NATIONAL HEALTHCARE CORP
Form 10-K
February 17, 2012

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

FORM 10-K

(Mark One)
[X] ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES AND EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2011

OR

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

For the transition period from _____ to _____

Commission File No. 001-13489

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

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

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

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

Title of Each Class	Name of Each Exchange on which Registered
Shares of Common Stock	**NYSE Amex**
Shares of Preferred Cumulative Convertible Stock	**NYSE Amex**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such period that the registrant was required to submit and post such files).

Yes [x] No [ ]

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company (as defined in Rule 12b-2 of the Act). Large accelerated filer [ ] Accelerated filer [x] Non-accelerated filer [ ] Smaller reporting company [ ]

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

The aggregate market value of Common Stock held by non-affiliates on June 30, 2011 (based on the closing price of such shares on the NYSE Amex) was approximately $363 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 14, 2012 was 13,862,738.

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 2012 shareholder's meeting.

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PART 1

ITEM 1. BUSINESS

General Development of Business

National HealthCare Corporation, which we also refer to as NHC or the Company, began business in 1971. Our principal business is the operation of long-term health care centers with associated assisted living and independent living centers. Our business activities include providing subacute skilled and intermediate nursing and rehabilitative care, senior living services, home health care services and hospice services. In addition, we provide management services, accounting and financial services and insurance services to third party owners of health care facilities. We operate in 11 states, and our owned and leased properties are located primarily in the southeastern United States.

Narrative Description of the Business

Our business is long-term health care services. At December 31, 2011, we operate or manage 75 longterm health care centers with a total of 9,456 licensed beds. These numbers include 54 centers with 7,294 beds that we lease or own and 21 centers with 2,162 beds that we manage for others. Of the 54 leased or owned centers, 34 are leased from National Health Investors, Inc. ("NHI").

Our 17 assisted living centers (13 leased or owned and four managed) have 653 units (575 units leased or owned and 78 units managed).

Our six independent living centers (four leased or owned and two managed) have 485 retirement apartments (338 apartments leased or owned and 147 apartments managed).

We operate 36 homecare programs licensed in three states (Tennessee, South Carolina and Florida) and provided 418,000 homecare patient visits to 14,700 patients in 2011.

We provide hospice services under the name of Solaris Hospice, LLC ("Solaris"), a wholly-owned subsidiary of NHC, in which we operate eight programs located in the state of South Carolina. We also have a partnership agreement with

Caris HealthCare, LP ("Caris") to develop hospice services in selected market locations in Tennessee and Virginia. With our Solaris Hospice programs and our partnership with Caris, we provide hospice care to over 1,000 patients per day in 25 locations. At December 31, 2011, we increased our non-controlling ownership interest in Caris from 56.9% to 64.4%. Effective January 1, 2012, we also contributed our eight Solaris Hospice programs to Caris for an additional non-controlling ownership interest percentage of 2.7%. The two transactions bring our total non-controlling ownership interest in Caris to 67.1% at January 1, 2012.

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

Long-Term Care Services and Net Operating Revenues. Health care services we provide include a comprehensive range of services. In fiscal 2011, 92.5% of our net operating revenues were derived from such health care services. Highlights of health care services activities during 2011 were as follows:

A.

Long-Term Health Care Centers. The most significant portion of our business and the base for our other long-term health care services is the operation of our skilled nursing centers. In our centers, 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 centers provide licensed therapy services, quality nutrition services, social services, activities, and housekeeping and laundry services. We own or lease and operate 54 long-term health care centers as of December 31, 2011. We manage 21 centers for third party owners. Revenues from the 54 centers we own or lease are reported as net patient revenues in our financial statements. Management fee income is recorded as other revenues from the 21 facilities that we manage. We generally charge 6% to 7% of facility net revenues for our management services. Average occupancy in long-term health care centers we operate was 90.6% during the year ended December 31, 2011.

B.

Rehabilitative Services. We provide therapy services through Professional Health Services, a division 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 1,000 highly trained, professional therapists in 2011. The majority of our rehabilitative services are for patients in our owned and managed long-term care centers. However, we also provide services to over 80 additional health care providers. Our rates for these services are competitive with other market rates.

C.

Medical Specialty Units. All of our long-term care centers 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 Alzheimer's disease 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 programming for persons with Alzheimer’s or related disorders in dedicated units within many of our skilled nursing centers. Our specialized rehabilitation programs are designed to shorten or eliminate hospital stays and help to reduce the cost of quality health care. We develop individualized patient care plans to target appropriate medical and functional planning objectives with a primary goal where feasible for a return to home or a similar environment.

D.

Managed Care Contracts. We operate five regional contract management offices, staffed by experienced case managers who contract with managed care organizations (MCO's) and insurance carriers for the provision of subacute and other medical specialty services within a regional cluster of our owned and managed centers. Managed care patient days were 143,223 in 2011, 116,973 in 2010, and 113,675 in 2009.

E.

Assisted Living Centers. Our assisted living centers are dedicated to providing personal care services and assistance with general activities of daily living such as dressing, bathing, meal preparation and medication management. We perform resident assessments to determine what services are desired or required and our qualified staff encourages residents to participate in a range of activities. We own or lease 13 and manage four assisted living centers. Of these 17 centers, 11 are located within the physical structure of a skilled nursing center or retirement center and six are freestanding. In 2011, the rate of occupancy was 84.7%. Certificates of Need are not required to build these projects

and we believe that overbuilding has occurred in some of our markets.

F.

Retirement Centers. Our four owned or leased and two managed retirement centers 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. In most cases, retirement centers also include longterm health care facilities, either in contiguous or adjacent licensed health care centers. Charges for services are paid from private sources without assistance from governmental programs. Retirement centers may be licensed and regulated in some states, but do not require the issuance of a Certificate of Need such as is required for health care centers. We have, in several cases, developed retirement centers adjacent to our health care properties with an initial construction of 40 to 80 units and which units are rented by the month;

thus these centers offer an expansion of our continuum of care. We believe these retirement units offer a positive marketing aspect of our health care centers.

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

G.

Homecare Programs. Our home health care programs (we call them homecare) assist those who wish to stay at home or in assisted living residences but still require some degree of medical care or assistance with daily activities. Registered and licensed practical nurses and therapy professionals provide skilled services such as infusion therapy, wound care and physical, occupational and speech therapies. Home health aides may assist with daily activities such as assistance with walking and getting in and out of bed, personal hygiene, medication assistance, light housekeeping and maintaining a safe environment. NHC operates 36 homecare licensed and Medicare-certified offices in three states (Tennessee, South Carolina, and Florida) and some of our homecare patients are previously discharged from our long-term health care centers. Medicare reimbursement for homecare services is paid under a prospective payment system. Under this payment system, we receive a prospectively determined amount per patient per 60 day episode as defined by Medicare guidelines. Medicare episodes remained steady at 20,100 in 2011 and 2010. Patients served increased from 14,500 in 2010 to 14,700 in 2011. Visits decreased from 435,100 in 2010 to 418,000 in 2011.

H.

Hospice. Hospice services provide for the physical, spiritual and psychosocial needs of individuals facing a life-limiting illness. Resources including palliative and clinical care, education, spiritual, counseling and other services take into consideration both the needs of patients and the needs of family members. With our Solaris Hospice programs and our partnership with Caris, we provide hospice care to over 1,000 patients per day in 25 locations.

I.

Pharmacy Operations. At December 31, 2011, we operated four regional pharmacy operations (one in east Tennessee, one in central Tennessee, one in South Carolina, and one in Missouri). These pharmacy operations use a central location to supply (on a separate contractual basis) pharmaceutical services (consulting and medications) and supplies. Regional pharmacies bill Medicare Part D Prescription Drug Plans (PDPs) electronically and directly for inpatients who have selected a PDP. Our regional pharmacies currently serve 48 owned facilities, seven managed facilities, and 13 trade entities.

Other Revenues. We generate revenues from insurance services to our managed centers, from management, accounting and financial services to third party owners of healthcare facilities and from rental income. In fiscal 2011, 7.5% of our net operating revenues were derived from such other sources. The significant sources of our other revenues are described as follows:

A.

Insurance Services. NHC owns a Tennessee domestic licensed insurance company. The company is licensed in several states and provides workers' compensation coverage to the majority of NHC operated and managed facilities in addition to other nursing homes, assisted living and retirement centers. A second wholly owned insurance subsidiary is licensed in the Cayman Islands and provides general and professional liability coverage in substantially all of NHC's owned and managed centers. This company elects to be taxed as a domestic subsidiary. We also self-insure our employees' (referred to as "partners") health insurance benefit program at a cost we believe is less than a commercially obtained policy. Finally, we operate a long-term care insurance division, which is licensed to sell commercially underwritten long-term care policies. NHC's revenues from insurance services totaled $15,657,000 in 2011.

B.

Management, Accounting and Financial Services. We provide management services to long-term health care centers, assisted living centers and independent living centers operated by third

party owners. We typically charge 6% to 7% of the managed centers' revenues as a fee for these services. Additionally, we provide accounting and financial services to other long-term care or related types of entities for small operators or not-for-profit entities. No management services are provided for entities in which we provide accounting and financial services. As of December 31, 2011, we perform management services for 27 centers and accounting and financial services for 28 centers. NHC's revenues from management, accounting and financial services totaled $21,510,000 in 2011.

C.

Rental Income. The healthcare properties currently owned and leased to third party operators include nine skilled nursing facilities and four assisted living communities. Effective January 1, 2011, we renewed the rental agreements with the third party operators. The renewed agreements continue for a five-year period ending on December 31, 2015.

Non-Operating Income. We generate non-operating income from equity in earnings of unconsolidated investments, from dividends and other 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:

A.

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 64.4% 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 sixteen locations in Tennessee and one location in Virginia.

Development and Growth

We are undertaking to expand our long-term care operations while protecting our existing operations and markets. The following table lists our recent construction and purchase activities.

Type of Operation	Description	Size	Location	Placed in Service
Hospice	Acquisition	133 ADC	Aiken, Charleston, Columbia, Myrtle Beach and Sumter, SC	January, 2009
Skilled Nursing	New Facility	120 Beds	Bluffton, SC	January, 2010
Assisted Living	New Facility	45 Units	Mauldin, SC	March, 2010

Homecare	Acquisition	353 ADC	Columbia, Rock Hill, and Summerville, SC	May, 2010
Skilled Nursing	Acquisition	120 Beds	Macon, MO	December, 2010
Skilled Nursing	Acquisition	120 Beds	Osage Beach, MO	December, 2010
Skilled Nursing	Acquisition	120 Beds	Springfield, MO	December, 2010
Assisted Living	New Facility	75 Units	Columbia, SC	May, 2011
Assisted Living	Addition	46 Units	Franklin, TN	June, 2011
Hospice	Acquisition	Additional 7.5% interest in Caris HealthCare LP	Knoxville, TN	December, 2011

Also, in 2012, we expect to begin construction on a 90-bed skilled nursing facility in Tullahoma, Tennessee, a 92-bed skilled nursing facility in Hendersonville, Tennessee and a 50-bed skilled nursing addition to NHC Lexington in Lexington, SC.

