

Our investments in marketable equity securities are carried at fair value with the changes in unrealized gains and losses recognized in our results of operations at each measurement date subsequent to January 1, 2018. Our investments in marketable debt securities are classified as available for sale securities and carried at fair value with the unrealized gains and losses recognized through accumulated other comprehensive income at each measurement date. If any adjustment to fair value on our available for sale securities reflects a significant decline in the value of the security, we consider all available evidence to evaluate the extent to which the decline is ''other than temporary''. Credit losses are identified when we do not expect to receive cash flows sufficient to recover the amortized cost basis of a security. In the event of a credit loss, only the amount associated with the credit loss is recognized in earnings, with the amount of loss relating to other factors recorded as a separate component of stockholders' equity.

Inventories

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

Mortgage and Other Notes Receivable

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

Property and Equipment

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

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

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

Long-Term Leases

The Company's lease portfolio primarily consists of finance and operating real estate leases for certain skilled nursing facilities, assisted and independent living facilities, homecare offices, and pharmacy warehouses. The original terms of the leases typically range from two to fifteen years. Several of the real estate leases include renewal options which vary in length and may not include specific rent renewal amounts. We determine if an arrangement is a lease at the inception of a contract. We determine the lease term by assuming exercise of renewal options that are reasonably certain to be exercised.

On January 1, 2019 (with the adoption of ASC Topic 842, *Leases*, see Note 6), the Company recorded right-of-use assets and liabilities on the consolidated balance sheets for non-cancelable real estate operating leases with original or remaining lease terms in excess of one year. Leases with a lease term of 12 months or less at inception are not recorded on our consolidated balance sheets and are expensed on a straight-line basis over the lease term in our consolidated statement of operations. Finance leases remain on the consolidated balance sheets as required by previous accounting guidance.

Operating lease right-of-use assets and liabilities are recorded at the present value of the lease payments over the lease term. The present values of the lease payments are discounted using the incremental borrowing rate associated with each lease. The variable components of the lease payment that fluctuate with the operations of a healthcare facility are not included in determining the right-of-use assets and lease liabilities. Rather, these variable components are expensed as incurred.

Goodwill

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

The following table represents activity in goodwill by segment as of and for the three years ended December 31, 2019 (*in thousands*):

	Three Years Ended December 31, 2019			
	Inpatient Services	Homecare	All Other	Total
January 1, 2017	$ —	$17,600	$—	$17,600
Additions	—	—	—	—
December 31, 2017	—	17,600	—	17,600
Additions	3,395	—	—	3,395
December 31, 2018	3,395	17,600	—	20,995
Additions	—	—	—	—
December 31, 2019	$3,395	$17,600	$—	$20,995

Accrued Risk Reserves

We are principally self–insured for risks related to employee health insurance and utilize wholly owned limited purpose insurance companies for workers' compensation and professional liability claims. Accrued risk reserves primarily represent the accrual for risks associated with employee health insurance, workers' compensation and professional liability claims. The accrued risk reserves include a liability for unpaid reported claims and estimates for incurred but unreported claims. Significant estimation is required in determining the reserves, particularly the assumptions of the severity of asserted claims and the quantity and severity of unknown claims. Our policy with respect to a significant portion of our workers' compensation and professional and general liability claims is to use an actuary to assist management in estimating our exposure for claims obligation (for both asserted and unasserted claims). Our health insurance reserve is based on our known claims incurred and an estimate of incurred but unreported claims determined by our analysis of historical claims paid. We reassess our accrued risk reserves on a quarterly basis, with changes in estimated losses being recorded in the consolidated statements of operations in the period first identified.

Other Current Liabilities

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

Continuing Care Contracts and Refundable Entrance Fees

We have one continuing care retirement center (''CCRC'') within our operations. Residents at this retirement center may enter into continuing care contracts with us. The contract provides that 10% of the resident entry fee becomes non–refundable upon occupancy, and the remaining refundable portion of the entry fee is calculated using the lessor of the price at which the apartment is re–assigned or 90% of the original entry fee, plus 40% of any appreciation if the apartment exceeds the original resident's entry fee.

Non-refundable fees are included as a component of the transaction price and are amortized into revenue over the actuarially determined remaining life of the resident, which is the expected period of occupancy by the resident. We pay the refundable portion of our entry fees to residents when they relocate from our community and the

apartment is re-occupied. Refundable entrance fees are not included as part of the transaction price and are classified as non-current liabilities in the Company's consolidated balance sheets. The balances of refundable entrance fees as of December 31, 2019 and December 31, 2018 were $7,455,000 and $8,078,000, respectively.

Obligation to Provide Future Services

We annually estimate the present value of the net cost of future services and the use of facilities to be provided to the current CCRC residents and compare that amount with the balance of non–refundable deferred revenue from entrance fees received. If the present value of the net cost of future services exceeds the related anticipated revenues, a liability is recorded (obligation to provide future services) with a corresponding charge to income. At December 31, 2019 and 2018, we have recorded a future service obligation in the amounts of $2,035,000 and $2,172,000, respectively.

Other Noncurrent Liabilities

Other noncurrent liabilities include reserves primarily related to various uncertain income tax positions.

Deferred Revenue

Deferred revenue includes the deferred gain on the sale of assets to National Health Corporation (''National''), as discussed in Note 18, and entrance fees that have been and are currently being received upon reservation and occupancy in the independent living centers we operate. The non–refundable portion (10%) of the entrance fee is included in deferred revenue and is being recognized over the remaining life expectancies of the residents.

Income Taxes

We utilize ASC Topic 740, *Income Taxes*, which requires an asset and liability approach for financial accounting and reporting for income taxes. Under this guidance, deferred tax assets and liabilities are determined based upon differences between financial reporting and tax basis of assets and liabilities and are measured using the enacted tax laws that will be in effect when the differences are expected to reverse. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. See Note 13 for further discussion of our accounting for income taxes.

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

Noncontrolling Interest

The noncontrolling interest in a subsidiary is presented within total equity in the Company's consolidated balance sheets. The Company presents the noncontrolling interest and the amount of consolidated net income attributable to NHC in its consolidated statements of operations. The Company's earnings per share is calculated based on net income attributable to NHC's stockholders. The carrying amount of the noncontrolling interest is adjusted based on an allocation of subsidiary earnings based on ownership interest.

Stock–Based Compensation

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

The fair value of the restricted stock units is determined based on the stock price on the date of grant. We estimated the fair value of stock options and stock purchased under our employee stock purchase plan using the Black–Scholes model. This model utilizes the estimated fair value of common stock and requires that, at the date of grant, we use the expected term of the grant, the expected volatility of the price of our common stock, risk–free interest rates and expected dividend yield of our common stock. The fair value is amortized on a straight–line basis over the requisite service periods of the awards.

Comprehensive Income

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

Concentration of Credit Risks

Our credit risks primarily relate to cash and cash equivalents, restricted cash and cash equivalents, accounts receivable, marketable securities, restricted marketable securities and notes receivable. Cash and cash equivalents are primarily held in bank accounts and overnight investments. Restricted cash and cash equivalents are primarily invested in commercial paper and certificates of deposit with financial institutions and other interest-bearing accounts. Accounts receivable consist primarily of amounts due from patients (funded through Medicare, Medicaid, other contractual programs and through private payors) and from other health care companies for management, accounting and other services. We perform continual credit evaluations of our clients and maintain appropriate allowances for doubtful accounts on any accounts receivable proving uncollectible, and continually monitor and adjust these allowances as necessary. Marketable securities and restricted marketable securities are held primarily in accounts with brokerage institutions. Notes receivable relate primarily to secured loans with health care facilities as discussed in Note 11.

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

Our financial instruments, principally our notes receivable, are subject to the possibility of loss of the carrying values as a result of the failure of other parties to perform according to their contractual obligations. We obtain various collateral and other protective rights, and continually monitor these rights in order to reduce such possibilities of loss. We evaluate the need to provide reserves for potential losses on our financial instruments based on management's periodic review of the portfolio on an instrument by instrument basis. See Note 11 for additional information on the notes receivable.

Recently Adopted Accounting Guidance

In February 2016, the Financial Accounting Standards Board (''FASB'') established ASC Topic 842, *Leases*, by issuing 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 either retrospectively to each prior reporting period presented in the financial statements or retrospectively at the beginning of the period of adoption.

In August 2018, the FASB issued ASU No. 2018-11, ''*Leases (Topic 842): Targeted Improvements*.'' The objective of this update is to reduce costs for entities adopting the new leases standard and to ease the application of the separation and allocation guidance for lessors. This ASU provided a new transition method whereas entities can initially apply the new lease guidance at the adoption date (rather than at the beginning of the earliest period presented) and recognize a cumulative effect adjustment to the opening balance of retained earnings in the period of adoption, while continuing to present the comparative periods under Topic 840, including its disclosure requirements. If an entity elects the new transition method, it is required to provide the Topic 840 disclosures for all periods that remain under the legacy period.

