NATIONAL HEALTHCARE CORP
Form 10-K
March 16, 2007

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2006

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

NATIONAL HEALTHCARE CORPORATION

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

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

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

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

Title of Each Class	Name of Each Exchange on which Registered
Shares of Common Stock	**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 [X]

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

Indicate by check mark whether the registrant (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 [X] No [ ]

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer (as defined in Rule 12b-2 of the Act). Large accelerated filer ___ Accelerated filer _X_ Non-accelerated filer ___

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes [ ] No [X]

The aggregate market value of Common Stock held by non-affiliates on June 30, 2006 (based on the closing price of such shares on the American Stock Exchange) was approximately $229 million. For purposes of the foregoing calculation only, all directors, named executive officers and persons known to the Registrant to be holders of 5% or more of the Registrant=s Common Stock have been deemed affiliates of the Registrant. The number of shares of Common Stock outstanding as of February 28, 2007 was 12,528,227.

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 2007 shareholder=s meeting.

PART 1

Item 1. Business.

General

National HealthCare Corporation (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. All of our operating entities are separately organized businesses, capitalized initially by us and maintained as independent subsidiaries. For accounting and tax purposes, however, they are consolidated within our consolidated financial statements.

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.

At December 31, 2006, we operate or manage 74 long-term health care centers with a total of 9,245 licensed beds. These numbers include 48 centers with 6,481 beds that we lease or own and 26 centers with 2,764 beds that we manage for others. Of the 48 leased or owned centers, 34 are leased from National Health Investors, Inc. (NHI) and 10 are leased from National Health Realty, Inc. (NHR). At December 31, 2006, we serve as a compensated investment advisor to NHR and did so for NHI until October 31, 2004.

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 2006, we operated 30 homecare programs and provided 434,021 homecare patient visits to 10,803 patients.

As of December 31, 2006, we operated 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. which provides hospice care.

Proposed Merger Agreement between National HealthCare Corporation and National Health Realty, Inc. On December 21, 2006, NHC and NHR announced that they have entered into an agreement and plan of merger. Completion of the merger, which is expected to occur in the summer of 2007, is subject to Hart-Scott-Rodino anti-trust review and approval by shareholders of both NHC and NHR, including a majority of the shares of NHR held by holders not affiliated with NHC. The merger will be preceded by and conditioned upon an internal reorganization of NHR, which will also be subject to approval by the NHR shareholders. There is no financing condition to the merger.

If the merger is completed as announced, NHR will cease to exist as a separate business and will be merged into NHC. Please see Item 7 and Item 8, Note 17 herein for more discussion of the proposed merger. It is expected that both National HealthCare Corporation and National Health Realty, Inc. will hold special meetings of each company=s shareholders at a future date to consider matters related to the merger agreement and that a joint proxy statement/prospectus, including annexes and documents incorporated by reference, will be issued by the companies.

Net Patient Revenues. Health care services we provide include a comprehensive range of services through related or separately structured long-term health care centers, specialized care units, pharmacy operations, rehabilitative

services, assisted living centers, retirement centers and homecare programs. In fiscal 2006, 89.2% of our net revenues were derived from such health care services. Highlights of health care services activities during 2006 were as follows:

A.

Long-Term Health Care Centers. As described in more detail throughout this document, we operated or managed 74 long-term health care centers as of December 31, 2006. Revenues from 48 of these facilities are reported as patient revenues on our financial statements, while management fee income is recorded as other revenues for 26 facilities, as these are managed for third party owners. We generally charge 6% of net revenues for our management services. Average occupancy in these long-term health care centers was 93.9% during the year ended December 31, 2006.

B.

Rehabilitative Services. We offer physical, speech, and occupational therapy through Professional Health Services, a division of NHC. We maintained a rehabilitation staff of over 700 highly trained, professional therapists in 2006. The majority of our rehabilitative services are for patients in our owned and managed long-term care centers. We also provide services to over 100 additional health care providers and operate four 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. We require all our centers to participate in the Medicare program, and 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.

D.

