

NATIONAL HEALTHCARE CORP
Form 10-K
March 17, 2008

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2007

OR

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

For the transition period from _____ to _____

Commission File No. 001-13489

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

Delaware
(State of Incorporation)

52-2057472
(I.R.S. Employer I.D. No.)

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

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

| Title of Each Class | Name of Each Exchange on which Registered |
|---|---|
| Shares of Common Stock | American Stock Exchange |
| Shares of Preferred Cumulative Convertible Stock | American Stock Exchange |

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 T

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 T

Indicate by check mark whether the registrant (a) 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 T 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. T

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 T 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 T

The aggregate market value of Common Stock held by non-affiliates on June 30, 2007 (based on the closing price of such shares on the American Stock Exchange) was approximately \$295 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 March 5, 2008 was 12,767,805.

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 statements for its 2008 shareholder's meeting.

Table of Contents

Part I

Item 1.

Business.

3

Item 1A.

Risk Factors

14

Item 1B.

Unresolved Staff Comments

21

Item 2.

Properties

22

Item 3.

Legal Proceedings

26

Item 4.

Submission of Matters to a Vote of Security Holders

27

Part II

Item 5.

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

27

Item 6.

Selected Financial Data

29

Item 7.

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

29

Item 7a.

Quantitative and Qualitative Disclosures about Market Risk

41

Item 8.

Financial Statements and Supplementary Data

43

Item 9.

Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

81

Item 9A.

Controls and Procedures

81

Item 9B.

Other Information

83

[Part III](#)

Item 10.

Directors, Executive Officers and Corporate Governance.

83

Item 11.

Executive Compensation

83

Item 12.

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

83

Item 13.

Certain Relationships and Related Transactions and Director Independence

83

Item 14.

Principal Accounting Fees and Services

83

Part IV

Item 15.

Exhibits and Financial Statement Schedules

84

SIGNATURES

86

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. We were incorporated as a Delaware corporation in 1997 when we changed from partnership form to corporate form. When we indicate ANHC@, we include all majority-owned subsidiaries, partnerships and limited liability companies in which we have an interest.

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, management services, hospice services, accounting and financial services and insurance services. We operate in 12 states, and our owned and leased properties are located primarily in the southeastern United States.

Merger of National HealthCare Corporation and National Health Realty, Inc. and Issuance of NHC Convertible Preferred Stock

On October 31, 2007, NHC completed its acquisition of National Health Realty, Inc., (NHR) as contemplated by the Agreement and Plan of Merger (the Merger Agreement), dated December 20, 2006, by and among Davis Acquisition Sub LLC, NHC/OP, L.P., NHR and NHC, following the approval of the merger by the stockholders of NHR and the adoption of the amendment to the Certificate of Incorporation of NHC and approval of the issuance of shares of NHC Series A Convertible Preferred Stock (NHC Preferred) by the stockholders of NHC.

Pursuant to the terms of the Merger Agreement, NHR merged into Davis Acquisition Sub LLC, a wholly-owned subsidiary of NHC. Each share of NHR, issued and outstanding immediately prior to the merger, and not owned by Davis Acquisition Sub LLC, NHC/OP, L.P., or NHC, was converted into the right to receive \$9.00 in cash, without interest and one share of NHC Preferred.

Each share of the NHC Preferred is entitled to annual preferred dividends of \$0.80 per share and has a liquidation preference of \$15.75 per share. The NHC Preferred, which is listed on the American Stock Exchange with the symbol NHC.PR.A , is convertible at any time at the option of the shareholder into NHC common stock at a conversion price of \$65.07. Each share of the NHC Preferred is convertible into 0.24204 of a share of NHC common stock. After the 5th anniversary of the closing date, NHC will have the option to redeem the NHC Preferred, in whole or in part, for \$15.75 cash per share (plus accrued but unpaid dividends); provided that the NHC Preferred will not be redeemable

prior to the 8th anniversary of the closing date unless the average closing price for NHC common stock for 20 trading sessions equals or exceeds the conversion price. The conversion price will be adjusted to reflect any future NHC stock splits or stock dividends. The cash required to complete the merger was provided substantially from NHC's existing liquidity reserves.