The Company adopted ASC Topic 842 as of January 1, 2019, electing the transition method that allows us to apply the standard as of the adoption date and record a cumulative adjustment in retained earnings, if applicable. We did not have a cumulative adjustment to retained earnings. The Company has elected the package of practical expedients permitted under the transition guidance, which among other things, allows the Company to carry forward the historical lease classification. The new standard also provides practical expedients for an entity's ongoing accounting. The Company has made an accounting policy to keep leases with an initial term of 12 months or less off

of the balance sheet and recognize those lease payments in the consolidated statements of operations on a straight-line basis over the lease term. The Company has also elected the practical expedient to not separate lease and non-lease components for all of its leases as the non-lease components are not significant to the overall lease costs. The consolidated financial statements for the period ending December 31, 2019, are presented under the new standard, while comparative years presented are not adjusted and continue to be reported in accordance with our historical accounting policy.

On June 20, 2018, the FASB issued ASU No. 2018-07, ''*Compensation – Stock Compensation (Topic 718): Improvements to Nonemployee Share-based Payment Accounting*.'' ASU No. 2018-07 simplifies the accounting for share-based payments granted to nonemployees for goods and services. Under the ASU, most of the guidance on such payments to nonemployees is aligned with the requirements for share-based payments granted to employees. On January 1, 2019, the Company early adopted the provisions of ASU No. 2018-07 and this standard did not have an impact on our consolidated financial statements.

On August 28, 2018, the FASB issued ASU No. 2018-13, ''*Fair Value Measurement (Topic 820): Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement*.'' ASU No. 2018-13 changes the fair value measurement disclosure requirements of ASC 820. Entities are no longer required to disclose the amount of and reasons for transfers between Level 1 and Level 2 of the fair value hierarchy, but they will be required to disclose the range and weighted average used to develop significant unobservable inputs for Level 3 fair value measurements. On January 1, 2019, the Company early adopted the provisions of ASU No. 2018-13 and this standard did not have a material impact on our consolidated financial statements.

In July 2019, the FASB issued ASU No. 2019-07, ''*Codification Updates to SEC Sections – Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10532, Disclosure Update and Simplification, and Nos. 33-10231 and 33-10442, Investment Company Reporting Modernization, and Miscellaneous Updates*,'' which aligns the guidance in various Securities and Exchange Commission ''SEC'' sections of the FASB ASC with the requirements of certain already effective SEC final rules. ASU No. 2019-07 was effective immediately. This standard did not have a material impact on the company's financial statements and related disclosures.

Recent Accounting Guidance Not Yet Adopted

In June 2016, the FASB issued ASU No. 2016-13, ''*Financial Instruments - Credit Losses: Measurement of Credit Losses on Financial Instruments*.'' ASU No. 2016-13 replaces the current incurred loss impairment methodology for credit losses with a methodology that reflects expected credit losses and requires consideration of a broader range of reasonable and supportable information to inform credit loss estimates. This ASU is effective for fiscal years beginning after December 15, 2019, including interim periods within those annual periods, with early adoption permitted for fiscal years beginning after December 15, 2018. We are currently evaluating the impact this standard will have on our policies and procedures and internal control framework.

Note 2 – Net Patient Revenues

The Company disaggregates revenue from contracts with customers by service type and by payor.

Revenue by Service Type

The Company's net patient services can generally be classified into the following two categories: (1) inpatient services, which includes the operation of skilled nursing facilities, assisted and independent living facilities, and a behavioral health hospital, and (2) homecare services.

(in thousands)	Year Ended December 31, 2019	2018	2017
Inpatient services	$893,201	$872,912	$853,662
Homecare services	54,671	59,862	63,080
Total net patient revenue	$947,872	$932,774	$916,742

For inpatient services, revenue is recognized on a daily basis as each day represents a separate contract and performance obligation. For homecare, revenue is recognized when services are provided based on the number of days of service rendered in the episode or on a per-visit basis. Typically, patients and third-party payors are billed monthly after services are performed or the patient is discharged and payments are due based on contract terms.

As our performance obligations relate to contracts with a duration of one year or less, the Company has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The Company has minimal unsatisfied performance obligations at the end of the reporting period as our patients are typically under no obligation to remain admitted in our facilities or under our care.

As the period between the time of service and time of payment is typically one year or less, the Company elected as a practical expedient under ASC 606-10-32-18 to not adjust for the effects of a significant financing component.

Revenue by Payor

The following table sets forth sources of net patient revenues for the periods indicated:

	Year Ended December 31,		
Source	**2019**	**2018**	**2017**
Medicare	34%	35%	35%
Managed Care	12%	12%	13%
Medicaid	27%	26%	26%
Private Pay and Other	27%	27%	26%
Total	100%	100%	100%

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.

Effective October 1, 2019, the Centers for Medicare and Medicaid Services (''CMS'') issued 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.

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

However, CMS issued a final rule, beginning January 1, 2020, that sets forth the implementation of the Patient-Driven Groupings Model (''PDGM'') that will change the unit of payment from a 60-day episode to a 30-day episode period. Under PDGM, the initial certification of patient eligibility, plan of care, and comprehensive assessment will remain valid for 60-day episodes of care, but payments for home health services will be made based upon 30-day payment periods. Additionally, the new rule ends requests for anticipated payments, or prepayments, and these will be completely phased out by 2021.

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

Private pay, managed care, and other payment sources include commercial insurance, individual patient funds, managed care plans and the Veterans Administration. Private paying patients, private insurance carriers and the

Veterans Administration generally pay based on the healthcare facilities charges or specifically negotiated contracts. For private pay patients in skilled nursing, assisted living and independent living facilities, the Company bills for room and board charges, with the remittance being due on receipt of the statement and generally by the 10th day of the month the services are performed.

Certain managed care payors for homecare services pay on a per-visit basis. This non-episodic based revenue is recorded on an accrual basis based upon the date of services at amounts equal to its established or estimated per-visit rates.

Third Party Payors

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

Medicare and Medicaid program revenues, as well as certain Managed Care program revenues, are subject to audit and retroactive adjustment by government representatives or their agents. The Medicare PPS methodology requires that patients be assigned to Resource Utilization Groups (''RUGs'') based on the acuity level of the patient to determine the amount paid to us for patient services. The assignment of patients to the various RUG categories is subject to post–payment review by Medicare intermediaries or their agents. 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. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled or are no longer subject to such audits, reviews, and investigations. We believe currently that any differences between the net revenues recorded and final determination will not materially affect the consolidated financial statements. We have made provisions of approximately $15,108,000 and $16,108,000 as of December 31, 2019 and 2018, respectively, for various Medicare, Medicaid, and Managed Care claims reviews and current and prior year cost reports.

Note 3 – Other Revenues

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

(in thousands)	Year Ended December 31, 2019	2018	2017
Insurance services	$ 6,209	$ 7,084	$ 8,003
Management and accounting service fees	18,533	15,175	16,169
Rental income	22,641	22,262	21,957
Other	1,128	1,386	1,024
Gain on sale of skilled nursing facility	—	1,668	—
Total other revenues	$48,511	$47,575	$47,153

Insurance Services

For workers' compensation insurance services, the premium revenues reflected in the consolidated statements of operations for the years ended December 31, 2019, 2018 and 2017 were $3,536,000, $4,392,000, and $5,300,000, respectively. Associated losses and expenses are reflected in the consolidated statements of operations as ″Salaries, wages and benefits.″

For professional liability insurance services, the premium revenues reflected in the consolidated statements of operations for the years ended December 31, 2019, 2018 and 2017 were $2,673,000, $2,692,000, and $2,703,000, respectively. Associated losses and expenses including those for self–insurance are included in the consolidated statements of operations as ‘‘Other operating costs and expenses’’.

Management Fees from National

We have managed skilled nursing facilities for National since 1988, and we currently manage five facilities. See Note 18 regarding our relationship with National.

During 2019, 2018 and 2017, National paid and we recognized approximately $6,627,000, $4,304,000, and $4,194,000, respectively, of management fees and interest on management fees. Unrecognized and unpaid management fees and interest on management fees from National total $19,148,000 and $21,398,000 at December 31, 2019 and 2018, respectively.

The unpaid fees from these five facilities, because collection of substantially all of the contract consideration was not probable when the performance obligation was satisfied, will be recognized as revenues only in the period in which the amounts are received as we have no remaining obligation for those services provided. Under the terms of our management agreement with National, the payment of these fees to us may be subordinated to other expenditures of the five skilled nursing facilities. We continue to manage these facilities so that we may be able to collect our fees in the future and because the incremental savings from discontinuing services to a facility may be small compared to the potential benefit. We may receive payment for the unrecognized management fees in whole or in part in the future only if cash flows from the operating and investing activities of centers or proceeds from the sale of the centers are sufficient to pay the fees. There can be no assurance that such future improved cash flows will occur.