LongTerm Health Care Centers

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

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

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

We provide management services to centers operated under management contracts and offsite accounting and financial services to other third party owners, all pursuant to separate contracts. The term of each contract and the amount of the management fee or accounting and financial services fee is determined on a casebycase basis. Typically, we charge 6% to 7% of net revenues of the managed centers for our management contracts and specific item fees for our accounting and financial service agreements. The initial terms of the contracts range from two years to ten years. In certain contracts, we maintain a right of first refusal should the owner desire to sell a managed center.

Long-Term Care Center Occupancy Rates

The following table shows certain information relating to occupancy rates for our owned and leased longterm health care centers:

	Year Ended December 31,		
	2011	2010	2009
Overall census	90.6%	92.0%	92.0%

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

Customers and Sources of Revenues

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

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

	Year Ended December 31,		
Source	2011	2010	2009
Medicare	44%	42%	41%
Private Pay, VA and Other	30%	31%	31%
Medicaid/Intermediate	19%	19%	20%
Medicaid/Skilled	7%	8%	8%
Total	100%	100%	100%

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

We attempt to attract an increased percentage of private and Medicare patients by providing rehabilitative services and increasing the marketing of those services through market areas and "Managed Care Offices", of which five were open at December 31, 2011. These services are designed to speed the patient's recovery and allow the patient to return home as soon as it is practical. In addition to educating physicians and patients to the advantages of the rehabilitative services, we have also implemented incentive programs which provide for the payment of bonuses to our regional and center personnel if they are able to achieve private and Medicare goals at their centers.

Medicare is a health insurance program for the aged and certain other chronically disabled individuals operated by the federal government. Medicare covers nursing home services for beneficiaries who require nursing care and/or rehabilitation services following a hospitalization of at least three consecutive days. For each eligible day a Medicare beneficiary is in a long-term health care center, Medicare pays the facility a daily payment, subject to adjustment for certain factors such as wage index in the particular geographic area. The payment covers all services provided by the long-term care center 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.

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

Medicaid is a medical assistance program for the indigent, operated by individual states with the financial participation of the federal government. The states in which we operate currently use prospective cost-based reimbursement systems. Under cost-based reimbursement systems, the long-term care center 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.

Government reimbursement programs such as Medicare and Medicaid prescribe, by law, the billing methods and amounts that health care providers may charge and be reimbursed to care for patients covered by these programs. Congress continually passes laws that effect major or minor changes in the Medicare and Medicaid programs.

Regulation and Licenses

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

states and other health care businesses, including home health and hospice agencies. In particular, to operate nursing facilities and provide health care services we must comply with federal, state and local laws relating to the delivery and adequacy of medical care, distribution of pharmaceuticals, equipment, personnel, operating policies, fire prevention, rate-setting, building codes and environmental protection.

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

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

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

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

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

at the facility.

While there are currently no significant legislative proposals to eliminate certificates of need pending in the states in which we do business, deregulation in the certificate of need area would likely result in increased competition among nursing home companies and could adversely affect occupancy rates and the supply of licensed and certified personnel.

Medicare and Medicaid Participation

All health care centers, owned, leased or managed by us are certified to participate in Medicare. Health care centers participating in Medicare are known as SNFs (Skilled Nursing Facilities). All but six of our affiliated nursing centers participate in Medicaid. All of our homecares (Home health agencies) and hospice agencies participate in Medicare which comprises over 90% of their respective revenue. Homecares and hospice agencies also participate in Medicaid.

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

Certifications and Participation Requirements; Efforts to Impose Reduced Payments

Changes in certification and participation requirements of the Medicare and Medicaid programs have restricted, and are likely to continue to restrict further, eligibility for reimbursement under those programs. Failure to obtain and maintain Medicare and Medicaid certification at our nursing centers would result in denial of Medicare and Medicaid payments which would likely result in a significant loss of revenue. In addition, private payors, including managed care payors, increasingly are demanding that providers accept discounted payments resulting in lost revenue for specific patients. Efforts to impose reduced payments, greater discounts and more stringent cost controls by government and other payors are expected to continue. For the fiscal year ended December 31, 2011, we derived 44% and 26% of our net patient revenues from the Medicare and Medicaid programs, respectively. Any reforms that significantly limit rates of reimbursement under the Medicare and Medicaid programs could have a material adverse effect on our profitability. We are unable to predict what reform proposals or reimbursement limitations will be adopted in the future or the effect such changes will have on our operations. No assurance can be given that such reforms will not have a material adverse effect on us.

Medicare Legislation and Regulations

Federal Health Care Reform

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act of 2010 ("HCERA"), which represents significant changes to the current U.S. health care system (collectively the "Acts"). The Acts affect aging services providers, our partners (employees) and our patients and residents in a multitude of ways. We have evaluated the provisions of the Acts and anticipate many of the provisions may be subject to further clarification and modification through the rule-making

process. It is uncertain at this time the effect the modifications will have on our future results of operations or cash flows.

In December 2010, President Obama signed into law the Medicare and Medicaid Extenders Act ("MMEA"). This legislation affects numerous health care providers and makes several important technical corrections to the health reform laws enacted earlier in 2010. An important item provided for in the MMEA legislation was for an immediate and retroactive updated methodology (Resource Utilization Group – Version Four, "RUG-IV") for determining Medicare payment rates to skilled nursing centers. The MMEA allowed skilled nursing center rates determined by RUG-IV to be applied as of October 1, 2010.

In August 2011 and pursuant to the Budget Control Act of 2011, Congress created a 12-member bipartisan committee called the Joint Select Committee on Deficit Reduction, or the Joint Committee. The Joint Committee was charged with issuing a formal recommendation by November 23, 2011 on how to reduce the federal deficit by at least $1.5 trillion over the next ten years. The Committee concluded their work in November and was not able to reach a bipartisan agreement before the Committee's deadline period. This failure by the Committee is scheduled to trigger automatic reductions in discretionary and mandatory spending starting in 2013, including reductions of not more than 2% to payments to Medicare providers. We are unable to predict the financial impact, if enacted, of the automatic payments cuts beginning in 2013. However, such impact may be adverse and material to our future results of operations and cash flows.

Skilled Nursing Facilities (SNFs)

SNF PPS - Medicare is uniform nationwide and reimburses nursing centers under a fixed payment methodology named the Skilled Nursing Facility Prospective Payment System ("SNF PPS"). PPS is an acuity based classification system that uses nursing and therapy indexes adjusted by geographical wage indexes to calculate per diem rates for each Medicare patient. Payment rates are updated annually and are generally increased or decreased each October when the federal fiscal year begins. The acuity classification system is named RUGs (Resource Utilization Groups IV). There are currently 67 classifications of RUG groups.

On July 29, 2011, Centers for Medicare and Medicaid Services ("CMS") issued a final rule providing for, among other things, a net 11.1% reduction in PPS payments to skilled nursing facilities for CMS's fiscal year 2012 (which began October 1, 2011) as compared to PPS payments in CMS's fiscal year 2011 (which ended September 30, 2011). The 11.1% reduction is on a net basis, after the application of a 2.7% market basket increase less a 1.0% multi-factor productivity adjustment required by the PPACA. The final CMS rule also adjusts the method by which group therapy is counted for reimbursement purposes, and changes the timing in which patients who are receiving therapy must be reassessed for purposes of determining their RUG category. We anticipate that, assuming other factors remain constant, CMS's reduced reimbursement rates and other changes effective for its fiscal year 2012 will have a significant and adverse effect on our results of operations when compared to the periods in CMS's fiscal year 2011. We estimate the resulting decrease in revenue from the fiscal year 2012 Medicare rate changes will be approximately $24,000,000 annually, or $6,000,000 per quarter. Furthermore, changes in government requirements for providing therapy services are estimated to increase our operating costs by approximately $6,000,000 annually, or $1,500,000 per quarter. The effect of the rate changes on our revenues is dependent upon our census and the mix of our patients at the recalibrated PPS pay rates. We are examining cost saving measures to help mitigate a portion of the revenue decrease and cost increase, but we are also committed to maintaining the quality of care to our patients. The PPS rates had a net market basket increase of 2.3% in 2010 and a net market basket decrease of 1.1% in 2009.

Homecares (HHAs)

HH PPS - Medicare is uniform nationwide and reimburses homecares under a fixed payment methodology named the Home Health Prospective Payment System ("HH PPS"). Generally, Medicare makes payments under the HH PPS on the basis of a national standardized 60day episode payment, adjusted for case mix and geographical wage index.

Payment rates are updated at the beginning of each calendar year. The acuity classification system is named HHRGs (Home Health Resource Groups).

In January 2011, we received a decrease in the overall HH PPS base rate of 5.2%. On October 31, 2011 and effective January 1, 2012, CMS issued a final ruling which stated an approximate 2.4% rate reduction from the 2011 HH PPS rates. The 2.4% rate reduction will impact individual providers unevenly. CMS finalized significant changes by eliminating hypertension as a factor in the calculation, reducing the weights on therapy episodes, and increasing weights on non-therapy episodes. Providers with high volume of therapy cases could see greater net rate reductions while others with non-therapy patients may see a negligible overall reduction in revenue or a slight increase. We estimate the effect of the revenue decrease for NHC homecare programs to be approximately $2,600,000 annually, or $650,000 per quarter.

Hospice

Medicare is uniform nationwide and reimburses hospice care by one of four predetermined daily or hourly rates based on the level of care we furnish to the beneficiary. These rates are subject to annual adjustments based on inflation and geographic wage considerations. Effective October 1, 2011, hospice agencies received Medicare payments which represented a 2.5% increase over the fiscal year 2011 payment rates.

Medicaid Legislation and Regulations

Skilled Nursing Facilities (SNF)

State Medicaid plans subject to budget constraints are of particular concern to us given the repeal of the Boren Amendment by the Balance Budget Act of 1997. The Boren Amendment provided fair reimbursement protection to nursing facilities. Changes in federal funding and pressure on certain provider taxes coupled with state budget problems have produced an uncertain environment. Industry studies predict the Medicaid crisis will continue with a state required contribution to Medicare Part D and anticipated budget deficits. States will more likely than not be unable to keep pace with nursing center inflation. States are under pressure to pursue other alternatives to long term care such as community and homebased services.