Pharmacy Operations. At year end, 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. Beginning January 1, 1999 with the implementation of the Prospective Payment System (PPS) for Skilled Nursing Facilities (SNFs) pharmacy reimbursement under the Medicare Part A program had shifted from direct billing by the regional pharmacy to a negotiated rate structure between skilled nursing centers and the pharmacy, with the skilled nursing center=s Medicare reimbursement being based on a prospective rate not related to actual patient pharmaceutical usage. Effective January 1, 2006, Medicare Part D was successfully implemented by Centers for Medicare and Medicaid Services (CMS). Part D shifted payment of most pharmaceuticals from Medicaid plans and some 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.

E.

Assisted Living Projects. We presently own, lease or manage 22 assisted living projects, 11 of which are located within the physical structure of a long-term health care center or retirement complex. Assisted living units provide basic room and board functions for the elderly with the on-staff availability to assist in minor medical needs on an as needed basis. Development of new units has been discontinued due to existing market conditions.

F.

Managed Care Contracts. We operate three Tennessee, one South Carolina, and one Missouri 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 44,409 in 2004, 47,358 in 2005 and 57,203 in

2006.

G.

Hospice. In 2003 we entered into a partnership agreement with Caris HealthCare in order to develop hospice programs in selected market locations. Eleven locations in Tennessee are now open with two additional locations due to open in 2007. We also plan to expand our hospice services to other states beginning in 2007.

H.

Homecare Programs. NHC operates 30 homecare 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. The reimbursement for homecare services under the Medicare program provides for a prospective pay system. Under the homecare prospective payment system, we receive a prospectively determined amount per patient per 60 day episode as defined by Medicare guidelines. Medicare episodes decreased from 17,837 in 2005 to 16,828 in 2006 primarily due to an increase in managed care patients. The number of patients served increased from 10,367 in 2005 to 10,803 in 2006. Visits decreased from 504,188 in 2005 to 434,021 in 2006 due to more effective case management and the increase in managed care patients.

Other Revenues. We generate revenues from management, accounting and financial services to third party long-term care, assisted living and independent living centers, from administrative and advisory services to NHI (discontinued December 31, 2006 and 2004, respectively) and NHR (which are health care real estate investment trusts), from insurance services to our managed centers, from dividends and other realized gains on securities and from interest income. In fiscal 2006, 10.9% of our net revenues were derived from such other sources. The significant other sources of 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 $18.8 million in 2006.

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, 2006, we perform management services for 24 centers and accounting and financial services for 32 centers. NHC=s revenues from management, accounting and financial services totaled $16.4 million in 2006.

C.

Advisory Services to National Health Realty, Inc. In 1997, we formed National Health Realty, Inc., as a wholly-owned subsidiary. We then transferred to NHR certain healthcare facilities then owned by NHC and distributed the shares of NHR to NHC=s shareholders. The distribution had the effect of separating NHC and NHR into two independent public companies. As a result of the distribution, all of the outstanding shares of NHR were distributed to the then NHC investors. NHR is listed on the American Stock Exchange.

We have entered into an Advisory Agreement with NHR whereby services related to investment activities and day-to-day management and operations are provided to NHR by NHC as Advisor. The Advisor is subject to the supervision of and policies established by NHR=s Board of Directors. The Advisory Agreement expired December 31, 2003 and thereafter is renewed from year to year unless earlier terminated. Either party may terminate the Advisory Agreement at any time on 90 days written notice. The Advisory Agreement may be terminated for cause at any time.

On August 1, 2005, concurrent with the lease extensions, the Advisory Agreement was revised to provide that beginning for the year 2005 for our services under the Advisory Agreement, we are entitled to annual compensation equal to the greater of (1) 2.5% of NHR=s gross consolidated revenues or (2) $500,000. It was also clarified that NHR (and not NHC) is to bear all of its own corporate costs such as directors= and officers= insurance, audit fees, etc.

Prior to the August 1, 2005 revision, the Advisory Agreement had provided that for our services under the Advisory Agreement, we were entitled to annual compensation of the greater of 2% of our gross consolidated revenues or the actual expenses incurred by us. During 2006, 2005, and 2004, compensation under the Advisory Agreement was $524,000, $508,000, and $411,000, respectively. Please see Item 7 for a discussion of a proposed merger between NHC and NHR.

D.