NHC paid a total of approximately \$97,571,000 in cash to NHR stockholders, plus cash in lieu of fractional shares, and issued 10,841,062 shares of NHC Preferred with a liquidation preference of \$170,555,000 pursuant to the terms of the Merger Agreement, based on the number of NHR shares of common stock deemed outstanding on October 31, 2007, as calculated under the Merger Agreement.

Accounting Treatment of the Purchase NHC accounted for the merger as a purchase transaction under accounting principles generally accepted in the United States. Under the purchase method of accounting, the assets purchased and liabilities assumed were recorded, as of the completion of the merger, at their respective fair values and added to those of NHC. The financial condition and results of operations of NHC after completion of the merger include

the balances and results of the purchase beginning on November 1, 2007 and are not restated retroactively to reflect the historical financial position or results of operations of NHR.

Following the completion of the merger, the earnings of the combined company reflect purchase accounting adjustments, including the effect of changes in the cost bases of the acquired assets and liabilities on depreciation and amortization expenses.

We may experience a reduction in our earnings per share as a result of the merger. We believe, however, that this negative consequence is offset by the accretive effect that the merger has had and is expected to have on NHC's free cash flow.

Narrative Description of the Business.

Our business is long-term health care services. At December 31, 2007, we operate or manage 73 long-term health care centers with a total of 9,153 licensed beds. These numbers include 48 centers with 6,539 beds that we lease or own and 25 centers with 2,614 beds that we manage for others. Of the 48 leased or owned centers, 34 are leased from National Health Investors, Inc. (NHI). Through October 31, 2007, ten centers were leased from National Health Realty, Inc. (NHR). Effective October 31, 2007, these previously leased properties were acquired by us.

Our 22 assisted living centers (10 leased or owned and 12 managed) have 830 units (358 units leased or owned and 472 units managed). Our six independent living centers (four leased or owned and two managed) have 488 retirement apartments (341 apartments leased or owned and 147 apartments managed).

During 2007, we operated 32 homecare programs and provided 388,321 homecare patient visits to 10,230 patients.

We operate specialized care units within certain of our healthcare centers such as Alzheimer's disease care units, sub-acute nursing units and a number of in-house pharmacies. Similar specialty units are under consideration at a number of our centers, as well as free standing projects. We have a 50% ownership in Caris Healthcare, L.P. (Caris) which provides hospice care.

Long-Term Care Services and Net Patient Revenues. Health care services we provide include a comprehensive range of services. In fiscal 2007, 87% of our net revenues were derived from such health care services. Highlights of health care services activities during 2007 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 48 long-term health care centers as of December 31, 2007. We manage 25 centers for third party owners. Revenues from the 48 centers we own or lease are reported as patient revenues in our financial statements. Management fee income is recorded as other revenues from the 25 facilities that we manage. We generally charge 6% of net revenues for our management services. Average occupancy in these long-term health care centers was 92.7% during the year ended December 31, 2007.

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 700 highly trained, professional therapists in 2007. 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 100 additional health care providers and operate three free-standing outpatient rehabilitation clinics in Tennessee. We are the designated sports medicine provider for Middle Tennessee State University in Murfreesboro, Tennessee. 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 sub-acute 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 one South Carolina, one Missouri, and three Tennessee 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 47,358 in 2005, 57,203 in 2006 and 74,428 in 2007.

E.

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, counseling and other services take into consideration both the needs of patients and the needs of family members. We licensed our first owned hospice program in Greenville, South Carolina in December 2007. This hospice is owned by us and managed by Caris HealthCare, L.P. (Caris). See Other Revenues in this section for more about Caris.

F.

Pharmacy Operations. At December 31, 2007, 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. Effective January 1, 2006, Medicare Part D was implemented by Centers for Medicare and Medicaid Services (CMS). Part D shifted payment of most pharmaceuticals from Medicaid plans to other payors (e.g. Private Pay, Insurance). Regional pharmacies bill Part D Prescription Drug Plans (PDPs) electronically and directly for inpatients who have selected a PDP. Our regional pharmacies currently serve approximately 50 long-term care centers.

G.

Assisted Living Projects. 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 10 and manage 12 assisted living centers, 11 of which are located within the physical structure of a skilled nursing center or retirement center and 11 of which are freestanding. In 2007, the rate of occupancy was 88.9%. Certificates of Need are not required to build these projects and we believe that overbuilding has occurred in some of our markets.