No rate increases or decreases were implemented for the fiscal years beginning July 1, 2011 for Medicaid programs in the states of Tennessee and Missouri. Tennessee, however, has announced that it will implement a 4.25% rate reduction beginning January 1, 2012. We estimate the resulting decrease in revenue in Tennessee will be approximately $2,600,000 annually, or $650,000 per quarter.

On April 7, 2011, effectively immediately, South Carolina implemented a three percent Medicaid rate reduction. We estimate the resulting decrease in revenue is approximately $1,480,000 annually, or $370,000 per quarter.

Competition

In most of the communities in which we operate health care centers, there are other health care centers with which we compete. We own, lease or manage (through subsidiaries) 75 long-term health care facilities located in 10 states. Each of these states are certificate of need states which generally requires the state to approve the opening of any new long-term health care facilities. There are hundreds of operators of long-term health care facilities in each of these states and no single operator, including us, dominates any of these state's long-term health care markets, except for some small rural markets which might have only one long-term health care facility. In competing for patients and

staff with these centers, 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 health care centers are important in obtaining patients, since members of the patient's family generally participate to a greater extent in selecting health care centers than in selecting an acute care hospital. We believe that by providing and emphasizing rehabilitative as well as skilled care services at our centers, we are able to broaden our patient base and to differentiate our centers from competing health care centers.

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

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

We experience competition in employing and retaining nurses, technicians, aides and other high quality professional and nonprofessional employees. In order to enhance our competitive position, we have an educational tuition loan program, an American Dietetic Association approved internship program, a specially designed nurse's

aide training class, and we make financial scholarship aid available to physical therapy vocational programs. We support the Foundation for Geriatric Education. We also conduct an "Administrator in Training" course, 24 months in duration, for the professional training of administrators. Presently, we have two fulltime individuals in this program. Four of our six regional vice presidents and 48 of our 75 health care center administrators are graduates of this program.

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

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

Employees

As of December 31, 2011, our Administrative Services Contractor plus our managed centers had approximately 12,670 full and part time employees, who we call "Partners". No employees are represented by a bargaining unit. We believe our current relations with our employees are good.

Investor Information

We maintain a worldwide web site at www.nhccare.com. We publish to this web site our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and press releases. We do not necessarily have these filed the same day as they are filed with the SEC or released to the public, but rather have a policy of placing these on the web site within two (2) business days of public release or SEC filing.

We also maintain the following documents on the web site:

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The NHC Code of Ethics. This Code has been adopted for all employees of our Administrative Services Contractor, officers and directors of the Company. The website will also disclose whether there have been any amendments or waivers to the Code of Ethics and Standards of conduct. To date there have been none.

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Information on our "NHC Valuesline", which allows our staff and investors unrestricted access to our Corporate Compliance Officer, executive officers and directors. The toll free number is 800-526-4064 and the communications may be incognito, if desired.

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The NHC Restated Audit Committee Charter.

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The NHC Compensation Committee Charter.

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The NHC Nomination and Corporate Governance Committee Charter

We will furnish, free of charge, a copy of any of the above documents to any interested investor upon receipt of a written request.

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. For the year ended December 31, 2011, we derived approximately 70% of our net patient revenues from the Medicare, Medicaid and other government programs. Third-party payor programs are highly regulated and are subject to frequent and substantial changes. Changes in the reimbursement rate or methods of payment from third-party payors, including the Medicare and Medicaid programs, or the implementation of other measures to reduce reimbursements for our services has in the past, and could in the future, result in a substantial reduction in our revenues and operating margins. Additionally, net revenue realizable under third-party payor agreements can change after examination and retroactive adjustment by payors during the claims settlement processes or as a result of post-payment audits. Payors may disallow requests for reimbursement based on determinations that certain costs are not reimbursable or reasonable because additional documentation is necessary or because certain services were not covered or were not reasonable and medically necessary. There also continue to be new legislative and regulatory proposals that could impose further limitations on government and private payments to health care providers. In some cases, states have enacted or are considering enacting measures designed to reduce their Medicaid expenditures and to make changes to private health care insurance. We cannot assure you that adequate reimbursement levels will continue to be available for the services provided by us, which are currently being reimbursed by Medicare, Medicaid or private third-party payors. Further limits on the scope of services reimbursed and on reimbursement rates could have a material adverse effect on our liquidity, financial condition and results of operations. It is possible that the effects of further refinements to PPS that result in lower payments to us or cuts in state Medicaid funding could have a material adverse effect on our results of operations. See Item 1, "Business – Regulation and Licenses" and "Medicare Legislation and Regulations" and "Medicaid Legislation and Regulations".

We conduct business in a heavily regulated industry, and changes in, or violations of regulations may result in increased costs or sanctions that reduce our revenue and profitability. In the ordinary course of our business, we are regularly subject to inquiries, investigations and audits by federal and state agencies to determine whether we are in compliance with regulations governing the operation of, and reimbursement for, skilled nursing, assisted living and independent living facilities, hospice, home health agencies and our other operating areas. These regulations include those relating to licensure, conduct of operations, ownership of facilities, construction of new and additions to existing facilities, allowable costs, services and prices for services. In particular, various laws, including federal and state anti-kickback and anti-fraud statutes, prohibit certain business practices and relationships that might affect the

provision and cost of health care services reimbursable under federal and/or state health care programs such as Medicare and Medicaid, including the payment or receipt of remuneration for the referral of patients whose care will be paid by federal governmental programs. Sanctions for violating the anti-kickback and anti-fraud statutes include criminal penalties and civil sanctions, including fines and possible exclusion from governmental programs such as Medicare and Medicaid.

In addition, the Stark Law broadly defines the scope of prohibited physician referrals under federal health care programs to providers with which they have ownership or other financial arrangements. Many states have adopted, or are considering, legislative proposals similar to these laws, some of which extend beyond federal health care programs, to prohibit the payment or receipt of remuneration for the referral of patients and physician referrals

regardless of the source of the payment for the care. These laws and regulations are complex and limited judicial or regulatory interpretation exists. We cannot assure you that governmental officials charged with responsibility for enforcing the provisions of these laws and regulations will not assert that one or more of our arrangements are in violation of the provisions of such laws and regulations.

The regulatory environment surrounding the long-term care industry has intensified, particularly for larger for-profit, multi-facility providers like us. The federal government has imposed extensive enforcement policies resulting in a significant increase in the number of inspections, citations of regulatory deficiencies and other regulatory sanctions, including terminations from the Medicare and Medicaid programs, denials of payment for new Medicare and Medicaid admissions and civil monetary penalties. If we fail to comply, or are perceived as failing to comply, with the extensive laws and regulations applicable to our business, we could become ineligible to receive government program reimbursement, be required to refund amounts received from Medicare, Medicaid or private payors, suffer civil or criminal penalties, suffer damage to our reputation in various markets or be required to make significant changes to our operations. We are also subject to federal and state laws that govern financial and other arrangements between health care providers. These laws often prohibit certain direct and indirect payments or fee-splitting arrangements between health care providers that are designed to induce the referral of patients to a particular provider for medical products and services. Possible sanctions for violation of any of these restrictions or prohibitions include loss of eligibility to participate in reimbursement programs and/or civil and criminal penalties. Furthermore, some states restrict certain business relationships between physicians and other providers of health care services. Many states prohibit business corporations from providing, or holding themselves out as a provider of, medical care. From time to time, we may seek guidance as to the interpretation of these laws; however, there can be no assurance that such laws will ultimately be interpreted in a manner consistent with our practices. In addition, we could be forced to expend considerable resources responding to an investigation or other enforcement action under these laws or regulations. Furthermore, should we lose licenses or certifications for a number of our facilities as a result of regulatory action or otherwise, we could be deemed in default under some of our agreements, including agreements governing outstanding indebtedness. We also are subject to potential lawsuits under a federal whistle-blower statute designed to combat fraud and abuse in the health care industry. These lawsuits can involve significant monetary awards to private plaintiffs who successfully bring these suits.

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

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

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

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

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

Recent legislation and the 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 Amex exchange, and rules implemented by the Securities and Exchange Commission (SEC), we have had to hire additional personnel and utilize additional outside legal, accounting and advisory services, and may continue to require such additional resources. Moreover, in the rapidly changing regulatory environment in which we now operate, there is significant uncertainty as to what will be required to comply with many of the new rules and regulations. As a result, we may be required to spend substantially more than we currently estimate, and may need to divert resources from other activities, as we develop our compliance plans.

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

By undertaking to provide management services, advisory services, and/or financial services to other entities, we become at least partially responsible for meeting the regulatory requirements of those entities. We

provide management and/or financial services to health care centers, assisting living centers and independent living centers owned by third parties. At December 31, 2011, we perform management services (which include financial services) for 27 such centers and accounting and financial services for an additional 28 such centers. The "Risk Factors" contained herein as applying to us may in many instances apply equally to these other entities for which we provide services. We have in the past and may in the future be subject to claims from the entities to which we provide management, advisory or financial services, or to the claims of third parties to those entities. Any adverse determination in any legal proceeding regarding such claims could have a material adverse effect on our business, our results of operation, our financial condition and cash flows.

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

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

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

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

Our senior management team has extensive experience in the healthcare industry. We believe they have been instrumental in guiding our business, instituting valuable performance and quality monitoring, and driving innovation. Accordingly, our future performance is substantially dependent upon the continued services of our senior

management team. The loss of the services of any of these persons could have a material adverse effect upon us.

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

We cannot assure you 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, 2011, we leased or owned 54 skilled nursing centers, 17 assisted living centers, and six independent living centers. Our ability to maintain and enhance our physical plant and equipment in a suitable condition to meet regulatory standards, operate efficiently and remain competitive in our markets requires us to commit a substantial portion of our free cash flow to continued investment in our physical plant and equipment. Certain of our competitors may operate centers that are not as old as our centers, or may appear more modernized than our centers, and therefore may be more attractive to prospective customers. In addition, the cost to replace our existing centers through acquisition or construction is substantially higher than the carrying value of our centers. We are undertaking a process to allocate more aggressively capital spending within our owned and leased centers 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.

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

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

infrastructure, it could adversely affect us and could have a material adverse effect on our business, results of operations, financial condition and cash flows.