Service Agreement with Management Advisory Source, LLC. In 1991, we formed National Health Investors, Inc. as a wholly-owned subsidiary. We then transferred to NHI certain healthcare facilities owned by NHC and distributed the shares of NHI to NHC's shareholders. The distribution had the effect of separating NHC and NHI into two independent public companies. As a result of the distribution, all of the outstanding shares of NHI were distributed to the then NHC investors. NHI is listed on the New York Stock Exchange.

Until November 1, 2004, we had an Advisory Agreement with NHI whereby we provided to NHI services related to investment activities and day-to-day management and operations. During 2004, our compensation under the NHI Advisory Agreement was $2,383,000.

Effective November 1, 2004, NHC=s Advisory Agreement with NHI was terminated. On that date, Management Advisory Source, LLC (AAdvisors@), a new unrelated company formed by Mr. W. Andrew Adams, undertook to provide advisory services to NHI. Mr. Adams served as NHI=s President and Board Chairman and as NHC=s Chief Executive Officer and Board Chairman prior to November 1, 2004. Effective November 1, 2004 and to enhance independence from NHC, Mr. Adams resigned as NHC=s Chief Executive Officer and terminated his managerial responsibilities with NHC. Mr. Adams remains on the NHC Board as Chairman, focusing on strategic planning, but has no management involvement with NHC.

Effective November 1, 2004, NHC, through its wholly-owned subsidiary, Tennessee Management Advisory Source, LLC (ATHA@) entered into an agreement to provide financial, accounting, data processing and administrative services to Advisors. Under the agreement, THA provided to Advisors and, at the request of Advisors, to NHI, services related to accounting, data processing, administration and evaluation of investments. THA=s role under the agreement was that of advisor and service provider, and THA in no way assumed responsibility for accounting, administrative, or investment decisions which are to be made by Advisors or NHI.

The term of the agreement was through December 31, 2005 and thereafter from year to year. However, either party could terminate the agreement at any time without cause upon 90 days written notice.

For our services under the agreement, we were entitled to compensation of $1,250,000 per year, payable monthly and annually inflated by 5%. NHC earned approximately $1,313,000 in 2006, $1,250,000 in 2005 and $397,000 in 2004 under the terms of the advisory agreement.

On March 13, 2006, we announced that we had reached an agreement with NHI to end the use of NHC=s senior officers as advisors to NHI. NHC=s board believes it to be in the best interest of NHC to accentuate its independence from NHI, its largest landlord. This transition was completed on December 31, 2006 and as of that date, we no longer provide any services to the Advisor or NHI.

E.

Principal Office. We maintain our home office staff in Murfreesboro, Tennessee in a building owned by a limited partnership, which is 95.6% owned by NHC.

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 for our management contracts and specific item fees for our accounting and financial service agreements. The initial term 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.

All health care centers we operate are licensed by the appropriate state and local agencies. All except five are certified as providers for Medicaid patients, and all are certified as Medicare providers. Certification of advised centers is the prerogative of the provider/owner. All licensed nursing homes, assisted living and homecare offices are subject to state and federal licensure and certification surveys. These surveys, from time to time, may produce statements of deficiencies. In response to such a statement, if any, the staff at each center would file a plan of correction and any alleged deficiencies would be corrected. Presently, none of our owned, leased and managed facilities are operating under material statements of deficiencies. We have a significant monetary bonus program for employees attached to passing these surveys with few or no deficiencies.

Health Care Center Construction

In May 2004, we completed construction and opened a new health care facility in Franklin, Tennessee, which has 160 long-term care beds (the license for 47 of these beds came from an existing facility) and 46 assisted living units. Furthermore, we completed the construction of a 30 long-term care bed addition in Murfreesboro, Tennessee in August 2004.

During 2006, we completed a renovation (cost of approximately $1,582,000) to a facility which we lease from NHI. In addition, we completed a 30 bed addition to an existing long-term facility located in Farragut, Tennessee and a 60 bed addition to an existing facility located in Mauldin, South Carolina. The cost of these additions was approximately $9,446,000. Two 60 bed additions to existing facilities costing approximately $7,604,000 located in Garden City, South Carolina and Columbia, South Carolina are scheduled to open during the first quarter of 2007. Construction of a 60 bed addition to an existing facility located in North Augusta, South Carolina expected to cost approximately $6,404,000 will begin in 2007. In March 2006, we purchased for approximately $5,400,000 a 200 bed long-term health care center located in Town and Country, Missouri. We had managed the center since 2001. Also during 2007, we will apply for Certificates of Need for additional beds in our markets and also evaluate the feasibility of expansion into new markets by building health care centers that provide services exclusively to private paying patients.