H.

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 long-term 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 managed and one owned retirement center which are Acontinuing care communities@, 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.

I.

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 32 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 decreased from 16,828 in 2006 to 16,277 in 2007 primarily due to an increase in managed care patients. The number of patients served decreased from 10,803 in 2006 to 10,230 in 2007. Visits decreased from 434,021 in 2006 to 388,321 in 2007 due to more effective case management and the increase in managed care patients.

Other Revenues. We generate revenues from insurance services to our managed centers, from management, accounting and financial services to third party long-term care, assisted living and independent living centers, from dividends and other realized gains on securities and from interest income. In fiscal 2007, 13% of our net revenues was 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 Apartners@) 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 \$15,914,000 in 2007.

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% 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 who typically have been or are in the process of being transferred from bankrupt organizations or from entities operating in states with economically unreasonable liability insurance premiums into the hands of small operators or not-for-profit entities. No management services are provided to these entities. As of December 31, 2007, we perform management services for 25 centers and accounting and financial services for 28 centers. NHC's revenues from management, accounting and financial services totaled \$16,799,000 in 2007.

C.

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. If the earnings from our equity investments are from business operations that are long-term care services, we report the earnings in Other Revenues in the Consolidated Statements of Income. Our most significant equity method investment is a 50% ownership and voting interest in Caris HealthCare L.P. (Caris), a business that specializes in hospice care services in NHC owned health care centers and in other settings. In 2003 we entered into a partnership agreement with Caris in order to develop hospice programs in selected market locations. Thirteen locations in Tennessee are now open with two additional locations due to open in 2008. We have also entered into an agreement with Caris whereby they will manage hospice operations owned by us.

We previously provided advisory and/or accounting services to National Health Realty Inc. (NHR) and Management Advisory Source, LLC (Advisors). The services agreement with Advisors required us to provide accounting services to Advisors and, as requested, to National Health Investors, Inc. (NHI). The services to NHR were terminated on October 31, 2007 when we merged with NHR. The services to Advisors were terminated on December 31, 2006 to help to accentuate our independence from NHI, our largest landlord.

Long-Term Health Care Centers

The health care centers operated by our subsidiaries provide in-patient skilled and intermediate nursing care services and in-patient and out-patient rehabilitation services. Skilled nursing care consists of 24-hour nursing service by registered or licensed practical nurses and related medical services prescribed by the patient's physician. Intermediate nursing care consists of similar services on a less intensive basis principally provided by non-licensed personnel. These distinctions are generally found in the long-term 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 full-time registered nurse coverage. All centers provide physical therapy and most have other rehabilitative programs, such as occupational or speech therapy. Each facility is located near at least one hospital and is qualified to accept patients discharged from such hospitals. Each 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. Many 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 owners, all pursuant to separate contracts. The term of each contract and the amount of the management fee or accounting and financial services fee is determined on a case-by-case basis. Typically, we charge 6% 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 continuing owned and leased long-term health care centers:

| | Year Ended December 31 | | |
|----------------|---------------------------|-------|-------|
| | 2007 | 2006 | 2005 |
| Overall census | 92.5% | 93.6% | 94.0% |

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 that 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 | | |
|-----------------------|---------------------------|------|------|
| <u>Source</u> | 2007 | 2006 | 2005 |
| Private | 29% | 28% | 25% |
| Medicare | 39% | 39% | 35% |
| Medicaid/Skilled | 9% | 10% | 14% |
| Medicaid/Intermediate | 22% | 22% | 23% |
| VA and Other | 1% | 1% | 3% |
| 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.

Private pay, VA and other sources include commercial insurance, individual patients' own funds, managed care plans and the Veterans Administration. Although payment rates vary among these sources, market forces and costs largely determine these rates.

Private paying patients, private insurance carriers and the Veterans Administration generally pay on the basis of the center's charges or specifically negotiated contracts. We 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, 2007. These services are designed to speed the patient's recovery and allow the patient to return home as soon as 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 obtain 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.

Medicaid is a medical assistance program for the indigent, operated by individual states with the financial

participation of the federal government.

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 agencies and hospices. 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, home health agencies and hospices 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 on us. If our skilled nursing facilities, home health agencies and hospices 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 methods, revenues and costs of doing business.