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

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

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

The long-term care industry is divided into a variety of competitive areas that market similar services. These competitors include skilled nursing, assisted living, independent living facilities, homecare services, hospice providers and other operations. Our facilities generally operate in communities that also are served by similar facilities operated by our competitors. Certain of our competitors are operated by not-for-profit, non-taxpaying or governmental agencies that can finance capital expenditures on a tax exempt basis and that receive funds and charitable contributions unavailable to us. Our facilities compete based on factors such as our reputation for quality care; the commitment and expertise of our staff; the quality and comprehensiveness of our treatment programs; the physical appearance, location and condition of our facilities and to a limited extend, the charges for services. In addition, we compete with other long-term care providers for customer referrals from hospitals. As a result, a failure to compete effectively with respect to referrals may have an adverse impact on our business. Many of these competing companies have greater financial and other resources than we have. We cannot assure you 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 payments 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 $75,000,000 revolving credit agreement. The revolving credit agreement provides for variable rates and if market interest rates rise, so will our required interest payments on any future borrowings under the revolving credit facility.

Although we currently have a modest amount of debt outstanding, we expect to borrow in the future to fund development and acquisitions. In the event we incur substantial indebtedness, this could have important consequences to you. For example, it could:

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

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

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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;

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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;

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

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

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

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

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

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

In addition, loan agreements governing our debt contain and may in the future contain financial and other restrictive covenants limiting our ability to engage in activities that may be in our long-term best interests. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of some or all of our debts.

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

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

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

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

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

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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.

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

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

In addition, the success of our investment strategies and asset allocations in the fixed-income portfolio may vary depending on the market environment. The fixed-income portfolio's performance also may be adversely impacted if,

among other factors: there is a lack of transparency regarding the underlying businesses of the issuers of the securities that we purchase; credit ratings assigned to such securities by nationally recognized credit rating agencies are based on incomplete information or prove unwarranted; or our risk mitigation strategies are ineffective for the applicable market conditions.

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

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

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

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

Our stock price is volatile and fluctuations in our operating results, quarterly earnings and other factors may result in declines in the price of our common stock. Equity markets are prone to, and in the last few years have experienced, extreme price and volume fluctuations. Volatility over the past few years has had a significant impact on the market price of securities issued by many companies, including us and other companies in the healthcare industry. If we are unable to operate our businesses as profitably as we have in the past or as our stockholders expect us to in the future, the market price of our common stock will likely decline as stockholders could sell shares of our common stock when it becomes apparent that the market expectations may not be realized. In addition to our operating results, many economic and other factors beyond our control could have an adverse effect on the price of our common stock including:

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general economic conditions;

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developments generally affecting the healthcare industry;

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

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

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litigation and governmental investigations;

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

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investor perceptions of us and our business;

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actions by institutional or other large stockholders;

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quarterly variations in operating results;

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changes in financial estimates and recommendations by securities analysts;

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press releases or negative publicity relating to our competitors or us or relating to trends in healthcare;

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sales of stock by insiders;

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natural disasters, terrorist attacks and pandemics

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additions or departures of key personnel; and

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our results of operations, financial performance and future prospects.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

Long-Term Health Care Centers

State	City	Center Name	Affiliation	Total Beds	Joined NHC
Alabama	Anniston	NHC HealthCare, Anniston	Leased[1]	151	1973
	Moulton	NHC HealthCare, Moulton	Leased[1]	136	1973
Georgia	Fort Oglethorpe	NHC HealthCare, Fort Oglethorpe	Owned	135	1989
	Rossville	NHC HealthCare, Rossville	Leased[1]	112	1971
Kansas	Chanute	Chanute HealthCare Center	Managed	77	2001
	Council Grove	Council Grove HealthCare Center	Managed	80	2001
	Haysville	Haysville HealthCare Center	Managed	119	2001
	Larned	Larned HealthCare Center	Managed	80	2001
	Sedgwick	Sedgwick HealthCare Center	Managed	62	2001
Kentucky	Glasgow	NHC HealthCare, Glasgow	Leased[1]	194	1971
	Madisonville	NHC HealthCare, Madisonville	Leased[1]	94	1973
Massachusetts	Greenfield	Buckley-Greenfield Health Care Center	Managed	120	1999
	Holyoke	Holyoke Health Care Center	Managed	102	1999
	Quincy	John Adams Health Care Center	Managed	71	1999
	Taunton	Longmeadow of Taunton	Managed	100	1999
Missouri	Columbia	Columbia HealthCare Center	Managed	97	2001
	Desloge	NHC HealthCare, Desloge	Leased[1]	120	1982
	Joplin	NHC HealthCare, Joplin	Leased[1]	126	1982
	Kennett	NHC HealthCare, Kennett	Leased[1]	170	1982
	Macon	Macon Health Care Center	Owned	120	1982
	Osage Beach	Osage Beach Rehabilitation and Health Care Center	Owned	120	1982
	St. Charles	Charlevoix HealthCare Center	Managed	142	2001
	St. Charles	NHC HealthCare, St. Charles	Leased[1]	120	1982
	St. Louis	NHC HealthCare, Maryland Heights	Leased[1]	220	1987
	Springfield	Springfield Rehabilitation and Health Care Center	Leased	120	1982
	Town & Country	NHC HealthCare, Town & Country	Owned	200	2001
	West Plains	NHC HealthCare, West Plains	Owned	120	1982
New Hampshire	Epsom	Epsom Health Care Center	Managed	108	1999
	Manchester	Maple Leaf Health Care Center	Managed	114	1999

	Manchester	Villa Crest Health Care Center	Managed	126	1999

Long-Term Health Care Centers
(continued)

State	City	Center Name	Affiliation	Total Beds	Joined NHC
South Carolina	Anderson	NHC HealthCare, Anderson	Leased[1]	290	1973
	Bluffton	NHC HealthCare, Bluffton	Owned	120	2010
	Charleston	NHC HealthCare, Charleston	Owned	88	2009
	Clinton	NHC HealthCare, Clinton	Owned	131	1993
	Columbia	NHC HealthCare, Parklane	Owned	180	1997
	Greenwood	NHC HealthCare, Greenwood	Leased[1]	152	1973
	Greenville	NHC HealthCare, Greenville	Owned	176	1992
	Laurens	NHC HealthCare, Laurens	Leased[1]	176	1973
	Lexington	NHC HealthCare, Lexington	Owned	120	1994
	Mauldin	NHC HealthCare, Mauldin	Owned	180	1997
	Murrells Inlet	NHC HealthCare, Garden City	Owned	148	1992
	North Augusta	NHC HealthCare, North Augusta	Owned	192	1991
	Sumter	NHC HealthCare, Sumter	Managed	138	1985
Tennessee	Athens	NHC HealthCare, Athens	Leased[1]	98	1971
	Chattanooga	NHC HealthCare, Chattanooga	Leased[1]	207	1971
	Columbia	Maury Regional Hospital	Managed	20	1996
	Columbia	NHC HealthCare, Columbia	Leased[1]	106	1973
	Columbia	NHC HealthCare, Hillview	Leased[1]	92	1971
	Cookeville	NHC HealthCare, Cookeville	Managed	94	1975
	Dickson	NHC HealthCare, Dickson	Leased[1]	191	1971
	Dunlap	NHC HealthCare, Sequatchie	Leased[1]	120	1976
	Farragut	NHC HealthCare, Farragut	Owned	90	1998
	Franklin	NHC Place, Cool Springs	Owned	180	2004
	Franklin	NHC HealthCare, Franklin	Leased[1]	80	1979
	Hendersonville	NHC HealthCare, Hendersonville	Leased[1]	122	1987
	Johnson City	NHC HealthCare, Johnson City	Leased[1]	160	1971
	Knoxville	NHC HealthCare, Fort Sanders	Owned[2]	172	1977
	Knoxville	Holston Health & Rehabilitation Center	Owned	109	2009
	Knoxville	NHC HealthCare, Knoxville	Leased[1]	139	1971
	Lawrenceburg	NHC HealthCare, Lawrenceburg	Managed	96	1985
	Lawrenceburg	NHC HealthCare, Scott	Leased[1]	60	1971
	Lewisburg	NHC HealthCare, Lewisburg	Leased[1]	100	1971
	Lewisburg	NHC HealthCare, Oakwood	Leased[1]	60	1973
	McMinnville	NHC HealthCare, McMinnville	Leased[1]	150	1971
	Milan	NHC HealthCare, Milan	Leased[1]	122	1971
	Murfreesboro	AdamsPlace	Owned	90	1997
	Murfreesboro	NHC HealthCare, Murfreesboro	Managed	181	1974
	Nashville		Managed	107	1992

		The Health Center of Richland Place			
	Oak Ridge	NHC HealthCare, Oak Ridge	Managed	128	1977
	Pulaski	NHC HealthCare, Pulaski	Leased(1)	102	1971
	Smithville	NHC HealthCare, Smithville	Leased(1)	114	1971
	Somerville	NHC HealthCare, Somerville	Leased(1)	72	1976
	Sparta	NHC HealthCare, Sparta	Leased(1)	120	1975
	Springfield	NHC HealthCare, Springfield	Leased(1)	107	1973
Virginia	Bristol	NHC HealthCare, Bristol	Leased(1)	120	1973

Assisted Living Units

State	City	Center	Affiliation	Units
Alabama	Anniston	NHC Place/Anniston	Owned	67
Kansas	Larned	Larned Health Care Center	Managed	19
	Haysville	Haysville Health Care Center	Managed	6
Kentucky	Glasgow	NHC HealthCare, Glasgow	Leased(1)	12
Missouri	St. Charles	Lake St. Charles Retirement Center	Leased(1)	26
New Hampshire	Manchester	Villa Crest Assisted Living	Managed	29
South Carolina	Charleston	The Palmettos of Charleston	Owned	60
	Columbia	The Palmettos of Parklane	Owned	75
	Greenville	The Palmettos of Mauldin	Owned	45
Tennessee	Dickson	NHC HealthCare, Dickson	Leased(1)	20
	Farragut	NHC Place, Farragut	Owned	84
	Franklin	NHC Place, Cool Springs	Owned	89
	Johnson City	NHC HealthCare, Johnson City	Leased(1)	2
	Murfreesboro	AdamsPlace	Owned	83
	Nashville	Richland Place	Managed	24
	Smithville	NHC HealthCare, Smithville	Leased(1)	6
	Somerville	NHC HealthCare, Somerville	Leased(1)	6

Retirement Apartments

State	City	Retirement Apartments	Affiliation	Units	Est.
Kansas	Larned	Larned HealthCare Center	Managed	10	2001
Missouri	St. Charles	Lake St. Charles Retirement Apts.	Leased(1)	152	1984

Tennessee	Chattanooga	Parkwood Retirement Apartments	Leased[1]	30	1986
	Johnson City	Colonial Hill Retirement Apartments	Leased[1]	63	1987
	Murfreesboro	AdamsPlace	Owned	93	1997
	Nashville	Richland Place Retirement Apts.	Managed	137	1993