Management Fees and Financial and Accounting Services for Other Healthcare Centers

During 2019, 2018 and 2017, we provided management services to certain healthcare facilities (in addition to the five National centers) operated by third party owners. For the years ended December 31, 2019, 2018 and 2017, we recognized management fees of $2,952,000, $2,532,000 and $2,794,000 from these centers, respectively.

During 2019 and 2018, we provided accounting and financial services to 20 healthcare facilities. No management services are provided for entities in which we provide accounting and financial services.

Rental Income

The Company leases real estate assets consisting of skilled nursing facilities and assisted living facilities to third party operators. Additionally, we sublease four Florida skilled nursing facilities included in our lease from National Health Investors (‘‘NHI’’) as noted in Note 6 – Long Term Leases.

The following table sets forth the undiscounted cash flows for future minimum lease payments receivable for leases in effect at December 31, 2019 (*in thousands*):

2020	$ 22,019
2021	23,011
2022	22,907
2023	22,738
2024	22,730
Thereafter	22,950
Total future minimum lease payments	$136,355

Gain on sale of skilled nursing facility

In October 2018, the Company sold a skilled nursing facility located in Madisonville, Kentucky. The total consideration paid to the Company was $4,300,000, which resulted in a gain of $1,668,000. The gain was recorded in ″Other revenue″ in the consolidated statement of operations.

Note 4 – Non–Operating Income

Non–operating income includes equity in earnings of unconsolidated investments, dividends and other realized gains and losses on marketable securities, interest income, and gains on acquisitions of additional ownership interests of equity method investments.

Our most significant equity method investment is a 75.1% non–controlling ownership interest in Caris HealthCare L.P. (''Caris''), a business that specializes in hospice care services. In 2018, Caris' equity in earnings were negatively impacted by $8,364,000 for the settlement of its Qui Tam legal matter (including legal fees).

	Year Ended December 31,		
(in thousands)	**2019**	**2018**	**2017**
Equity in earnings of unconsolidated investments	$ 9,744	$ 1,020	$ 6,932
Dividends and net realized gains on sale of securities	7,840	7,417	7,335
Interest income	7,188	7,183	6,172
Gain on acquisition of equity method investments	1,975	2,050	—
Total non-operating income	$26,747	$17,670	$20,439

Gain on acquisition of equity method investments

Effective June 1, 2019, the Company expanded its controlled operations through an acquisition of the remaining ownership interest of a 60-bed memory care facility in St. Peters, Missouri. We previously held a noncontrolling interest in the facility and accounted for the investment as an equity method investment. The operating results of the business have been included in the consolidated financial statements since the remaining ownership interest acquisition date.

Upon acquiring the remaining ownership interest, the Company recorded and increased its previously held equity interest up to fair value as of the acquisition date. This remeasurement of our equity interest at fair value resulted in a gain of $1,975,000 during the second quarter of 2019. The gain was recorded in ''Non-operating income'' in the consolidated statements of operations.

In July 2018, the Company expanded its operations through an acquisition of additional ownership resulting in a controlling financial interest of a 14-bed geriatric psychiatric hospital in Osage Beach, Missouri. We previously held a noncontrolling interest and accounted for the hospital as an equity method investment. The operating results of the business have been included in the consolidated financial statements since the controlling interest acquisition date. Upon acquiring a controlling financial interest, the Company fair valued its previously held equity interest as of the acquisition date. This remeasurement of our equity interest at fair value resulted in a gain of $2,050,000 during the third quarter of 2018.

Note 5 – 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 our behavioral health hospital, and (2) homecare services. These reportable operating segments are consistent with information used by the Company's Chief Executive Officer, as 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.

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

	Year Ended December 31, 2019			
	Inpatient Services	Homecare	All Other	Total
Revenues:				
Net patient revenues	$893,201	$54,671	$ —	$947,872
Other revenues	910	—	47,601	48,511
Net operating revenues	894,111	54,671	47,601	996,383
Costs and Expenses:				
Salaries, wages and benefits	526,430	33,037	33,364	592,831
Other operating	242,435	17,003	9,004	268,442
Facility rent	32,748	1,854	5,916	40,518
Depreciation and amortization	38,731	250	3,438	42,419
Interest	1,578	—	1,557	3,135
Total costs and expenses	841,922	52,144	53,279	947,345
Income (loss) before non-operating income	52,189	2,527	(5,678)	49,038
Non-operating income	—	—	26,747	26,747
Unrealized gains on marketable equity securities	—	—	12,230	12,230
Income before income taxes	$ 52,189	$ 2,527	$33,299	$ 88,015

	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			
	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

Note 6 – Long–Term Leases

Upon adopting ASC Topic 842, as noted in Note 1 - Summary of Significant Accounting Policies, the Company has elected the package of practical expedients offered in the transition guidance which allows management not to reassess lease identification, lease classification, and initial direct costs. The Company has elected the accounting policy practical expedient to exclude recording short-term leases, for all asset classes, as right-of-use assets and lease liabilities on the consolidated balance sheets. Finally, the Company has elected the accounting policy practical expedient to recognize lease components and non-lease components together and not as separate parts of a lease for real estate leases.

Operating Leases with NHI

As of December 31, 2019, we leased from NHI the real property of 35 skilled nursing facilities, seven assisted living centers and three independent living centers under two separate lease agreements. As part of the first lease agreement, we sublease four Florida skilled nursing facilities to a third-party operator.

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

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

Base rent expense under both NHI lease agreements totals $34,200,000 annually. Percentage rent under the leases is based on a quarterly calculation of revenue increases and is payable on a quarterly basis. Percentage rent expense under both leases for 2019, 2018, and 2017 was $3,587,000, $3,713,000 and $3,057,000, respectively.

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

Finance Leases

Effective June 1, 2014, NHC began leasing and operating three senior healthcare facilities in the state of Missouri under three separate lease agreements. Two of the healthcare facilities are skilled nursing facilities that also include assisted living facilities and the third healthcare facility is a memory care facility. Each of the leases is a ten-year lease with two five–year renewal options. Under the terms of the leases, base rent totals $5,200,000 annually with rent thereafter escalating by 4% of the increase in facility revenue over the 2014 base year.

Fixed assets recorded under the finance leases, which are included in property and equipment in the consolidated balance sheets, are as follows *(in thousands)*:

	December 31,	
	2019	**2018**
Buildings and personal property	$ 39,032	$ 39,032
Accumulated amortization	(22,859)	(18,970)
	$ 16,173	$ 20,062

Lease Classification

At December 31, 2019, the Company recorded the following on the consolidated balance sheets (*in thousands*):

Right-of-Use Assets	**Balance Sheet Classification**	**December 31, 2019**
Finance lease assets	Net property and equipment	$ 16,173
Operating lease right-of-use assets	Operating lease right-of-use assets	202,909
Total		$219,082

Lease Liabilities	**Balance Sheet Classification**	**December 31, 2019**
Current:		
Finance lease liabilities	Finance lease obligations, current portion	$ 4,166
Operating lease liabilities	Operating lease liabilities, current portion	24,243
Noncurrent:		
Finance lease liabilities	Finance lease obligations, less current portion	14,963
Operating lease liabilities	Operating lease liabilities, less current portion	178,666
Total		$222,038

Weighted-average remaining lease terms and discount rates at December 31, 2019 is as follows:

Weighted-average remaining lease terms (in years)	
Finance	4.2
Operating	7.1
Weighted-average discount rate	
Finance	6.0%
Operating	6.0%

Lease Costs

For the year ended December 31, 2019, the lease costs recorded in the consolidated statement of operations are as follows *(in thousands):*

	Year Ended December 31, 2019
Finance lease costs:	
Depreciation of leased assets	$ 3,889
Interest of lease liabilities	1,306
Total finance lease costs	5,195
Operating lease costs:	
Operating lease costs	35,881
Variable lease costs	3,587
Short-term lease costs	1,050
Total operating lease costs	40,518
Total lease costs	$45,713

Minimum Lease Payments

The following table summarizes the maturity of our finance and operating lease liabilities as of December 31, 2019 (*in thousands*):

	Finance Leases	Operating Leases
2020	$ 5,200	$ 35,569
2021	5,200	35,236
2022	5,200	34,869
2023	5,200	34,475
2024	867	34,319
Thereafter	—	74,150
Total minimum lease payments	$21,667	$248,618
Less: amounts representing interest	(2,538)	(45,709)
Present value of future minimum lease payments	19,129	202,909
Less: current portion	(4,166)	(24,243)
Noncurrent lease liabilities	$14,963	$178,666

Other

Supplemental cash flow data for the year ended December 31, 2019 was as follows *(in thousands)*:

Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows for operating leases	$35,881
Operating cash flows for finance leases	1,306
Financing cash flows for finance leases	3,923