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 long-term 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 or the services offered 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 by Our Centers

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 five of our affiliated nursing centers participate in Medicaid. All of our homecares (Home Health Agencies) participate in Medicare which comprises over 95% of their revenue. Homecares 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 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, 2007, we derived 39% and 31% 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

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 was instituted as mandated by the Balanced Budget Act of 1997. PPS became effective for our nursing centers effective January 1, 1999. 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 each October when the federal fiscal year begins. The acuity classification system is named RUGs (Resource Utilization Groups III). SNF PPS as implemented had an adverse impact on our industry and our business by decreasing payments materially. Refinements in the form of temporary add-ons provided some relief until October 1, 2002. Annual market basket (inflationary) increases have continued to improve payments since that time.

On July 28, 2005, the Centers for Medicare and Medicaid Services (CMS) issued a final rule updating the SNF PPS and consolidated billing provisions. The rule updates the per-diem payment rates under the SNF PPS for federal fiscal year (FY) 2006.

The final rule caused a redistribution of payments among providers. This is accomplished by refinements expanding the Resource Utilization Groups (RUGs) from 44 RUG groups to 53 RUG groups and by eliminating

temporary rate add-ons. The elimination of temporary add-ons has always been tied to the long awaited RUG refinement. RUG refinement increases the case mix weight that applies to both nursing and non-ancillary therapy ancillary costs. This is a permanent change in the PPS methodology.

Effective October 1, 2007, our PPS rates were increased by 5.5% due to inflation factors (3.3%) and Core-Based Statistical Area (CBSA) designations.

Prescription Drugs B Medicare Part D - On December 8, 2003, the Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This landmark legislation has caused significant changes to the long term care business. The MMA legislation provides seniors and people with disabilities with the first comprehensive prescription drug benefit ever offered under the Medicare program, the most significant improvement to senior health care in nearly 40 years. Under Part D, private insurance companies contract with Medicare to provide coverage for anyone eligible for Part D that chooses to enroll in a Prescription Drug Plan (PDP). Most patients are enrolled in a PDP including Medicaid and Private Pay patients. There are multiple PDP=s.

Prior to MMA, prescriptions were billed to state Medicaid plans for Medicaid (indigent) patients. Some patients continue to be covered by other private insurance companies outside of Part D. As part of the Consolidated Billing component of the Medicare Part A SNF PPS plan enacted with the Balance Budget Act of 1997 (BBA), prescription drugs for patients in a Part A stay are billed to Part A and not Part D. The provider purchases prescriptions from a drug supplier and bills charges to Medicare Part A under the per diem established by CMS. Whereas, for a patient whose prescriptions are billed to Medicare Part D, the drug supplier bills Part D and the provider is only billed for non-covered and co-pay amounts.

Most of our nursing centers and assisted living centers are supplied prescriptions by our owned regional pharmacies known as Network Pharmacies. Network provides prescriptions to 46 owned, 11 managed, and 15 trade entities. MMA brought great concern over prescription revenue and collections as with any new reimbursement plan. Network personnel worked tirelessly in 2006 to successfully implement Part D in addition to accepting new business. Writeoffs of uncollectible claims have been less than what we expected. We anticipate more changes to Part D in 2007 such as improvements to various PDP plans and modification of which drugs are covered by PDP formularies. In addition, we expect that changes to PDP payment methodology by CMS could have a negative effect on rates. Substantial increases in drug costs could occur which would negatively impact our gross margin for prescriptions.

Therapy -Therapy caps went into effect on January 1, 2006. The DRA of 2005 provides an exception process under which additional services could be approved when medically justified. Therapy caps are increased to \$1,740 per patient per calendar year for Physical/Speech and Occupational therapy. The financial impact of therapy caps is not measurable at this time. The effect to our business may or may not be significant.

Homecares (HHAs)

Medicare is uniform nationwide and reimburses homecares under a fixed payment methodology named the Prospective Payment System (HH PPS). PPS was instituted as mandated by the Balanced Budget Act of 1997. PPS became effective for our homecares effective October 1, 2000. Generally, Medicare makes payment under the HH PPS on the basis of a national standardized 60-day episode payment, adjusted for case mix and geographical wage index. Payment rates are updated periodically and were last adjusted on January 1, 2007. The acuity classification system is named HHRGs (Home Health Resource Groups).