Homecare Programs

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

Hospice Programs

State	City	Hospice Programs	Affiliation	Est.
South Carolina	Aiken	Solaris Hospice – Aiken	Owned	2010
	Anderson	Solaris Hospice – Anderson	Owned	2009
	Charleston	Solaris Hospice – Charleston	Owned	2010
	Columbia	Solaris Hospice – Columbia	Owned	2010
	Greenville	Solaris Hospice – Greenville	Owned	2009
	Greenwood	Solaris Hospice – Greenwood	Owned	2011
	Myrtle Beach	Solaris Hospice – Myrtle Beach	Owned	2010
	Sumter	Solaris Hospice – Sumter	Owned	2010
Tennessee	Athens	Caris Healthcare – Athens	Caris	2006
	Chattanooga	Caris Healthcare – Chattanooga	Caris	2005
	Columbia	Caris Healthcare – Columbia	Caris	2004
	Cookeville	Caris Healthcare – Cookeville	Caris	2004
	Crossville	Caris Healthcare – Crossville	Caris	2010
	Dickson	Caris Healthcare – Dickson	Caris	2007
	Greenville	Caris Healthcare – Greenville	Caris	2007
	Johnson City	Caris Healthcare – Johnson City	Caris	2004
	Knoxville	Caris Healthcare – Knoxville	Caris	2004
	Lenoir City	Caris Healthcare – Lenoir City	Caris	2009
	Milan	Caris Healthcare – Milan	Caris	2004
	Murfreesboro	Caris Healthcare – Murfreesboro	Caris	2005
	Nashville	Caris Healthcare – Nashville	Caris	2004
	Sevierville	Caris Healthcare – Sevierville	Caris	2007
	Somerville	Caris Healthcare – Somerville	Caris	2005
	Springfield	Caris Healthcare – Springfield	Caris	2006
Virginia	Bristol	Caris Healthcare – Bristol	Caris	2011

(1)Leased from NHI

(2)NHC HealthCare/Fort Sanders is owned by a separate limited partnership. The Company owns approximately 25% of the partnership interest in Fort Sanders.

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

Long-Term Care		
The Aristocrat	Naples, FL	60
The Health Center at Coconut Creek	Coconut Creek, FL	120
The Health Center of Daytona Beach	Daytona Beach, FL	73
The Imperial Health Care Center	Naples, FL	113
The Health Center of Windermere	Orlando, FL	120
Charlotte Harbor Health Care Center	Port Charlotte, FL	180
The Health Center at Standifer Place	Chattanooga, TN	544
The Health Center of Lake City	Lake City, FL	120
The Health Center of Pensacola	Pensacola, FL	180
Assisted Living		
The Place at Vero Beach	Vero Beach, FL	135
The Place at Merritt Island	Merritt Island, FL	95
The Place at Stuart	Stuart, FL	100
Standifer Place Assisted Living	Chattanooga, TN	49

ITEM 3. LEGAL PROCEEDINGS

General and Professional Liability Lawsuits and Insurance

The long term 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 nursing facilities and their employees in providing care to residents. As of December 31, 2011, we and/or our managed centers are currently defendants in 30 such claims covering the years 2005 through December 31, 2011.

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

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

Beginning in 2008 and continuing through 2011, additional insurance is purchased through third party providers that serve to supplement the coverage provided through our wholly-owned captive insurance company.

As a result of the terms of our insurance policies and our use of a wholly-owned insurance company, we have retained significant self-insured risk with respect to general and professional liability. We use independent actuaries to estimate 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

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 or results of operations. 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.

PART II

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

The shares of common stock of National HealthCare Corporation are listed on the NYSE Amex exchange under the symbol NHC. NHC was previously listed on the American Stock Exchange until its acquisition by NYSE in October 2009. The closing price for the NHC common shares on February 14, 2012 was $45.91. On December 31, 2011, NHC had approximately 5,600 stockholders, comprised of approximately 2,200 stockholders of record and an additional 3,400 stockholders indicated by security position listings. The following table sets out the quarterly high and low sales prices and cash dividends declared of NHC's common shares.

	Stock Prices		Cash Dividends Declared
	High	Low	
2011			
1st Quarter	$ 48.20	$ 42.50	$ .28
2nd Quarter	49.88	43.30	.30
3rd Quarter	53.08	30.00	.30
4th Quarter	44.82	29.97	.30
2010			
1st Quarter	$ 38.20	$ 34.61	$ .26
2nd Quarter	36.25	33.02	.28
3rd Quarter	37.18	33.51	.28
4th Quarter	47.99	35.76	.28

At December 31, 2011, there are no publicly announced programs to repurchase our common stock. On August 10, 2010, NHC repurchased 182,900 shares of its common stock at a price of $32.50 per share. There were no repurchases of our common stock in 2011.

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

Since November 1, 2007, the shares of convertible preferred stock of NHC are listed on the NYSE Amex exchange under the symbol NHC.PRA. The following table sets out the quarterly high and low sales prices and cash dividends declared of NHC's preferred shares.

	Stock Prices		Cash Dividends Declared
	High	Low	
2011			
1st Quarter	$ 15.04	$ 12.73	$ .20
2nd Quarter	15.52	14.40	.20
3rd Quarter	15.85	12.50	.20
4th Quarter	14.10	13.25	.20
2010			
1st Quarter	$ 13.25	$ 11.10	$ .20
2nd Quarter	13.15	12.00	.20
3rd Quarter	14.59	10.44	.20
4th Quarter	15.01	12.63	.20

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

Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted-average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by security holders	1,482,077	46.92	564,048
Equity compensation plans not approved by security holders	–	–	–
Total	1,482,077	46.92	564,048

The following graph and chart compare the cumulative total stockholder return for the period from December 31, 2006 through December 31, 2011 on an investment of $100 in (i) NHC's common stock, (ii) the Standard & Poor's 500 Stock Index ("S&P 500 Index") and (iii) the Standard & Poor's Health Care Index ("S&P Health Care Index"). Cumulative total stockholder return assumes the reinvestment of all dividends. Stock price performances shown in the graph are not necessarily indicative of future price performances.

ITEM 6. SELECTED FINANCIAL DATA

The following table represents selected financial information for the five years ended December 31, 2011. The data for 2011, 2010 and 2009 has been derived from financial statements included elsewhere in this Form 10K and should be read in conjunction with those financial statements, accompanying footnotes and Management's Discussion and Analysis.

	As of and for the Year Ended December 31,				
	2011	2010	2009	2008	2007[1][2]
	(in thousands, except per share data)				
Operating Data:					
Net operating revenues	$ 773,537	$ 720,653	$ 673,202	$ 637,875	$ 579,360
Total costs and expenses	(696,191)	(663,026)	(622,330)	(600,323)	(525,800)
Non-operating income	20,533	23,340	16,784	15,735	18,674
Income before income taxes	97,879	80,967	67,656	53,287	72,234
Income tax provision	(33,807)	(28,272)	(27,607)	(16,916)	(26,785)
Net income	64,072	52,695	40,049	36,371	45,449
Dividends to preferred stockholders	(8,671)	(8,673)	(8,673)	(8,673)	(1,831)
Net income available to common stockholders	55,401	44,022	31,376	27,698	43,618
Earnings per common share:					
Basic	$ 4.02	$ 3.22	$ 2.31	$ 2.16	$ 3.47
Diluted	3.90	3.22	2.31	2.11	3.36
Cash dividends declared:					
Per preferred share	$ .80	$ .80	$ .80	$ .80	$ .169
Per common share	1.18	1.10	1.02	.93	.81
Balance Sheet Data:					
Total assets	$ 865,672	$ 829,505	$ 788,532	$ 777,296	$ 698,408
Accrued risk reserves	98,732	105,549	107,456	106,000	88,382
Long-term debt, less current portion	10,000	10,000	10,000	10,000	10,000
Stockholders' equity	611,736	561,146	525,779	480,817	455,708

(1)

Effective January 1, 2007, the Company adopted ASC Topic 740, *Income Taxes*.

(2)

On October 31, 2007, the Company completed its acquisition of NHR.

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 long-term health care services. At December 31, 2011 we operate or manage 75 long-term health care centers with 9,456 beds in 10 states and provide other services in one additional state. These operations are provided by separately funded and maintained subsidiaries. We provide long-term health care services to patients in a variety of settings including long-term nursing centers, managed care specialty units, sub-acute care units, Alzheimer's care units, hospice care, homecare programs, assisted living centers and independent living centers. In addition, we provide management services, accounting services and insurance services to third party owners of long-term health care centers.

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.

Medicare Reimbursement Rate Changes

In July 2011, CMS announced a final rule reducing Medicare skilled nursing facility PPS payments in fiscal year 2012 by $3.87 billion, or 11.1% lower than payments for fiscal year 2011. We estimate the resulting decrease in revenue from the fiscal year 2012 Medicare rate changes will be approximately $24,000,000 annually or $6,000,000 quarterly. Furthermore, changes in government requirements for providing therapy services are estimated to increase our operating costs by approximately $6,000,000 annually, or $1,500,000 per quarter. We are examining cost saving measures to help mitigate a portion of the revenue decrease and cost increase, but we are also committed to maintaining the quality of care to our patients.

Development and Growth

We are undertaking to expand our long-term care operations while protecting our existing operations and markets. The following table lists our recent construction and purchase activities.

Type of Operation	Description	Size	Location	Placed in Service
Hospice	Acquisition	133 ADC	Aiken, Charleston, Columbia, Myrtle Beach and Sumter, SC	January, 2009
Skilled Nursing	New Facility	120 Beds	Bluffton, SC	January, 2010
Assisted Living	New Facility	45 Units	Mauldin, SC	March, 2010
Homecare	Acquisition	353 ADC	Columbia, Rock Hill, and Summerville, SC	May, 2010
Skilled Nursing	Acquisition	120 Beds	Macon, MO	December, 2010
Skilled Nursing	Acquisition	120 Beds	Osage Beach, MO	December, 2010
Skilled Nursing	Acquisition	120 Beds	Springfield, MO	December, 2010
Assisted Living	New Facility	75 Units	Columbia, SC	May, 2011
Assisted Living	Addition	46 Units	Franklin, TN	June, 2011
Hospice	Acquisition		Knoxville, TN	December, 2011

Additional 7.5% interest in Caris HealthCare LP

Also, in 2012, we expect to begin construction on a 90-bed skilled nursing facility in Tullahoma, Tennessee, a 92-bed skilled nursing facility in Hendersonville, Tennessee and a 50-bed skilled nursing addition to NHC Lexington in Lexington, SC.