Note 7 – Earning Per Share

The following table summarizes the earnings and the weighted average number of common shares used in the calculation of basic and diluted earnings per share *(in thousands, except share and per share amounts)*:

	Year Ended December 31,		
	2019	2018	2017
Basic:			
Weighted average common shares outstanding	15,270,154	15,224,886	15,189,920
Net income attributable to common stockholders of National Healthcare Corporation	$ 68,211	$ 58,964	$ 56,205
Earnings per common share, basic	$ 4.47	$ 3.87	$ 3.70
Diluted:			
Weighted average common shares outstanding	15,270,154	15,224,886	15,189,920
Dilutive effect of stock options	89,892	11,940	29,042
Assumed average common shares outstanding	15,360,046	15,236,826	15,218,962
Net income attributable to common stockholders of National Healthcare Corporation	$ 68,211	$ 58,964	$ 56,205
Earnings per common share, diluted	$ 4.44	$ 3.87	$ 3.69

Note 8 – Investments in Marketable Securities

Our investments in marketable securities include marketable equity securities and restricted marketable debt securities. Our investments in marketable equity securities are carried at fair value with the changes in unrealized gains and losses recognized in our results of operations at each measurement date. Our investments in restricted marketable debt securities are classified as available for sale securities and carried at fair value with the unrealized gains and losses recognized through accumulated other comprehensive income at each measurement date. Realized gains and losses from securities sales are recognized in results of operations upon disposition of the securities using the specific identification method on a trade date basis.

Marketable securities and restricted marketable securities consist of the following *(in thousands)*:

	December 31, 2019		December 31, 2018	
(in thousands)	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Investments available for sale:				
Marketable equity securities	$ 30,176	$152,453	$ 30,176	$140,223
Restricted investments available for sale:				
Corporate debt securities	63,414	65,653	69,439	67,632
Asset–backed securities	54,451	55,185	62,772	62,068
U.S. Treasury securities	13,379	13,410	22,038	21,457
State and municipal securities	12,922	13,158	21,818	21,436
	$174,342	$299,859	$206,243	$312,816

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

	December 31, 2019			December 31, 2018		
	Shares	Cost	Fair Value	Shares	Cost	Fair Value
NHI Common Stock	1,630,642	$24,734	$132,865	1,630,642	$24,734	$123,179

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

(in thousands)	December 31, 2019 Cost	December 31, 2019 Fair Value	December 31, 2018 Cost	December 31, 2018 Fair Value
Maturities:				
Within 1 year	$ 15,726	$ 15,767	$ 11,448	$ 11,401
1 to 5 years	88,314	90,408	98,487	97,430
6 to 10 years	40,126	41,231	64,932	62,527
Over 10 years	—	—	1,200	1,235
	$144,166	$147,406	$176,067	$172,593

Gross unrealized gains related to marketable equity securities are $122,290,000 and $110,081,000 as of December 31, 2019 and 2018, respectively. Gross unrealized losses related to marketable equity securities are $13,000 and $34,000 as of December 31, 2019 and 2018, respectively. For the years ended December 31, 2019 and 2018, the Company recognized net unrealized gains of $12,230,000 and $1,138,000, respectively, in the consolidated statements of operations.

Gross unrealized gains related to available for sale marketable debt securities are $3,407,000 and $335,000 as of December 31, 2019 and 2018, respectively. Gross unrealized losses related to available for sale marketable debt securities are $167,000 and $3,809,000 as of December 31, 2019 and 2018, respectively.

For the marketable securities in gross unrealized loss positions, (a) it is more likely than not that the Company will not be required to sell the investment securities before recovery of the unrealized losses, and (b) the Company expects that the contractual principal and interest will be received on the investment securities. As a result, the Company recognized no other-than-temporary impairment for the years ended December 31, 2019 and 2018.

Proceeds from the sale of available for sale marketable debt securities during the years ended December 31, 2019, 2018, and 2017 were $44,500,000, $4,539,000, and $50,197,000, respectively. Net investment gains of $127,000, $18,000, and $262,000 were realized on these sales during the years ended December 31, 2019, 2018, and 2017, respectively. No sales were reported for the marketable equity securities for the years ended December 31, 2019, 2018, and 2017.

Note 9 – Fair Value Measurements

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

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

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

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

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

Valuation of Marketable Securities

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

We validated the prices provided by our broker by reviewing their pricing methods, obtaining market values from other pricing sources, analyzing pricing data in certain instances and confirming that the relevant markets are active. After completing our validation procedures, we did not adjust or override any fair value measurements provided by our broker as of December 31, 2019 or 2018.

Other

The carrying amounts of cash and cash equivalents, restricted cash and cash equivalents, accounts receivable, and accounts payable approximate fair value due to their short–term nature. The estimated fair value of notes receivable approximates the carrying value based principally on their underlying interest rates and terms, maturities, collateral and credit status of the receivables. Our long–term debt approximates fair value due to variable interest rates. At December 31, 2019 and 2018, there were no material differences between the carrying amounts and fair values of NHC's financial instruments.

The following table summarizes fair value measurements by level at December 31, 2019 and December 31, 2018 for assets and liabilities measured at fair value on a recurring basis *(in thousands)*:

		Fair Value Measurements Using		
December 31, 2019	**Fair Value**	**Quoted Prices in Active Markets For Identical Assets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Cash and cash equivalents	$ 50,334	$ 50,334	$ —	$—
Restricted cash and cash equivalents	10,676	10,676	—	—
Marketable equity securities	152,453	152,453	—	—
Corporate debt securities	65,653	48,584	17,069	—
Asset–backed securities	55,185	—	55,185	—
U.S. Treasury securities	13,410	13,410	—	—
State and municipal securities	13,158	1,975	11,183	—
Total financial assets	$360,869	$277,432	$83,437	$—

		Fair Value Measurements Using		
December 31, 2018	**Fair Value**	**Quoted Prices in Active Markets For Identical Assets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Cash and cash equivalents	$ 43,247	$ 43,247	$ —	$—
Restricted cash and cash equivalents	11,673	11,673	—	—
Marketable equity securities	140,223	140,223	—	—
Corporate debt securities	67,632	47,921	19,711	—
Asset–backed securities	62,068	—	62,068	—
U.S. Treasury securities	21,457	21,457	—	—
State and municipal securities	21,436	—	21,436	—
Total financial assets	$367,736	$264,521	$103,215	$—

Note 10 – Property and Equipment

Property and equipment, at cost, consists of the following *(in thousands)*:

	December 31,	
	2019	2018
Land	$ 61,018	$ 59,300
Leasehold improvements	122,520	118,142
Buildings and improvements	644,236	611,516
Furniture and equipment	177,717	171,058
Construction in progress	11,713	19,072
Property and equipment, at cost	1,017,204	979,088
Less: Accumulated depreciation	(481,774)	(444,438)
Net property and equipment	$ 535,430	$ 534,650

The Company estimates the cost to complete construction in progress is approximately $1,556,000 at December 31, 2019.

Note 11 – Notes Receivable

At December 31, 2019 and 2018, we have notes receivable from healthcare facilities totaling $15,079,000 and $10,996,000, respectively, reflected in the accompanying consolidated balance sheets. The notes include working capital loans and a first mortgage, ranging from 6% to 8% fixed interest rates and periodic payments required prior to maturity. The notes mature in the years from 2020 to 2025.

Note 12 – Long–Term Debt

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

	Interest Rate at Dec. 31, 2019	Maturities	December 31, 2019	December 31, 2018
Credit Facility, interest payable monthly	Variable, 3.1%	2020	$ 10,000	$55,000
Less current portion			(10,000)	—
			$ —	$55,000

$60,000,000 Credit Facility

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

As of December 31, 2019, the available borrowing capacity for the credit facility is $50 million.

The Credit Agreement contains customary representations and financial covenants, including covenants that restrict, among other things, asset dispositions, mergers and acquisitions, dividends, restricted payments, debt, liens, investments and affiliate transactions. The Credit Agreement contains customary events of default. As of December 31, 2019, the Company is compliant with all financial covenants.