On December 8, 2003, the Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. As a result, payments to home health agencies increased by 2.3% beginning on January 1, 2004. Effective April 1, 2005 the rural add-on of 5% was eliminated causing a 3% decrease in revenues to all providers.

The Deficit Reduction Act (DRA) of 2005 froze the home health payment rate for 2006. HHAs serving rural beneficiaries experienced a one-year five percent add-on payment under the legislation. The rural add-on payment

provided for a 2.5% increase in total payments or, for our homecare operations, approximately \$1.2 million in FY 2006 due to a significant number of our homecares serving rural counties.

For 2007, we received a market basket update of 3.3% with offsetting reductions resulting from the elimination of the one-year five percent add-on for rural areas that was implemented in 2006.

For 2008, we received a market basket update of 3.0% coupled with rate reductions of 2.75% per year for years 2008 through 2010 to be followed by a 2.71% reduction in 2011. Changes were also made to case-mix weights, moving from 83 case-mix categories in 2007 to 153 case-mix categories in 2008. The ten visit threshold at which higher payment rates would occur was replaced with a multi-step threshold with incremental payments for increased visits.

Medicaid Legislation and Regulations

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 home-based services.

In Tennessee, annual Medicaid rate increases were implemented effective July 1, 2007. In South Carolina, the annual Medicaid rate increases were implemented effective October 1, 2007. In Missouri, Medicaid implemented a global increase in all providers rates on February 1, 2007 and an additional global increase on July 1, 2007.

Health Care Center Construction and Purchases

We have completed or anticipate completion of the following long-term health care centers.

| Description | Number of Beds | Location | Cost | Date Placed in Service or Expected Completion |
|--------------|----------------|-------------------|--------------|---|
| Bed Addition | 60 | Garden City, SC | \$ 5,259,014 | 1 st Quarter 2007 |
| Bed Addition | 60 | Columbia, SC | 4,325,726 | 1 st Quarter 2007 |
| Bed Addition | 60 | North Augusta, SC | 6,657,000 | April 2008 |

In November 2007, we purchased the real estate, personal property, inventory and net working capital of a 544-bed long-term care center and a 66-unit assisted living facility located in Chattanooga, Tennessee for approximately \$14,760,000. The property has been leased to a third party provider.

In January 2008, we purchased a 109-bed skilled nursing and rehabilitation facility for \$6,347,000 located in Knoxville, Tennessee. In addition, we purchased two tracts of land located in South Carolina and one tract located in Tennessee. These tracts were undeveloped and are held for future development.

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) 73 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 health census.

As we expanded into the assisted living market, we monitored 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 non-professional employees. In order to enhance our competitive position, we have an educational tuition loan program, an American Dietetic Association approved internship program, a specially designed nurse's aide training class, and we make financial scholarship aid available to physical therapy vocational programs. We support the Foundation for Geriatric Education. We also conduct an AAdministrator in Training@ course, 24 months in duration, for the professional training of administrators. Presently, we have four full-time individuals in this program. Four of our six regional vice presidents and 48 of our 73 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 through our relationship with NHI. Our insurance services are provided primarily to centers for which we also provide management and 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, 2007, our Administrative Services Contractor plus our managed centers had approximately 11,000 full and part time employees, who we call APartners@. 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:

*

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.

*

Information on our ANHC 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.

*

The NHC Restated Audit Committee Charter.

*

The NHC Compensation Committee Charter.

*

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.

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, 2007, we derived approximately 60% of our net 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, [ABusiness Regulation and Licenses@](#) and [AMedicare Legislation and Regulations@](#) and [AMedicaid 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. The Department of Health and Human Services has released final rules to implement a number of these requirements, and several HIPAA initiatives have become effective, including privacy protections, transaction standards, and security standards. If we fail to comply with these standards, we could be subject to criminal penalties and civil sanctions.

Significant legal actions, which are commonplace in our industry, 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, workers= compensation, and health insurance 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, workers= compensation and health 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 subsidiary 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.