During 2012, we will apply for Certificates of Need for additional beds in our markets and also evaluate the feasibility of expansion into new markets by building private pay health care centers or by the purchase of existing health care centers.

Accrued Risk Reserves

Our accrued professional liability reserves, workers' compensation reserves and health insurance reserves totaled $98,732,000 at December 31, 2011 and are a primary area of management focus. We have set aside restricted cash and marketable securities to fund our professional liability and workers' compensation reserves.

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

Application of Critical Accounting Policies

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

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

Revenue Recognition - Third Party Payors

Approximately 70% of our net patient revenues are derived from Medicare, Medicaid, and other government programs. Amounts earned under these programs are subject to review by the Medicare and Medicaid intermediaries or their agents. In our opinion, adequate provision has been made for any adjustments that may result from these reviews. Any differences between our original estimates of reimbursements and subsequent revisions are reflected in operations in the period in which the revisions are made often due to final determination or the period of payment no longer being subject to audit or review. We have made provisions of approximately $16,807,000 as of December 31, 2011 for various Medicare and Medicaid current and prior year cost reports and claims reviews.

Revenue Recognition - Private Pay

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

Revenue Recognition - Subordination of Fees and Uncertain Collections

We provide management services to certain long-term care facilities and to others we provide accounting and financial services. We generally charge 6% to 7% of net revenues for our management services and a predetermined fixed rate per bed for the accounting and financial services. Our policy is to recognize revenues associated with both management services and accounting and financial services on an accrual basis as the services are provided. However, under the terms of our management contracts, payments for our management services are subject to subordination to other expenditures of the long-term care center being managed. Furthermore, for certain of the third parties with whom we have contracted to provide services and which we have determined, based on insufficient historical collections and the lack of expected future collections, that collection is not reasonably assured, our policy is to recognize income only in the period in which the amounts are realized. We may receive payment for the unpaid and unrecognized management fees in whole or in part in the future only if cash flows from the operating and investing activities of the centers or proceeds from the sale of the centers are sufficient to pay the fees. There can be no assurance that such future cash flows will occur. The realization of such previously unrecognized revenue could cause our reported net income to vary significantly from period to period.

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

See Notes 2, 3 and 4 to the Consolidated Financial Statements regarding our relationships with National, NHI, and the recognition of management fees from long-term care centers owned by third parties.

Accrued Risk Reserves

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

Professional liability remains an area of particular concern to us. The entire long term care industry has seen a dramatic increase in personal injury/wrongful death claims based on alleged negligence by nursing homes and their employees in providing care to residents. As of December 31, 2011, we and/or our managed centers are defendants in 30 such claims inclusive of years 2002 through 2011. It remains possible that those pending matters plus potential unasserted claims could exceed our reserves, which could have a material adverse effect on our financial position, results of operations and cash flows. It is also possible that future events could cause us to make significant adjustments or revisions to these reserve estimates and cause our reported net income to vary significantly from period to period.

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

Credit Losses

Certain of our accounts receivable from private paying patients and certain of our notes receivable are subject to credit losses. We have attempted to reserve for expected accounts receivable credit losses based on our past experience with similar accounts receivable and believe our reserves to be adequate.

We continually monitor and evaluate the carrying amount of our notes receivable in accordance with ASC Topic 310, *Receivables*. It is possible, however, that the accuracy of our estimation process could be materially impacted as the composition of the receivables changes over time. We continually review and refine our estimation process to make it as reactive to these changes as possible. However, we cannot guarantee that we will be able to accurately estimate credit losses on these balances. It is possible that future events could cause us to make significant adjustments or revisions to these estimates and cause our reported net income to vary significantly from period to period.

Uncertain Tax Positions

NHC continually evaluates for uncertain tax positions. These uncertain 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 our uncertain tax positions including related penalties and interest. 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.

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

Results of Operations

The following table and discussion sets forth items from the consolidated statements of income as a percentage of net revenues for the audited years ended December 31, 2011, 2010 and 2009.

Percentage of Net Revenues

	Year Ended December 31,		
	2011	2010	2009
Revenues:			
Net patient revenues	92.5%	92.1%	92.3%
Other revenues	7.5	7.9	7.7
Net operating revenues	100.0	100.0	100.0
Costs and Expenses:			
Salaries, wages and benefits	55.4	55.5	55.1
Other operating	25.7	27.3	27.9
Rent	5.1	5.3	5.5
Depreciation and amortization	3.7	3.8	3.8
Interest	0.1	0.1	0.1
Total costs and expenses	90.0	92.0	92.4
Income before non-operating income	10.0	8.0	7.6
Non-operating income	2.7	3.3	2.5
Income before income taxes	12.7	11.3	10.1
Income tax provision	(4.4)	(4.0)	(4.1)

Net Income	8.3	7.3	6.0
Dividends to preferred stockholders	(1.1)	(1.2)	(1.3)
Net income available to common stockholders	7.2	6.1	4.7

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

Period to Period Increase (Decrease)

	2011 vs. 2010		2010 vs. 2009	
(dollars in thousands)	Amount	Percent	Amount	Percent
Revenues:				
Net patient revenues	$ 51,860	7.8	$ 42,040	6.8
Other revenues	1,024	1.8	5,411	10.5
Net operating revenues	52,884	7.3	47,451	7.0
Costs and Expenses:				
Salaries, wages and benefits	28,402	7.1	29,562	8.0
Other operating	1,423	0.7	8,871	4.7
Rent	1,650	4.3	754	2.0
Depreciation and amortization	1,760	6.5	1,712	6.7
Interest	(70)	(13.6)	(203)	(28.4)
Total costs and expenses	33,165	5.0	40,696	6.5
Income before non-operating income	19,719	34.2	6,755	13.3
Non-operating income	(2,807)	(12.0)	6,556	39.1
Income before income taxes	16,912	20.9	13,311	19.7
Income tax provision	5,535	19.6	665	2.4
Net Income	11,377	21.6	12,646	31.6
Dividends paid to preferred stockholders	(2)	–	–	–
Net income available to common stockholders	$ 11,379	25.8	$ 12,646	40.3

Our long-term health care services, including therapy and pharmacy services, provided 89.7%, 89.1% and 89.4% of net patient revenues in 2011, 2010, and 2009, respectively. Homecare and hospice programs provided 10.3%, 10.9%, and 10.6% of net patient revenues in 2011, 2010, and 2009, respectively.

The overall average census in owned and leased health care centers for 2011 was 90.6% compared to 92.0% in 2010 and 2009, respectively.

Approximately 70% of our net patient revenues are derived from Medicare, Medicaid, and other government programs. As discussed above in the Application of Critical Accounting Policies section, amounts earned under these programs are subject to review by the Medicare and Medicaid intermediaries. See Application of Critical Accounting Policies for discussion of the effects that this revenue concentration and the uncertainties related to such revenues have on our revenue recognition policies.

Government Program Financial Changes

Cost containment will continue to be a priority for Federal and State governments for health care services, including the types of services we provide. Government reimbursement programs such as Medicare and Medicaid prescribe, by law, the billing methods and amounts that health care providers may charge and be reimbursed to care for patients covered by these programs. Congress has passed a number of laws that have effected major changes in the Medicare and Medicaid programs. The Balanced Budget Act of 1997 sought to achieve a balanced federal budget by, among other things, reducing federal spending on Medicare and Medicaid to various providers. The Balanced Budget Act of 1997 defined the Medicare Prospective Payment System ("PPS") and this System has subsequently been refined in 1999, 2000, 2005, 2006 and 2010.

Federal Health Care Reform

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act of 2010 ("HCERA"), which represents

significant changes to the current U.S. health care system (collectively the "Acts"). The Acts affect aging services providers, our partners (employees) and our patients and residents in a multitude of ways. We have evaluated the provisions of the Acts and anticipate many of the provisions may be subject to further clarification and modification through the rule-making process. It is uncertain at this time the effect the modifications will have on our future results of operations or cash flows.

In December 2010, President Obama signed into law the Medicare and Medicaid Extenders Act (“MMEA”). This legislation affects numerous health care providers and makes several important technical corrections to the health reform laws enacted earlier in 2010. An important item provided for in the MMEA legislation is for an immediate and retroactive updated methodology (Resource Utilization Group – Version Four, “RUG-IV”) for determining Medicare payment rates to skilled nursing centers. The MMEA allowed skilled nursing center rates determined by RUG-IV to be applied as of October 1, 2010.

In August 2011 and pursuant to the Budget Control Act of 2011, Congress created a 12-member bipartisan committee called the Joint Select Committee on Deficit Reduction, or the Joint Committee. The Joint Committee was charged with issuing a formal recommendation by November 23, 2011 on how to reduce the federal deficit by at least $1.5 trillion over the next ten years. The Committee concluded their work in November and was not able to make a bipartisan agreement before the Committee’s deadline period. This failure by the Committee is scheduled to trigger automatic reductions in discretionary and mandatory spending starting in 2013, including reductions of not more than 2% to payments to Medicare providers. We are unable to predict the financial impact, if enacted, of the automatic payments cuts beginning in 2013. However, such impact may be adverse and material to our future results of operations and cash flows.

Medicare

On July 29, 2011, CMS issued a final rule providing for, among other things, a net 11.1% reduction in PPS payments to skilled nursing facilities for CMS's fiscal year 2012 (which began October 1, 2011) as compared to PPS payments in CMS's fiscal year 2011 (which ended September 30, 2011). The 11.1% reduction is on a net basis, after the application of a 2.7% market basket increase less a 1.0% multi-factor productivity adjustment required by the PPACA. The final CMS rule also adjusts the method by which group therapy is counted for reimbursement purposes, and changes the timing in which patients who are receiving therapy must be reassessed for purposes of determining their RUG category. We anticipate that, assuming other factors remain constant, CMS's reduced reimbursement rates and other changes effective for its fiscal year 2012 will have a significant and adverse effect on our results of operations when compared to the periods in CMS's fiscal year 2011. We estimate the resulting decrease in revenue from the fiscal year 2012 Medicare rate changes will be approximately $24,000,000 annually, or $6,000,000 per quarter. Furthermore, changes in government requirements for providing therapy services are estimated to increase our operating costs by approximately $6,000,000 annually, or $1,500,000 per quarter. The effect of the rate changes on our revenues is dependent upon our census and the mix of our patients at the recalibrated PPS pay rates. We are examining cost saving measures to help mitigate a portion of the revenue decrease and cost increase, but we are also committed to maintaining the quality of care to our patients. The PPS rates had a net market basket increase of 2.3% in 2010 and a net market basket decrease of 1.1% in 2009.