The aggregate maturities of long–term debt for the five years subsequent to December 31, 2019 are as follows *(in thousands)*:

	Long–Term Debt
2020	$10,000
2021	—
2022	—
2023	—
2024	—
Thereafter	—
Total	$10,000

Note 13 – Income Taxes

The provision for income taxes is comprised of the following components *(in thousands)*:

	Year Ended December 31,		
	2019	2018	2017
Current Tax Provision			
Federal	$13,356	$13,583	$23,038
State	1,101	1,612	2,150
Total current tax provision	14,457	15,195	25,188
Deferred Tax Provision			
Federal	4,048	610	(6,548)
State	1,534	380	227
Total deferred tax provision	5,582	990	(6,321)
Income Tax Provision	$20,039	$16,185	$18,867

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

	December 31,	
	2019	2018
Deferred tax assets:		
Allowance for doubtful accounts receivable	$ 46	$ 48
Accrued risk reserves	1,625	1,433
Accrued expenses	5,926	5,504
Financial reporting depreciation in excess of tax depreciation	3,966	6,340
Stock based compensation	666	959
Non-refundable entrance fees	89	103
Obligation to provide future services	530	580
Deferred revenue	5,425	3,480
State net operating loss carryforwards	—	5,762
Operating lease liabilities	52,870	—
Total gross deferred tax assets	71,143	24,209
Less: Valuation allowance	—	(5,762)
Deferred tax assets less valuation allowance	$71,143	$18,447

	December 31,	
	2019	2018
Deferred tax liabilities:		
Unrealized gains on marketable securities	$(32,638)	$(28,032)
Deferred gain on sale of assets, net	(2,094)	(2,146)
Book basis in excess of tax basis of intangible assets	(2,063)	(1,748)
Book basis in excess of tax basis of securities	(2,172)	(1,889)
Long–term investments	(3,318)	(3,182)
Operating lease assets	(52,870)	—
Total deferred tax liabilities	$(95,155)	$(36,997)
Net deferred tax liability	$(24,012)	$(18,550)

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

	Year Ended December 31,		
	2019	2018	2017
Tax provision at federal statutory rate	$18,483	$15,726	$26,092
Increase (decrease) in income taxes resulting from:			
Tax expense from minority interest	61	71	204
State, net of federal benefit	3,850	3,213	2,647
Nondeductible expenses	207	478	230
Return to provision	(793)	(1,418)	—
Share based payments	(263)	(136)	(237)
Insurance expense	(82)	(128)	(103)
Revalue tax assets/liabilities due to federal tax reform	—	—	(8,488)
Other, net	128	15	(338)
Unrecognized tax benefits	512	586	613
Expiration of statute of limitations	(2,064)	(2,222)	(1,753)
Total increases (decreases)	1,556	459	(7,225)
Effective income tax expense	$20,039	$16,185	$18,867

The exercise of non–qualified stock options results in state and federal income tax benefits to the Company related to the difference between the market price at the date of exercise and the option exercise price. During 2019, 2018 and 2017, $263,000, $136,000, and $237,000, respectively, attributable to the tax (expense) benefit of stock options exercised and restricted stock vested, was recorded. Such tax benefits are recorded in the income statement.

Our deferred tax assets have been evaluated for realization based on historical taxable income, tax planning strategies, the expected timing of reversals of existing temporary differences and future taxable income anticipated. Our deferred tax assets are more likely than not to be realized in full due to the existence of sufficient taxable income of the appropriate character under the tax law.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (‘‘2017 Tax Act’’) was signed into law making significant changes to the Internal Revenue Code. The SEC issued Staff Accounting Bulletin No. 118 (‘‘SAB 118’’), which provides guidance on accounting for the tax effects of the 2017 Tax Act. As of December 31, 2017, we made a reasonable estimate that the revaluation of our net deferred tax liability using the new federal corporate tax rates resulted in a provisional net tax benefit of $8,488,000, which reduced our net deferred tax liability balance. After analyzing existing statute and additional guidance on the 2017 Tax Act, we have not made any adjustments to the provisional adjustment made as of December 31, 2017.

Uncertain tax positions may arise where tax laws may allow for alternative interpretations or where the timing of recognition of income is subject to judgment. We believe we have adequate provisions for unrecognized tax benefits related to uncertain tax positions. However, because of uncertainty of interpretation by various tax authorities and the possibility that there are issues that have not been recognized by management, we cannot guarantee we have

accurately estimated our tax liabilities. We believe that our liabilities reflect the anticipated outcome of known uncertain tax positions in conformity with ASC Topic 740 *Income Taxes*. Our liabilities for unrecognized tax benefits are presented in the consolidated balance sheets within other noncurrent liabilities.

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

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

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

	Deferred Tax Asset	Liability For Unrecognized Tax Benefits	Liability For Interest and Penalties	Liability Total
Balance, January 1, 2017	8,023	12,965	3,337	16,302
Additions based on tax positions related to the current year	1,219	1,219	—	1,219
Additions for tax positions of prior years	342	844	865	1,709
Reductions for statute of limitation expirations	(1,682)	(2,508)	(927)	(3,435)
Revaluation due to federal tax reform	(2,854)	—	—	—
Balance, December 31, 2017	5,048	12,520	3,275	15,795
Additions based on tax positions related to the current year	811	811	—	811
Additions for tax positions of prior years	209	388	937	1,325
Reductions for statute of limitation expirations	(505)	(1,786)	(941)	(2,727)
Balance, December 31, 2018	5,563	11,933	3,271	15,204
Additions based on tax positions related to the current year	1,418	1,418	—	1,418
Additions for tax positions of prior years	907	1,002	973	1,975
Reductions for statute of limitation expirations	(475)	(1,604)	(935)	(2,539)
Balance, December 31, 2019	$ 7,413	$12,749	$3,309	$16,058

During the year ended December 31, 2019, we have recognized a $1,604,000 decrease in unrecognized tax benefits and an accompanying $935,000 decrease of related interest and penalties due to the effect of statute of limitations lapse. The favorable impact on our tax provision was $2,064,000. During the years ended December 31, 2018 and 2017, the favorable impact on our tax provision due to the effect of statute of limitations lapsing was $2,222,000 and $1,753,000, respectively.

Unrecognized tax benefits of $5,829,000, net of federal benefit at December 31, 2019, attributable to permanent differences, would favorably impact our effective tax rate if recognized. We do not expect significant increases or decreases in unrecognized tax benefits within the twelve months beginning December 31, 2019, except for the effect of decreases related to the lapse of statute of limitations estimated at $2,834,000.

Interest and penalties expense related to U.S. federal and state income tax returns are included within income tax expense. Interest and penalties expense (benefit) was $38,000, $(4,000), and $(62,000) for the years ended December 31, 2019, 2018, and 2017, respectively.

The Company is no longer subject to U.S. federal and state examinations by tax authorities for years before 2016 (with few state exceptions).

Note 14 – Stock Repurchase Program

In August 2019, the Board of Directors authorized a common stock purchase program. The program will allow for repurchases of up to $25 million of its common stock. The stock repurchase plan began on September 1, 2019 and will expire on August 31, 2020. No repurchases have been made under this plan.

During the first quarter of 2019 and under a previous plan which expired on August 31, 2019, the Company purchased 10,396 shares of its common stock for a total cost of $872,000. 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.

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

Note 15 – Stock–Based Compensation

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

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

In May 2010, our stockholders approved the 2010 Omnibus Equity Incentive Plan (″the Equity Plan″) pursuant to which 1,200,000 shares of our common stock were available to grant as stock–based payments to key employees, directors, and non–employee consultants. In May 2015, our stockholders approved to amend the Equity Plan to increase the number of shares of our common stock authorized from the original 1,200,000 shares to 2,575,000 shares. At December 31, 2019, 632,142 shares were available for future grants under the Equity Plan.

Additionally, we have an employee stock purchase plan that allows employees to purchase our shares of stock through payroll deductions. The plan allows employees to terminate participation at any time.

Compensation expense is recognized only for the awards that ultimately vest. The Company accounts for forfeitures when they occur. Stock–based compensation totaled $1,878,000, $1,778,000, and $1,678,000, for the years ended December 31, 2019, 2018, and 2017, respectively. Stock–based compensation is included in salaries, wages and benefits in the consolidated statements of operations. Tax deductions for the options exercised totaled $3,918,000, $1,047,000, and $933,000 for the years ended December 31, 2019, 2018, and 2017, respectively. The total intrinsic value of shares exercised was $3,960,000, $1,047,000, and $933,000 for the years ended December 31, 2019, 2018 and 2017, respectively.

At December 31, 2019, the Company had $3,550,000 of unrecognized compensation cost related to unvested stock-based compensation awards. This unrecognized compensation cost will be amortized over an approximate three-year period.

Stock Options

The Company is required to estimate the fair value of stock–based awards on the date of grant. The fair value of each option award is estimated using the Black–Scholes option valuation model with the weighted average assumptions indicated in the following table. Each grant is valued as a single award with an expected term based upon expected employment and termination behavior. Compensation cost is recognized over the requisite service period in a manner consistent with the option vesting provisions. The straight–line attribution method requires that compensation expense is recognized at least equal to the portion of the grant–date fair value that is vested at that date. The expected volatility is derived using weekly historical data for periods immediately preceding the date of grant.

The risk–free interest rate is the approximate yield on the United States Treasury Strips having a life equal to the expected option life on the date of grant. The expected life is an estimate of the number of years an option will be held before it is exercised. The following table summarizes the assumptions used to value the options granted in the periods shown.