Occupancy Rates

The following table shows certain information relating to occupancy rates for our continuing owned, leased, and debt guaranteed managed long-term health care centers:

	Year Ended December 31		
	2006	2005	2004
Overall census	93.9%	94.0%	93.9%

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).

Termination of Florida Health Care Center Operations

Unable to obtain liability insurance in the state of Florida (but not elsewhere), we elected to discontinue our Florida long-term health care center operations on September 30, 2000. At that time in Florida we operated two owned skilled nursing facilities and thirteen leased facilities of which three were freestanding assisted living facilities, and we had management contracts with nine facilities owned by third parties. Our former Vice President of Operations and his staff in the state of Florida resigned in August 2000. These individuals, plus additional Florida based outside investors, formed new entities and entered into a series of new leases on the thirteen leased properties and our two owned properties, which leases are for a five-year term. The leases have currently been extended through December 31, 2010. We sold the current assets and current liabilities and leased our furniture, fixtures and leasehold improvements of our owned and leased Florida facilities to the same group of entities. Additionally, and with the consent of the third party owners, the Florida management contracts were assigned to other entities primarily owned and controlled by our former Vice President of Operations. These transactions closed on September 30, 2000, with an effective date of October 1, 2000. New licenses were issued for the respective operators as of that day. Although our obligations for rent payments owed on leased centers remain in effect due to a master lease, we are receiving a credit for lease payments made by the new providers, which were current as of December 31, 2006. Through the master lease agreement, we still maintain a right of first refusal with NHI and NHR to purchase any of the Florida facilities should NHI or NHR receive an offer from an unrelated party.

Assisted Living Units

We presently lease or own 10 and manage 12 assisted living units, 11 of which are located within the physical structure of a long-term health care center or retirement center and 11 of which are freestanding. In 2006, the rate of occupancy was 89.9%. Assisted living units provide basic room and board functions for the elderly with the on-staff availability to assist in minor medical needs on an as needed basis. Certificates of Need are not necessary to build these projects and we believe that overbuilding has occurred in some of our markets.

Retirement Centers

Our four 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 leased 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.

Our managed continuing care community, the 137 unit Richland Place Retirement Center, was opened in January, 1993 and is fully occupied. We opened the leased 58 unit AdamsPlace in Murfreesboro, Tennessee during 1998 and during 2002 expanded it to 93 units.

Homecare Programs

Our home health programs (we call them homecare) provide nursing and rehabilitative services to individuals in their residences and are licensed by the Tennessee, South Carolina and Florida state governments and certified by the federal government for participation in the Medicare program. Each of our 30 Medicare certified homecare programs is managed by an administrator and under the clinical direction of a registered nurse, with speech, occupational and physical therapists either employed by the program or on a contract basis. 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 of care as defined by Medicare guidelines.

Regulation

Long term health care centers are subject to extensive federal, state and in some cases, local regulatory, licensing, and inspection requirements. These requirements relate, among other things, to the adequacy of physical buildings and equipment, qualifications of administrative personnel and nursing staff, quality of nursing provided and continued compliance with laws and regulations relating to the operation of the centers. In all states in which we operate, before the 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.

HIPAA Compliance

The Health Insurance Portability and Accountability Act of 1996 (AHIPAA@) has mandated an extensive set of regulations to standardize electronic patient health, administrative and financial data transactions, and to protect the privacy of individually identifiable health information.

The Company has a HIPAA Task Force and designated privacy and security officers. The privacy requirements contained in HIPAA regulations were presented to every employee and are presented on a continuing basis to new hires during the orientation process. Privacy notices are posted in each facility, and are provided to every new admission. The Company uses a standard Business Associate Agreement with vendors and providers.

The Company has identified information inflow and outflow throughout the organization and has implemented the appropriate security safeguards to be HIPAA-compliant. Failure to comply with HIPAA could result in fines and/or penalties that could have a material adverse effect on us.

Sources of Revenue

Our revenues are primarily derived from our health care centers. The source and amount of the revenues are determined by (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.