For 2011, our average Medicare per diem rate for skilled nursing facilities increased 13.5% compared to the same period in 2010. No assurances can be given as to whether Congress will increase or decrease reimbursement in the future, the timing of any action or the form of relief, if any, that may be enacted.

On October 31, 2011 and effective January 1, 2012, CMS issued a final ruling for homecare programs which stated an approximate 2.4% rate reduction from the 2011 HH PPS rates. The 2.4% rate reduction will impact individual providers unevenly. CMS finalized significant changes by eliminating hypertension as a factor in the calculation, reducing the weights on therapy episodes, and increasing weights on non-therapy episodes. Providers with high volume of therapy cases could see greater net rate reductions while others with non-therapy patients may see a negligible overall reduction in revenue or a slight increase. We estimate the effect of the revenue decrease for NHC homecare programs to be approximately $2,600,000 annually, or $650,000 per quarter.

Effective October 1, 2011, hospice agencies received Medicare payments which represented a 2.5% increase.

Medicaid

No rate increases or decreases were implemented for the fiscal years beginning July 1, 2011 for Medicaid programs in the states of Tennessee and Missouri. Tennessee, however, has announced that it will implement a 4.25% rate reduction beginning January 1, 2012. We estimate the resulting decrease in revenue in Tennessee will be approximately $2,600,000 annually, or $650,000 per quarter.

On April 7, 2011, effectively immediately, South Carolina implemented a three percent Medicaid rate reduction. We estimate the resulting decrease in revenue is approximately $1,480,000 annually, or $370,000 per quarter.

Overall our average Medicaid per diem increased 0.5% in 2011 compared to 2010. We face challenges with respect to states' Medicaid payments, because many currently do not cover the total costs incurred in providing care to those patients. States will continue to control Medicaid expenditures and also look for adequate funding sources, including provider assessments. The DRA includes several provisions designed to reduce Medicaid spending. These provisions include, among others, provisions strengthening the Medicaid asset transfer restrictions for persons seeking to qualify for Medicaid long-term care coverage, which could, due to the timing of the penalty period, increase facilities' exposure to uncompensated care. Other provisions could increase state funding for home and community-based services, potentially having an impact on funding for nursing facilities. There is no assurance that the funding for our services will increase or decrease in the future.

2011 Compared to 2010

Results for 2011 compared to 2010 include a 7.3% increase in net operating revenues and a 20.9% increase in net income before income taxes.

Net patient revenues increased $51,860,000 or 7.8% compared to the same period last year. Medicare, Medicaid and private pay per diem rates increased 13.5%, 0.5% and 0.7%, respectively, in 2011 compared to 2010. In combination with our per diem increases, the addition of our newly constructed or acquired businesses during the 2011 year helped increase net patient revenues approximately $18,589,000. The new operations consisted of three skilled nursing facilities and two assisted living communities.

Other revenues this year increased $1,024,000 or 1.8% to $58,048,000. Other revenues in 2011 include management and accounting service fees of $21,510,000 ($20,897,000 in 2010) and insurance services revenue of $15,657,000 ($17,068,000 in 2010). Rental income of $19,124,000 in 2011 increased $1,749,000 compared to 2010. NHC provided management services for 21 skilled nursing centers, four assisted living communities, and two independent living communities in 2011. We also provided accounting and financial services to 28 healthcare facilities in 2011. Rental income increased due to the renewed rental agreements of thirteen of our properties with third party operators.

See Application of Critical Accounting Policies, *Revenue Recognition - Subordination of Fees and Uncertain Collections* for a discussion of the factors that may cause management fee revenues to fluctuate from period to period.

Non-operating income in 2011 decreased $2,807,000 or 12.0% to $20,533,000. The decrease in 2011 is due to the nonrecurring gain ($3,563,000) that was recorded in 2010 due to the acquisition of two Missouri long-term health care centers. The remaining increase is due to an increase in equity in earnings of our unconsolidated investments ($681,000).

Total costs and expenses for 2011 increased $33,165,000 or 5.0% to $696,191,000 from $663,026,000 in 2010. Salaries, wages and benefits, the largest operating costs of this service company, increased $28,402,000 or 7.1% to $428,672,000 from $400,270,000. Other operating expenses increased $1,423,000 or 0.7% to $198,439,000 for 2011 compared to $197,016,000 in 2010. Rent expense increased $1,650,000 or 4.3% to $39,736,000. Depreciation and amortization increased 6.5% to $28,901,000. Interest costs decreased to $443,000.

Salaries, wages and benefits as a percentage of net operating revenue was 55.4% and 55.5% for the years ended December 31, 2011 and 2010, respectively. The increases in salaries, wages and benefits are primarily due to increased staffing from the opening or acquisition of the three skilled nursing facilities and two assisted living

communities during 2011 ($9,880,000). We also had increased costs in our existing skilled nursing facilities ($9,754,000), increased costs for therapist services ($6,664,000) and inflationary wage increases.

Other operating expense as a percentage of net operating revenues was 25.7% and 27.3% for the years ended December 31, 2011 and 2010, respectively. The increases in other operating expenses are primarily due to the opening or acquisition of the new operations. The three skilled nursing facilities and two assisted living communities increased other operating expenses $8,474,000. Our existing skilled nursing facilities also increased other operating expenses approximately $4,394,000, but the increases in expenses were offset due to the favorable results within our accrued risk reserves of approximately $10,702,000.

Rent expense in 2011 increased by approximately $1,650,000 compared to the prior year due to increased percentage rent to National Health Investors, Inc. (NHI) of $1,847,000. Percentage rent to NHI is equal to 4% of the increase in facility revenues over the 2007 revenues, the base year of the lease agreement.

Depreciation expense increased primarily due to the acquisition and construction of depreciable assets in the last year. The increase in depreciation for the twelve months ended December 31, 2011 was $1,760,000.

The income tax provision for 2011 is $33,807,000 (an effective tax rate of 34.5%). The income tax provision and effective tax rate for 2011 were favorably impacted by statute of limitations expirations resulting in a benefit to the provision of $3,992,000 or 4.1% of income before taxes in 2011. The income tax provision and effective tax rate for 2011 were unfavorably impacted by adjustments to unrecognized tax benefits resulting in an increase in the tax provision of $85,000 composed of $351,000 tax and $(266,000) interest and penalties or 0.1% of income before taxes in 2011.

The income tax provision for 2010 is $28,272,000 (an effective tax rate of 34.9%). The income tax provision and effective tax rate for 2010 were favorably impacted by statute of limitations expirations resulting in a benefit to the provision of $3,721,000 or 4.6% of income before taxes in 2010. The income tax provision and effective tax rate for 2010 were unfavorably impacted by adjustments to unrecognized tax benefits resulting in an increase in the tax provision of $660,000 composed of $449,000 tax and $211,000 interest and penalties or 0.8% of income before taxes in 2010.

The effective tax rate for 2012 is expected to be in the range of 35% to 39%.

2010 Compared to 2009

Results for 2010 compared to 2009 include a 7.0% increase in net operating revenues and a 19.7% increase in net income before income taxes.

Net patient revenues increased $42,040,000 or 6.8% compared to the same period last year. Medicare, Medicaid and private pay per diem rates increased 4.8%, 3.0% and 4.2%, respectively, in 2010 compared to 2009. In combination with our per diem increases, the addition of our newly constructed or acquired businesses during the 2010 year helped increase net patient revenues approximately $11,208,000. The new businesses consisted of four skilled nursing facilities, one assisted living community, and three homecare programs.

Other revenues in 2010 increased $5,411,000 or 10.5% to $57,024,000. Other revenues in 2010 include management and accounting service fees of $20,897,000 ($17,845,000 in 2009) and insurance services revenue of $17,068,000 ($14,560,000 in 2009). Rental income of $17,375,000 in 2010 decreased $370,000 compared to 2009. NHC provided management services for 23 skilled nursing centers, four assisted living communities, three independent living communities, and accounting and financial services for 28 centers in 2010. See Application of Critical Accounting Policies, *Revenue Recognition - Subordination of Fees and Uncertain Collections* for a discussion of the factors that may cause management fee revenues to fluctuate from period to period.

Non-operating income in 2010 increased $6,556,000 or 39.1% to $23,340,000. The increase is primarily due to the amount of the recovery of assets ($3,563,000) in the acquisition of two Missouri long-term health care centers acquired on December 1, 2010. We managed the facilities prior to our acquisition and had written certain assets down or off our balance sheet. See Footnote 17 to our Consolidated Financial Statements for additional

disclosure regarding the acquisition. The remaining increase is due to an increase in interest and dividend income related to our marketable securities and restricted marketable securities ($2,679,000).

Total costs and expenses for 2010 increased $40,696,000 or 6.5% to $663,026,000 from $622,330,000 in 2009. Salaries, wages and benefits, the largest operating costs of this service company, increased $29,562,000 or 8.0% to $400,270,000 from $370,708,000. Other operating expenses increased $8,871,000 or 4.7% to $197,016,000 for 2010 compared to $188,145,000 in 2009. Rent expense increased $754,000 or 2.0% to $38,086,000. Depreciation and amortization increased 6.7% to $27,141,000. Interest costs decreased to $513,000.

Salaries, wages and benefits as a percentage of net operating revenue was 55.5% and 55.1% for the years ended December 31, 2010 and 2009, respectively. The increases in salaries, wages and benefits are primarily due to increased staffing from the opening or acquisition of the four skilled nursing facilities, one assisted living community, and three homecare programs during 2010 ($7,106,000). We also had increased costs in our existing skilled nursing facilities ($9,165,000), increased costs for therapist services ($4,452,000), an increased provision for workers' compensation claims ($2,728,000), and inflationary wage increases.

Other operating expense as a percentage of net operating revenues was 27.3% and 27.9% for the years ended December 31, 2010 and 2009, respectively. The increases in other operating expenses are primarily due to the opening or acquisition of the new operations. The four skilled nursing facilities, one assisted living community, and three homecare programs increased other operating expenses $5,695,000. Our existing skilled nursing facilities also increased other operating expenses approximately $3,691,000.

Rent expense in 2010 increased by approximately $754,000 compared to the prior year due to increased percentage rent to National Health Investors, Inc. (NHI) of $365,000. Percentage rent to NHI is equal to 4% of the increase in facility revenues over the 2007 revenues, the base year of the lease agreement.

Depreciation expense increased primarily due to the acquisition and construction of depreciable assets in the last year. The increase in depreciation for the twelve months ended December 31, 2010 was $1,712,000.