	Year Ended December 31,		
	2019	2018	2017
Risk–free interest rate	2.30%	2.46%	2.08%
Expected volatility	17.4%	16.1%	16.6%
Expected life, in years	2.3	3.0	4.8
Expected dividend yield	2.73%	3.29%	3.10%

The following table summarizes option activity:

	Number of Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value
Options outstanding at January 1, 2017	177,959	55.48	—
Options granted	1,125,443	72.96	—
Options exercised	(48,995)	51.25	—
Options cancelled	(15,000)	72.94	—
Options outstanding at December 31, 2017	1,239,407	71.19	—
Options granted	110,265	61.39	—
Options exercised	(68,291)	54.31	—
Options cancelled	(118,000)	72.11	—
Options outstanding at December 31, 2018	1,163,381	71.16	—
Options granted	53,316	77.89	—
Options exercised	(346,168)	71.57	—
Options cancelled	(85,000)	72.94	—
Options outstanding at December 31, 2019	785,529	$71.24	$11,931,000
Options exercisable at December 31, 2019	204,029	$68.20	$ 3,720,000

Options Outstanding December 31, 2019	Exercise Prices	Weighted Average Exercise Price	Weighted Average Remaining Contractual Life in Years
139,968	$60.73–$62.78	$61.81	2.1
645,561	$72.94–$77.92	73.29	2.3
785,529		$71.24	2.3

Note 16 – Contingencies and Guarantees

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 both for our owned or leased entities and certain of the entities to which we provide management or accounting services. The liability we have recognized for reported claims and estimates for incurred but unreported claims totals $96,011,000 and $96,024,000 at December 31, 2019 and 2018, respectively. The liability is included in accrued risk reserves in the consolidated balance sheets. The amounts are subject to adjustment for actual claims incurred. It is possible that these claims plus unasserted claims could exceed our insurance coverages and our reserves, which would have a material adverse effect on our financial position, results of operations and cash flows.

As a result of the terms of our insurance policies and our use of wholly owned limited purpose insurance companies, we have retained significant insurance risk with respect to workers' compensation and 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 deductibles and exposures in excess of coverage limits, and we maintain reserves for these obligations. Such estimates are based on many variables including historical and statistical information and other factors.

Workers' Compensation

For workers' compensation, we utilize a wholly owned Tennessee domiciled property/casualty insurance company to write coverage for NHC affiliates and for third–party customers. Policies are written for a duration of twelve months and cover only risks related to workers' compensation losses. All customers are companies which operate in the long–term care industry. Business is written on a direct basis.

General and Professional Liability Insurance and Lawsuits

The senior care industry has experienced significant increases in both the number of personal injury/wrongful death claims and in the severity of awards based upon alleged negligence by skilled nursing facilities and their employees in providing care to residents. The Company has been, and continues to be, subject to claims and legal actions that arise in the ordinary course of business, including potential claims related to patient care and treatment. The defense of these lawsuits may result in significant legal costs, regardless of the outcome, and can result in large settlement amounts or damage awards. Additional insurance is purchased through third party providers that serve to supplement the coverage provided through our wholly owned captive insurance company.

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

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. 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.

Governmental Regulations

Laws and regulations governing the Medicare, Medicaid and other federal healthcare programs are complex and subject to interpretation. Management believes that it is in compliance with all applicable laws and regulations in all material respects. However, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusions from the Medicare, Medicaid and other federal healthcare programs.

Debt Guarantees

At December 31, 2019, no agreement to guarantee the debt of other parties exists.

Note 17 – Equity Method Investment in Caris HealthCare, L.P.

As of December 31, 2019, we have 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. The carrying value of our investment is $36,673,000 and $30,625,000 at December 31, 2019 and 2018, respectively. The carrying amounts are included in investments in limited liability companies in the consolidated balance sheets. The difference between the carrying value of our investment and our capital account balance in Caris is due to the additional limited partner ownership interest the Company acquired from current and former partners. Summarized financial information of Caris for the years ended December 31, 2019, 2018, and 2017 is provided below *(in thousands)*.

	December 31,		
	2019	2018	2017
Current assets	$25,664	$17,539	$24,582
Noncurrent assets	12,336	10,266	10,490
Liabilities	10,784	8,657	10,113
Partners' capital	27,216	19,148	24,959
Revenue	62,034	56,410	53,586
Expenses	48,803	55,507	46,436
Net income	13,231	903	7,150

Consolidation Considerations

Due to our ownership percentage in Caris, we have considered whether Caris should be consolidated by NHC under the guidance provided in ASC Topic 810, *Consolidation*. We do not consolidate Caris because (1) Caris' equity at risk is sufficient to finance its activities without additional subordinated financial support, (2) the general partner of the Partnership has the power to direct the activities that most significantly impact the economic performance of Caris, and (3) the equity holders of Caris possess the characteristics of a controlling financial interest, including voting rights that are proportional to their economic interests. Supporting the assertions above is the following: (1) the ownership percentage of the general partner remains equally divided between NHC and another party, (2) the general partner manages and controls the Partnership with full and complete discretion, and (3) the limited partners have no right or power to take part in the control of the business of the Partnership, which is where our ownership percentage increases have occurred.

Note 18 – Relationship with National Health Corporation

National Health Corporation (″National″), which is wholly owned by the National Health Corporation Leveraged Employee Stock Ownership Plan (″ESOP″), was formed in 1986 and is our administrative services affiliate and contractor. As discussed below, all of the personnel conducting our business, including our executive management team, are employees of National and may have ownership interests in National only through their participation as employees in the ESOP.

Management Contracts

We currently manage five skilled nursing facilities for National under a management contract. The management contract has been extended until January 1, 2028. See Note 3 for additional information regarding management services fees recognized from National.

Financing Activities

During 1991, we borrowed $10,000,000 from National. The note payable required quarterly interest payments at the prime rate minus 0.85 percent. The entire principal was repaid during the third quarter of 2018.

In conjunction with our management contract, we have entered into a line of credit arrangement whereby we may have amounts due from National from time to time. The maximum loan commitment under the line of credit is $2,000,000. At December 31, 2019, National did not have an outstanding balance on the line of credit.

The maximum line of credit commitment amount of $2,000,000 is also the amount of a deferred gain that has been outstanding since NHC sold certain assets to National in 1988. The amount of the deferred gain is expected to remain deferred until the management contract with National expires, currently scheduled in January 2028. The deferred gain is included in deferred revenue in the consolidated balance sheets.

Payroll and Related Services

The personnel conducting our business, including our executive management team, are employees of National and may have ownership interests in National only through their participation in the ESOP. National provides payroll services to NHC, provides employee fringe benefits, and maintains certain liability insurance. We pay to National all the costs of personnel employed for our benefit, as well as an administrative fee equal to 1% of payroll costs. The administrative fee paid to National for the years ended December 31, 2019, 2018, and 2017 was $5,131,000, $5,064,000, and $5,134,000, respectively. At December 31, 2019 and 2018, the Company has recorded $1,653,000 and $3,081,000, respectively, in accounts receivable and $79,000 and $80,000, respectively, in accounts payable in the consolidated balance sheets as a result of the timing differences between interim payments for payroll and employee benefits services costs.

National's Ownership of Our Stock

At December 31, 2019, National owns 1,084,763 shares, or approximately 7.1%, of our outstanding common stock.

Consolidation Considerations

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

Note 19 – Variable Interest Entity

Accounting guidance requires that a variable interest entity (''VIE''), according to the provisions of ASC Topic 810, *Consolidation*, must be consolidated by the primary beneficiary. The primary beneficiary is the party that has both the power to direct activities of a VIE that most significantly impact the entity's economic performance and the obligation to absorb losses of the entity or the right to receive benefits from the entity that could potentially be significant to the VIE. We perform ongoing qualitative analysis to determine if we are the primary beneficiary of a VIE. At December 31, 2019, we are the primary beneficiary of one VIE and therefore consolidate that entity.

Springfield, Missouri Lease

In December 2010, we signed an operating agreement to lease Springfield Rehabilitation and Health Care Center, a 120–bed skilled nursing facility located in Springfield, Missouri. The terms of the lease include a ten-year lease and include five additional, five-year lease options as well as a purchase option. The operating lease agreement was established on the same date third party owners purchased the real estate of the 120–bed skilled nursing facility. The third-party owners purchased the real estate for $4,500,000, which is the amount NHC loaned the owners to purchase the facility under the terms of the lease agreement and the mortgage note. The risks and rewards associated with the operations of the facility and any appreciation or deprecation in the value of the real estate of the facility

is borne by NHC. A mortgage note receivable from the third-party owners of $11,047,000 at December 31, 2019 and 2018 is eliminated in our consolidated financial statements. Land and buildings and improvements of $11,047,000 at December 31, 2019 and 2018 have been recorded in our consolidated financial statements, as well as the operations of the facility because we are the primary beneficiary in the relationship.

Note 20 – Selected Quarterly Financial Data

(unaudited, in thousands, except per share amounts)

The following table sets forth selected quarterly financial data for the two most recent fiscal years.