We are invested in an enhanced cash fund that has been affected by turmoil in the financial and credit markets that started in the summer of 2007 in the United States. At December 31, 2007, we reported an aggregate investment of \$35,492,000 in the Columbia Strategic Cash Portfolio Fund (the Fund) which invests principally in high quality corporate debt, mortgage-backed securities and asset-backed securities. During December, 2007 the Fund's manager notified us that Fund cash redemptions to investors were suspended and the Fund would begin an orderly liquidation and dissolution of its assets for distribution to the Fund holders that is expected to be completed in 2009. As the fund

is liquidated, we expect to receive our pro rata share of the Fund in cash distributions. However, it is possible that Fund distributions may be suspended for a longer period than indicated by the Fund manager and that the Fund value may be less than the current net asset value stated by the Fund manager. Our inability to withdraw our investment in the Fund may cause us to borrow funds sooner than would otherwise be required. It is possible that future events could require us to make significant adjustments or revisions to our estimates of the Fund value.

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 controls 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 American Stock 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 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, 2007, we perform management services (which include financial services) for 25 such centers and accounting and financial services for an additional 28 such centers. Furthermore, we previously provided advisory services to NHR, prior to the merger with NHC, a publicly traded REIT and financial services to Management Advisory Source, LLC which company provides advisory services to NHI, a publicly traded REIT. The ARisk 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 or our employees.

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.

We may not be able to successfully integrate our acquisition of NHR or realize the potential benefits of the acquisition, which could cause our business to suffer. In October 2007, we acquired NHR. We may not be able to combine successfully the operations of NHR with our operations and, even if such integration is accomplished, we may never realize the potential benefits of the acquisition. The integration of NHR with our operations will also require attention from management, possibly reducing its ability to focus on other operations or other projects. Any delays or increased costs of combining the two companies could adversely affect our operations, financial results, and liquidity.

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, 2007, we leased or owned 48 skilled nursing centers, 22 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 ARisk 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. The external analysis is completed by a certified actuary with extensive experience in the long-term care industry. 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 a new information technology infrastructure 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 the new system and software and refinement of existing software 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.

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 extent, 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 an undrawn \$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:

*

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

*

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

*

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

*

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

*

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

*

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

*

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

*

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

*

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

*

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

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 curtail discretionary capital expenditures.

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(2) | 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 Nursing Home | Managed | 120 | 1999 |
| | Holyoke | Buckley Center for Nursing & Rehab. | Managed | 102 | 1999 |
| | Quincy | John Adams Continuing 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 | Joplin HealthCare Center | Managed | 92 | 2001 |
| | Joplin | NHC HealthCare, Joplin | Leased(1) | 126 | 1982 |
| | Kennett | NHC HealthCare, Kennett | Leased(1) | 170 | 1982 |
| | Macon | Macon Health Care Center | Managed | 120 | 1982 |
| | Osage Beach | Osage Beach Health Care Center | Managed | 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 | Managed | 120 | 1982 |
| | Town & Country | Town & Country HealthCare Center | Owned | 200 | 2001 |
| | West Plains | West Plains Health Care Center | Owned(3) | 120 | 1982 |

| | | | | | |
|------------------|------------|--------------------------------|---------|-----|------|
| New Hampshire | Epsom | Epsom Manor | Managed | 108 | 1999 |
| | Manchester | Maple Leaf Health Care Center | Managed | 114 | 1999 |
| | Manchester | Villa Crest Health Care Center | Managed | 126 | 1999 |