The decrease in interest costs is primarily due to the Company paying off the revolving credit facility during the fourth quarter of 2009.

The income tax provision for 2010 is $28,272,000 (an effective tax rate of 34.9%). The income tax provision and effective tax rate for 2010 were favorably impacted by statute of limitations expirations resulting in a benefit to the provision of $3,721,000 or 4.6% of income before taxes in 2010. The income tax provision and effective tax rate for 2010 were unfavorably impacted by adjustments to unrecognized tax benefits resulting in an increase in the tax provision of $660,000 composed of $449,000 tax and $211,000 interest and penalties or 0.8% of income before taxes

in 2010.

The income tax provision for 2009 was $27,607,000 (an effective tax rate of 40.8%). The income tax provision and effective tax rate for 2009 were favorably impacted by statute of limitations expirations and adjustment to unrecognized tax benefits resulting in a benefit to the provision of $1,553,000 or 2.3% of income before taxes in 2009. The income tax provision and effective tax rate for 2009 were unfavorably impacted by adjustments to unrecognized tax benefits resulting in an increase in the tax provision of $4,179,000 composed of $2,589,000 tax and $1,591,00 interest and penalties or 6.2% of income before taxes in 2009.

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 operations, hospice operations, insurance services, management services and accounting services. Our primary uses of cash include salaries, wages and other operating costs of our home office and the facilities we operate, the cost of additions to and acquisitions of real property, rent expenses, and dividend distributions. These sources and uses of cash are reflected in our Consolidated Statements of Cash Flows and are discussed in further detail below. The following is a summary of our sources and uses of cash flows (dollars in thousands):

	Year Ended		One Year Change		Year Ended	Two Year Change	
	12/31/11	12/31/10	$	%	12/31/09	$	%
Cash and cash equivalents at beginning of period	$ 28,478	$ 39,022	$(10,544)	(27.0)	$ 49,033	$(20,555)	(41.9)
Cash provided from operating activities	80,654	62,404	18,250	29.2	85,150	(4,496)	(5.3)
Cash used in investing activities	(31,746)	(46,351)	14,605	31.5	(39,185)	7,439	19.0
Cash provided from (used in) financing activities	(16,378)	(26,597)	10,219	38.4	(55,976)	39,598	70.7
Cash and cash equivalents at end of period	$ 61,008	$ 28,478	$ 32,530	114.2	$ 39,022	$ 21,986	56.3

Operating Activities

Net cash provided by operating activities for the year ended December 31, 2011 was $80,654,000 as compared to $62,404,000 and $85,150,000 for the years ended December 31, 2010 and 2009, respectively. Cash provided by operating activities consisted of net income of $64,072,000, adjustments for non-cash items of $36,472,000, and $19,890,000 used for working capital and other activities. Working capital primarily consisted of an increase in restricted cash and cash equivalents of $7,830,000, a decrease in accrued risk reserves of $6,817,000, and an increase in federal income taxes receivable of $3,779,000.

The increase in restricted cash and cash equivalents is from NHC and other healthcare facilities paying insurance premiums into NHC insurance companies, which restrict the cash payment. The decrease in accrued risk reserves is due from the favorable results during the 2011 fiscal year.

Investing Activities

Cash used in investing activities totaled $31,746,000 for the year ended December 31, 2011, as compared to $46,351,000 and $39,185,000 for the years ended December 31, 2010 and 2009, respectively. Cash used for property and equipment additions was $23,597,000, $32,838,000, and $44,064,000 for the years ended December 31, 2011 and 2010 and 2009, respectively. Cash in the amount of $7,500,000 was used in the December 31, 2011 acquisition of an additional 7.5% limited partnership interest in Caris. Purchases and sales of marketable securities resulted in a net use of cash of $2,096,000. Investments in notes receivable totaled $650,000 in 2011 compared to $-0- in 2010. Cash provided by collections of notes receivable was $1,872,000 in 2011 compared to $1,300,000 in 2010.

Construction costs included in additions to property and equipment in 2011 include $5,369,000 for the completion of a 75-unit assisted living facility in Columbia, South Carolina and a 46-unit assisted living addition to our Franklin, Tennessee community.

The purchases of marketable securities were funded primarily from restricted cash and cash equivalents to earn a better rate of return.

Financing Activities

Net cash used in financing activities totaled $16,378,000, $26,597,000 and $55,976,000 for the years ended December 31, 2011, 2010, and 2009, respectively. Dividends paid to common stockholders for the 2011 year were $15,952,000 compared to $14,780,000 in 2010. Dividends paid to preferred stockholders were $8,671,000 in 2011 compared to

$8,673,000 in 2010. Proceeds from the issuance of common stock, primarily from the exercise of stock options, totaled $8,392,000 in 2011 compared to $2,655,000 in the prior year. In August 2010, the Company repurchased 182,900 shares of common stock, which used $5,944,000 of cash.

Table of Contractual Cash Obligations

Our contractual cash obligations for periods subsequent to December 31, 2011 are as follows (in 000's):

	Total	Less than 1 year	1-3 Years	3-5 Years	After 5 Years
Long-term debt principal	$ 10,000	$ –	$ –	$ –	$ 10,000
Long-term debt – interest	1,656	276	552	552	276
Operating leases	337,000	33,700	67,400	67,400	168,500
Total Contractual Cash Obligations	$ 348,656	$ 33,976	$ 67,952	67,952	178,776

Income taxes payable for uncertain tax positions under ASC 740 of $4,457,000 attributable to permanent differences, at December 31, 2011 has not been included in the above table because of the inability to estimate the period in which payment is expected to occur. See Note 13 of the Consolidated Financial Statements for a discussion on income taxes.

Short-term liquidity

Effective October 26, 2011, we extended the maturity of our $75,000,000 revolving credit agreement to October 25, 2012. At December 31, 2011, we do not have any funds borrowed against the credit agreement. The entire amount of $75,000,000 is available to be drawn for general corporate purposes, including working capital and acquisitions.

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 $61,008,000, marketable securities of $85,051,000 and as needed, our borrowing capacity, are expected to be adequate to meet our contractual obligations and to finance our operating requirements and our growth and development plans in the next twelve months.

Long-term liquidity

Our $75,000,000 revolving credit agreement matures on October 25, 2012. We currently anticipate renewing the credit agreement at that time. While we have had no indication from the lender there is any question about renewal, there has been no commitment at this time. We entered into this loan originally on October 30, 2007, and have renewed the loan four times, with a one year maturity. At the inception and at each renewal, the lender offered alternative notes with longer maturities, but the Company chose a one-year maturity because of the terms. If we have an outstanding balance and are not able to refinance our debt as it matures, we will be required to use our cash and marketable securities to meet our debt obligations. This will limit our ability to fund future growth opportunities.

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 healthcare, customer demand, success of our marketing efforts, pressures from competitors, and the state of the economy, including the state of financial and credit markets.

Guarantees and Contingencies

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

At December 31, 2011, 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, 2011, we did not participate in any such financial investments.

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.

Other Matters

On July 24, 2009, the Company received a civil investigative demand from the Tennessee Attorney General's Office, requesting production of documents related to NHC's business relationships with non-profit entities. The Company has responded to the demand and complied as required with the terms of the demand.

New Accounting Pronouncements

See Note 1 to the Consolidated Financial Statements for the impact of new accounting standards.

ITEM 7a. QUANTITATIVE AND QUALITATIVE DISCLOSURE ABOUT MARKET RISK

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

Interest Rate Risk

The fair values of our fixed-income investments fluctuate in response to changes in market interest rates. Increases and decreases in prevailing interest rates generally translate into decreases and increases, respectively, in the fair values of those instruments. Additionally, the fair values of interest rate sensitive instruments may be affected by the creditworthiness of the issuer, prepayment options, the liquidity of the instrument and other general market conditions. At December 31, 2011, we have available for sale debt securities in the amount of $83,625,000. The fixed maturity 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 maturity portfolio allows our insurance company subsidiaries to achieve an adequate risk-adjusted return while maintaining sufficient liquidity to meet obligations.

As of December 31, 2011, both our long-term debt and revolving credit facility bear interest at variable interest rates. Currently, we have long-term debt outstanding of $10.0 million and the revolving credit facility is zero. However, we do intend to borrow funds on our credit facility in the future. Based on a hypothetical credit facility borrowing of $75 million and our outstanding long-term debt, a 1% change in interest rates would change our interest cost by approximately $850,000.

Approximately $4.6 million of our notes receivable bear interest at variable rates (generally at the prime rate plus 2%). Because the interest rates of these instruments are variable, a hypothetical 1% change in interest rates would result in a related increase or decrease in interest income of approximately $46,000.

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 maturity 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 commercial mortgage-backed securities comprise approximately 73.9% of the fair value of the fixed maturity portfolio. At December 31, 2011, the credit quality ratings for our fixed maturity portfolio consisted of the following investment grades (as a percent of fair value): 44.3% AAA rated, 18.9% AA rated, 31.7% A rated, and 1.2% BBB rated.

Equity Price and Concentration Risk

Our available for sale equity securities are recorded at their fair market value based on quoted market prices. Thus, there is exposure to equity price risk, which is the potential change in fair value due to a change in quoted market prices. At December 31, 2011, the fair value of our equity marketable securities is approximately $85,051,000. Of the $85.0 million equity securities portfolio, our investment in National Health Investors, Inc. (“NHI”) comprises approximately $71,716,000, or 84.3%, 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 $8,505,000. At December 31, 2011, our equity securities had unrealized gains of $57,138,000 and $387,000 of unrealized losses. Of the $57,138,000 unrealized gains, $46,982,000 is related to NHI.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Stockholders

National HealthCare Corporation

We have audited the accompanying consolidated balance sheets of National HealthCare Corporation as of December 31, 2011 and 2010 and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2011. Our audits also included the financial statement schedule listed in Item 15(a). These financial statements and schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of National HealthCare Corporation at December 31, 2011 and 2010 and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2011, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, present fairly in all material respects the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), National HealthCare Corporation's internal control over financial reporting as of December 31, 2011, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 17, 2012, expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee

February 17, 2012

NATIONAL HEALTHCARE CORPORATION

Consolidated Statements of Income

(in thousands, except share and per share amounts)

	Years Ended December 31,		
	2011	2010	2009
Revenues:			
Net patient revenues	$ 715,489	$ 663,629	$ 621,589
Other revenues	58,048	57,024	51,613
Net operating revenues	773,537	720,653	673,202
Costs and Expenses:			
Salaries, wages and benefits	428,672	400,270	370,708
Other operating	198,439	197,016	188,145
Rent	39,736	38,086	37,332
Depreciation and amortization	28,901		