2019	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Net operating revenues	$248,285	$247,151	$247,067	$253,880
Income from operations	15,784	10,189	6,568	16,497
Non–operating income	6,001	8,272	6,663	5,811
Unrealized gains (losses) on marketable equity securities	6,838	(54)	9,312	(3,866)
Net income attributable to NHC	21,269	13,711	19,461	13,770
Basic earnings per share	1.39	.90	1.27	0.91
Diluted earnings per share	1.39	.89	1.27	0.89

2018	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Net operating revenues	$242,961	$242,142	$246,326	$248,920
Income from operations	15,883	12,165	10,834	17,194
Non–operating (loss) income	(3,065)	5,654	8,467	6,614
Unrealized (loss) gains on marketable equity securities	(15,517)	12,448	3,486	721
Net (loss) income attributable to NHC	(2,791)	22,461	21,142	18,152
Basic (loss) earnings per share	(0.18)	1.47	1.39	1.19
Diluted (loss) earnings per share	(0.18)	1.47	1.39	1.19

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

Based on their evaluation as of December 31, 2019, the Chief Executive Officer and Principal Accounting Officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in Rules 13a–15(e) and 15d–15(e) under the Securities Exchange Act of 1934, as amended) were effective to ensure that the information required to be disclosed by us in this Annual Report on Form 10–K was recorded, processed, summarized and reported within the time periods specified in the SEC's rules and instructions for Form 10–K.

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

We are responsible for establishing and maintaining adequate internal control over financial reporting (as defined in Rule 13a–15(f) under the Securities Exchange Act of 1934, as amended). We assessed the effectiveness of our internal control over financial reporting as of December 31, 2019. In making this assessment, our management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (″COSO″) in Internal Control–Integrated Framework (2013 Framework). We have concluded that, as of December 31, 2019, our internal control over financial reporting is effective based on these criteria. Our independent registered public accounting firm, Ernst & Young, LLP, has issued an attestation report on the effectiveness of the Company's internal control over financial reporting included herein.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholders and Board of Directors of National HealthCare Corporation

Opinion on Internal Control Over Financial Reporting

We have audited National HealthCare Corporation's internal control over financial reporting as of December 31, 2019, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, National HealthCare Corporation (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2019, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2019 and 2018, and the related consolidated statements of operations, comprehensive income, equity, and cash flows for each of the three years in the period ended December 31, 2019, and the related notes and financial statement schedule listed in the Index at Item 15(a) and our report dated February 21, 2020 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. 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 audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 21, 2020

Changes in Internal Control

There were no changes in our internal control over financial reporting during the quarter ended December 31, 2019 that have materially affected or are reasonably likely to materially affect our internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information in our definitive 2020 proxy statement set forth under the captions *Directors of the Company* and *Executive Officers of the Company* is hereby incorporated by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information in our definitive 2020 proxy statement set forth under the caption *Compensation Discussion & Analysis* is hereby incorporated by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information in our definitive 2020 proxy statement set forth under the captions *Section 16(A) Beneficial Ownership Reporting Compliance* is hereby incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS AND DIRECTOR INDEPENDENCE

The information in our definitive 2020 proxy statement set forth under the caption *Certain Relationships and Related Transactions* is hereby incorporated by reference.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information in our definitive 2020 proxy statement set forth under the caption *Report of the Audit Committee* is hereby incorporated by reference (which will be filed within 120 days of the end of the fiscal year to which this report relates).

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULE

The following documents are filed as a part of this report:

(a) (1) Financial Statements:

The Financial Statements are included in Item 8 and are filed as part of this report.

(2) Financial Statement Schedule:

NATIONAL HEALTHCARE CORPORATION
SCHEDULE II – VALUATION AND QUALIFYING ACCOUNTS
FOR THE YEARS ENDED DECEMBER 31, 2019, 2018 AND 2017
(in thousands)

Column A	Column B	Column C		Column D	Column E
		Additions			
Description	Balance–Beginning of Period	Charged to Costs and Expenses	Charged to other Accounts	Deductions	Balance–End of Period
For the year ended December 31, 2017					
Accrued risk reserves	$91,162	$71,229	$–	$69,116	$93,275
For the year ended December 31, 2018					
Accrued risk reserves	$93,275	$75,052	$–	$72,303	$96,024
For the year ended December 31, 2019					
Accrued risk reserves	$96,024	$79,959	$–	$79,972	$96,011

All other financial statement schedules are not required under the related instructions or are inapplicable and therefore have been omitted.

(3) Exhibits:

EXHIBIT INDEX

Exhibit No.	Description	Page No. or Location
3.1	Certificate of Incorporation of National HealthCare Corporation	Incorporated by reference to Exhibit 3.1 to the Registrant's registration statement on Form S–4 (File No. 333–37185) dated October 3, 1997)
3.2	Certificate of Amendment to the Certificate of Incorporation of National HealthCare Corporation	Specifically incorporated by reference to Exhibit 3.5 attached to Form 10-Q filed on August 3, 2017
3.3	Certificate of Designations of Series A Convertible Preferred Stock of National HealthCare Corporation	Incorporated by reference to Exhibit 2.1 to the current report on Form 8–K filed on December 20, 2006
3.4	Certificate of Designation Series B Junior Participating Preferred Stock	Incorporated by reference to Exhibit 3.1 to the Registrant's registration statement on Form 8–A, dated August 3, 2007
3.5	Restated Bylaws as amended February 14, 2013	Specifically incorporated by reference to Exhibit 3.5 to the quarterly report on Form 10–Q filed on May 8, 2013.
4.1	Form of Common Stock	Specifically incorporated by reference to Exhibit 4.1 attached to Form 10-Q filed on August 3, 2017
4.2	Description of each class of securities registered under Section 12 of the Exchange Act	Filed Herewith
10.1	Master Agreement of Lease dated as of October 17, 1991 by and among National Health Investors, Inc. and National HealthCorp, L.P.	Incorporated by reference to Exhibit 10.1 to the Registrant's registration statement on Form S–4 filed October 3, 1997
10.2	Form of Service Agreement by and between National Health Corporation and National HealthCare Corporation	Incorporated by reference to Exhibit 10.5.1 to the Registrant's registration statement on Form S–4 filed October 3, 1997
10.5	Amendment No. 1 to Master Agreement to Lease between National Health Investors, Inc. and National HealthCorp L.P.	Incorporated by reference to Exhibit 10.19 from 2005 Form 10–K filed March 16, 2006
10.6	Amendment No. 2 to Master Agreement to Lease between National Health Investors, Inc. and National HealthCare L.P.	Incorporated by reference to Exhibit 10.20 from 2005 Form 10–K filed March 16, 2006
10.7	Amendment No. 3 to Master Agreement to Lease between National Health Investors, Inc. and National HealthCare L.P.	Incorporated by reference to Exhibit 10.21 from 2005 Form 10–K filed March 16, 2006

Exhibit No.	Description	Page No. or Location
10.8	Amendment No. 4 to Master Agreement to Lease between National Health Investors, Inc. and National HealthCare L.P.	Incorporated by reference to Exhibit 10.22 from 2005 Form 10–K filed March 16, 2006
10.9	Amendment No. 5 to Master Agreement to Lease between National Health Investors, Inc. and National HealthCare Corporation	Incorporated by reference to Exhibit 10.23 from 2005 Form 10–K filed March 16, 2006
*10.10	National HealthCare Corporation's 2010 Omnibus Equity Incentive Plan	Incorporated by reference to Exhibit A to 2010 Proxy Statement filed April 1, 2010.
*10.11	First Amendment dated February 14, 2011 to the National HealthCare Corporation 2010 Omnibus Equity Incentive Plan	Incorporated by reference to Exhibit 10.16 from 2015 Form 10-K filed February 19, 2016.
*10.12	Amendment dated March 10, 2015 to National HealthCare Corporation's 2010 Omnibus Equity Incentive Plan	Incorporated by reference to Appendix A to 2015 Proxy Statement filed April 1, 2015.
*10.13	2017 NHC Executive Officer Performance Based Compensation Plan	Incorporated by reference to Appendix B to 2017 Proxy Statement filed April 4, 2017.
10.14	Amendment to Purchase and Sale Agreement with Modifications to Master Agreement to Lease between National Health Investors, Inc. and National HealthCare Corporation	Incorporated by reference to Exhibit 10.1 of National HealthCare Corporation's Form 10–Q filed on November 5, 2013
10.15	Agreement to Lease between NHI–REIT of Northeast, LLC, Landlord and NHC/OP, L.P. and National HealthCare Corporation, Co–Tenants	Incorporated by reference to Exhibit 10.4 of National HealthCare Corporation's Form 10–Q filed on November 5, 2013
10.16	Amended and Restated Amendment No. 6 to Master Agreement to Lease between National Health Investors, Inc. and National HealthCare Corporation	Incorporated by reference to Exhibit 10.2 of National HealthCare Corporation's Form 10–Q filed on November 5, 2013
10.17	Amendment No. 7 to Master Agreement to Lease between National Health Investors, Inc. and National HealthCare Corporation	Incorporated by reference to Exhibit 10.3 of National HealthCare Corporation's Form 10–Q filed on November 5, 2013
10.18	Credit Agreement dated as of October 7, 2015 among National HealthCare Corporation and Bank of America	Incorporated by reference to Exhibit 10.1 of National HealthCare Corporation's quarterly report on Form 10–Q filed on November 5, 2015
10.19	Pledge and Security Agreement dated as of October 7, 2015 between National HealthCare Corporation and Bank of America	Incorporated by reference to Exhibit 10.2 of National HealthCare Corporation's quarterly report on Form 10–Q filed on November 5, 2015