Edgar Filing: NATIONAL HEALTHCARE CORP - Form 10-K

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 |
| | Clinton | NHC HealthCare, Clinton | Owned(3) | 131 | 1993 |
| | Columbia | NHC HealthCare, Parklane | Owned(3) | 180 | 1997 |
| | Greenwood | NHC HealthCare, Greenwood | Leased(1) | 152 | 1973 |
| | Greenville | NHC HealthCare, Greenville | Owned(3)) | 176 | 1992 |
| | Laurens | NHC HealthCare, Laurens | Leased(1) | 176 | 1973 |
| | Lexington | NHC HealthCare, Lexington | Owned(3) | 120 | 1994 |
| | Mauldin | NHC HealthCare, Mauldin | Owned(3) | 180 | 1997 |
| | Murrells Inlet | NHC HealthCare, Garden City | Owned(3) | 148 | 1992 |
| | North Augusta | NHC HealthCare, North Augusta | Owned(3) | 132 | 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 | Leased(1) | 20 | 1996 |
| | Columbia | NHC HealthCare, Columbia | Managed | 106 | 1973 |
| | Columbia | NHC HealthCare, Hillview | Leased(1) | 92 | 1971 |
| | Cookeville | NHC HealthCare, Cookeville | Leased(1) | 94 | 1975 |
| | Dickson | NHC HealthCare, Dickson | Managed | 191 | 1971 |
| | Dunlap | NHC HealthCare, Sequatchie | Leased(1) | 120 | 1976 |
| | Farragut | NHC HealthCare, Farragut | Owned(3) | 90 | 1998 |
| | Franklin | NHC Place, Cool Springs | Leased(1) | 160 | 2004 |
| | Franklin | NHC HealthCare, Franklin | Owned | 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 | Leased(1) | 172 | 1977 |
| | Knoxville | NHC HealthCare, Knoxville | Owned(2) | 139 | 1971 |
| | Lawrenceburg | NHC HealthCare, Lawrenceburg | Leased(1) | 96 | 1985 |
| | Lawrenceburg | NHC HealthCare, Scott | Managed | 62 | 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(3) | 90 | 1997 | |
| Murfreesboro | NHC HealthCare, Murfreesboro | Leased(1) | 181 | 1974 | |

Edgar Filing: NATIONAL HEALTHCARE CORP - Form 10-K

| | | | | | |
|----------|-------------|-------------------------------------|-----------|-----|------|
| | Nashville | The Health Center of Richland Place | Managed | 107 | 1992 |
| | Oak Ridge | NHC HealthCare, Oak Ridge | Managed | 128 | 1977 |
| | Pulaski | NHC HealthCare, Pulaski | Managed | 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(3) | 68 |
| Arizona | Gilbert | The Place at Gilbert | Managed | 50 |
| | Glendale | The Place at Glendale | Managed | 38 |
| | Tucson | The Place at Tucson | Managed | 50 |
| | Tucson | The Place at Tanque Verde | Managed | 38 |
| Kansas | Larned | Larned Health Care Center | Managed | 19 |
| Kentucky | Glasgow | NHC HealthCare, Glasgow | Leased(1) | 8 |
| Missouri | St. Charles | Lake St. Charles Retirement Center | Leased(1) | 25 |
| New Hampshire | Epsom | Heartland Place | Managed | 54 |
| | Manchester | Villa Crest Assisted Living | Managed | 29 |
| South Carolina | Conway | The Place at Conway | Managed | 42 |
| Tennessee | Dickson | NHC HealthCare, Dickson | Leased(1) | 20 |
| | Farragut | NHC Place, Farragut | Owned(3) | 84 |
| | Franklin | NHC Place, Cool Springs | Owned | 46 |
| | Gallatin | The Place at Gallatin | Managed | 42 |
| | Johnson City | NHC HealthCare, Johnson City | Leased(1) | 6 |
| | Kingsport | The Place at Kingsport | Managed | 44 |
| | Murfreesboro | AdamsPlace | Owned(3) | 83 |
| | Nashville | Richland Place | Managed | 24 |
| | Smithville | NHC HealthCare, Smithville | Leased(1) | 6 |
| | Somerville | NHC HealthCare, Somerville | Leased(1) | 12 |
| | Tullahoma | The Place at Tullahoma | Managed | 42 |

Retirement Apartments

| State | City | Retirement Apartments | Affiliation | Units | Est. |
|--------|--------|--------------------------|-------------|-------|------|
| Kansas | Larned | Larned HealthCare Center | Managed | 10 | 2001 |

Edgar Filing: NATIONAL HEALTHCARE CORP - Form 10-K

| | | | | | |
|-----------|--------------|--|-----------|-----|------|
| Missouri | St. Charles | Lake St. Charles Retirement Apartments | Leased(1) | 155 | 1984 |
| Tennessee | Chattanooga | Parkwood Retirement Apartments | Leased(1) | 30 | 1986 |
| | Johnson City | Colonial Hill Retirement Apartments | Leased(1) | 63 | 1987 |
| | Murfreesboro | AdamsPlace | Owned(3) | 93 | 1997 |
| | Nashville | Richland Place Retirement Apartments | Managed | 137 | 1993 |