Exhibit No.	Description	Page No. or Location
10.20	Note dated October 7, 2015 between National HealthCare Corporation and Bank of America	Incorporated by reference to Exhibit 10.3 of National HealthCare Corporation's quarterly report on Form 10–Q filed on November 5, 2015
10.21	Contribution Agreement dated December 29, 2011 between National HealthCare Corporation and Caris HealthCare, L.P. pursuant to which NHC acquired a 7.5% interest in Caris from McRae in exchange for $7,500,000	Incorporated by reference to Exhibit 10.26 to National HealthCare Corporation's annual report on Form 10–K filed on February 21, 2014
10.22	Assignment of membership interest in Solaris Hospice, LLC dated December 29, 2011 and effective on January 1, 2012, whereby NHC assigned its membership interest to Caris in exchange for an additional 2.7% limited partnership interest in Caris.	Incorporated by reference to Exhibit 10.27 to National HealthCare Corporation's annual report on Form 10–K filed on February 21, 2014
10.23	Purchase and Sale Agreement and Extension of Master Lease dated December 26, 2012 between National Health Investors, Inc. and National HealthCare Corporation	Incorporated by reference to Exhibit 10.29 to National HealthCare Corporation's annual report on Form 10–K filed on February 21, 2014
14	Code of Ethics of National HealthCare Corporation	Available at NHC's website www.nhccare.com or in print upon request to: National HealthCare Corp. Attn: Investor Relations P. O. Box 1398 Murfreesboro, TN 37133–1398 Telephone (615) 890–2020
21	Subsidiaries of Registrant	Filed Herewith
23	Consent of Independent Registered Public Accounting Firm – Ernst & Young LLP	Filed Herewith
31.1	Rule 13a–14(a)/15d–14(a) Certification of Chief Executive Officer	Filed Herewith
31.2	Rule 13a–14(a)/15d–14(a) Certification of Principal Accounting Officer	Filed Herewith
32	Certification pursuant to 18 U.S.C. Section 1350 by Chief Executive Officer and Principal Accounting Officer	Filed Herewith
101.INS	Inline XBRL Instance Document (the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document)	
101.SCH	Inline XBRL Taxonomy Extension Schema Document	

Exhibit No.	Description	Page No. or Location
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document	
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document	
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document	
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document	
104	Cover Page Interactive File (embedded within the Inline XBRL document and included in Exhibit 101)	

* Indicates management contract or compensatory plan or arrangement.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

NATIONAL HEALTHCARE CORPORATION

Date: February 21, 2020

BY: /s/ Stephen F. Flatt
Stephen F. Flatt
Chief Executive Officer and Director

Pursuant to the requirements of the Securities Exchange Act of 1934, this Report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Date: February 21, 2020

/s/ Stephen F. Flatt
Stephen F. Flatt
Chief Executive Officer and Director
(Principal Executive Officer)

Date: February 21, 2020

/s/ Brian F. Kidd
Brian F. Kidd
Senior Vice President and Controller
(Principal Financial Officer)
(Principal Accounting Officer)

Date: February 21, 2020

/s/ Robert G. Adams
Robert G. Adams
Chairman of the Board

Date: February 21, 2020

/s/ J. Paul Abernathy
J. Paul Abernathy
Director

Date: February 21, 2020

/s/ W. Andrew Adams
W. Andrew Adams
Director

Date: February 21, 2020

/s/ Ernest G. Burgess
Ernest G. Burgess
Director

Date: February 21, 2020

/s/ Emil E. Hassan
Emil E. Hassan
Director

Date: February 21, 2020

Richard F. LaRoche, Jr.
Director

EXHIBIT 31.1

CERTIFICATION

I, Stephen F. Flatt, certify that:

1. I have reviewed this annual report on Form 10-K of National HealthCare Corporation;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this annual report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

    b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent function);

    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 21, 2020

/s/ Stephen F. Flatt

Stephen F. Flatt
Chief Executive Officer

EXHIBIT 31.2

CERTIFICATION

I, Brian F. Kidd, certify that:

1. I have reviewed this annual report on Form 10-K of National HealthCare Corporation;

2. Based on my knowledge, this annual report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this annual report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

    b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent function);

    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 21, 2020

/s/ Brian F. Kidd

Brian F. Kidd
Senior Vice President and Controller
(Principal Financial Officer)

Exhibit 32

Certification of Annual Report on Form 10-K
of National HealthCare Corporation
For the Year Ended December 31, 2019

The undersigned hereby certify, pursuant to 18 U.S.C. Section 906 of the Sarbanes-Oxley Act of 2002, that, to the undersigned's best knowledge and belief, the Annual Report on Form 10-K for National HealthCare Corporation (''Issuer'') for the period ending December 31, 2019 as filed with the Securities and Exchange Commission on the date hereof (the ''Report''):

(a) fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(b) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Issuer.

This Certification accompanies the Annual Report on Form 10-K of the Issuer for the annual period ended December 31, 2019.

This Certification is executed as of February 21, 2020.

/s/ Stephen F. Flatt

Stephen F. Flatt
Chief Executive Officer

/s/ Brian F. Kidd

Brian F. Kidd
Principal Accounting Officer

A signed original of this written statement required by Section 906 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

OFFICERS AND DIRECTORS

Corporate Officers

Stephen F. Flatt
Chief Executive Officer

R. Michael Ussery
President and Chief Operating Officer

Vicki L. Dodson
Senior Vice President, Patient Services

B. Anderson Flatt, Sr.
Senior Vice President, Chief Information Officer

Brian F. Kidd
Senior Vice President, Controller and Principal Accounting Officer

Josh A. McCreary
Senior Vice President, General Counsel, and Secretary

Leroy E. McIntosh, Jr.
Senior Vice President, Ancillary Services and Service Line Strategy

Jeffrey R. Smith
Senior Vice President and Treasurer

Board of Directors

Robert G. Adams
Chairman of the Board

Dr. J. Paul Abernathy*
Independent Director
Chairman – Nominating and Corporate Governance Committee

W. Andrew Adams
Affiliated Director

Ernest G. Burgess, III*
Independent Director

Stephen F. Flatt
Inside Director

Emil E. Hassan*
Independent Director
Chairman, Compensation Committee

Richard F. LaRoche, Jr.*
Independent Director
Chairman, Audit Committee

**Member of the Audit Committee, Compensation Committee, and Nominating and Corporate Governance Committee*

CORPORATE INFORMATION

Corporate Headquarters
National HealthCare Corporation
100 E. Vine Street
Murfreesboro, TN 37130
Phone: 615-890-2020
Fax: 615-890-0123
www.nhccare.com

Transfer Agent and Registrar
Computershare Trust Company, N.A.
P. O. Box 505000
Louisville, KY 40233-5000
800-568-3476
www.computershare.com/investor

Listed
NYSE American
NHC

Annual Stockholders' Meeting
City Center, 14th Floor
100 E. Vine Street
Murfreesboro, Tennessee
May 7, 2020
4:00 pm Central Time

Annual Report on Form 10-K
Copies of our Annual Report on Form 10-K and all other U. S. Securities and Exchange Commission Filings are available free of charge on our website or by writing us at the address listed above.

Independent Registered Public Accounting Firm
Ernst & Young LLP
222 2nd Avenue S, Ste. 2100
Nashville, TN 37201

We intend to hold our annual meeting in person. However, we are actively monitoring the coronavirus (COVID-19); we are sensitive to the public health and travel concerns our shareholders may have and the protocols that federal, state, and local governments may impose. In the event it is not possible or advisable to hold our annual meeting in person, we will announce alternative arrangements for the meeting as promptly as practicable, which may include holding the meeting solely by means of remote communication. Please monitor our annual meeting website at **https://nhccare.com/investor-relations** for updated information. If you are planning to attend our meeting, please check the website one week prior to the meeting date. As always, we encourage you to vote your shares prior to the annual meeting.

NHC

NATIONAL HEALTHCARE CORPORATION

National HealthCare Corporation

100 East Vine Street • Murfreesboro, TN 37130

615-890-2020 • nhccare.com