The following table sets forth sources of net patient revenues from health care centers and homecare services for the periods indicated:

	Year Ended December 31		
Source	2006	2005	2004
Private	25%	25%	25%
Medicare	39%	35%	34%
Medicaid/Skilled	10%	14%	13%
Medicaid/Intermediate	23%	23%	25%
VA and Other	3%	3%	3%
Total	100%	100%	100%

Private Revenue Sources

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 AManaged Care Offices@, of which seven were open at year end. 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.

Government Health Care Reimbursement Programs

Medicare

The federal health insurance program for the elderly is Medicare (Title 18 of the Social Security Act), which is administered by the United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), formerly HCFA.

Medicare is a health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare is segmented in different parts:

*

Part A Hospital Insurance B covers inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

*

Part B Medical Insurance B covers physician services, therapy, enteral, urological, ostomy, tracheostomy, durable medical equipment, and some home health care. Services must be medically necessary for reimbursement by the program.

*

Part C Medicare Advantage Program - a managed care option for Medicare beneficiaries.

*

Part D Prescription Drug Coverage - a new Medicare prescription drug coverage option that began January 1, 2006 is available to all Medicare beneficiaries. Medicare Prescription Drug Coverage is insurance provided by private companies. Beneficiaries select their company and pay a premium for coverage.

Medicaid

State programs for medical assistance to the indigent are known as Medicaid (Title XIX of the Social Security Act). These programs are operated by state agencies which adopt their own medical reimbursement methodology and standards, but which are entitled to receive supplemental funds from the federal government if the state plan is approved by CMS. Medicaid is the federal-state matching program in all states in which we operate. Medicaid plans vary sometimes significantly from state to state. Variations include reporting forms, rate setting time frames, funding levels, and coverage requirements for patients, etc. Generally all Medicaid plans set an annual reimbursement daily rate known as a per diem. Typically, the Medicaid per diem is based upon historical data and trended with a cost of living (inflation) factor. Several state plans are case-mix (acuity) based similar to the Medicare Prospective Payment System (PPS). Medicaid reimbursement is subject to state budgetary constraints.

Other Payors

Some of our nursing centers generate revenues from the United State Veterans Administration for providing services to veterans.

Some of our nursing centers care for hospice patients that are placed by various hospice companies. NHC has a fifty percent ownership interest in Caris HealthCare, a hospice company. Hospice care provides a comprehensive set of services coordinated by an interdisciplinary team to provide for the needs of terminally ill patients. Hospice companies reimburse our centers based on an agreed upon per diem, unless the patient is dual eligible. If the patient is dual eligible, we are paid the facility=s Medicaid per diem.

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, 2006, we derived 39% and 33% 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, 2006, our PPS rates were increased by 6.2% due to inflation factors (3.1%) and Core-Based Statistical Area (CBSA) designations.

Medicare Bad Debts - The Deficit Reduction Act (DRA) of 2005 mandates the reduction of the private pay share only of bad debt payments (which are included in Medicare payments) to skilled nursing facilities. The first year, FY 2006, the reduction in revenue was only $25,000.

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 14 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, 2006. 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 mandates the home health payment rate for 2006 would be frozen. HHAs serving rural beneficiaries would see a one-year five percent add-on payment under the legislation. The rural add-on payment would provide 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 expect to receive a market basket update of 3.3% with offsetting reductions resulting from the elimination of the one-year five percent add-on that was implemented in 2006.

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, 2006. However, due to delayed CMS approval of the Tennessee state Medicaid plan, payment was delayed until January, 2007. In South Carolina, Medicaid has continued to fund and set new rates as usual effective October 1, 2006.

Competition

In most of the communities in which we operate health care centers, there are other health care centers with which we compete. We own, lease or manage (through subsidiaries) 74 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 six full-time individuals in this program. Four of our six regional vice presidents and 45 of our 74 health care center administrators are graduates of this program.

We experience competition in providing management and accounting services to other long-term health care providers. Those services are provided primarily to owners with whom we have had previous involvement through ownership or 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, 2006, 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:

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

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Information on our 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.

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The NHC Restated Audit Committee Charter.

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The NHC Compensation Committee Charter.

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The NHC Nomination and Corporate Governance Committee Charter

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

Item 1A. Risk Factors

You should carefully consider the risk factors set forth below, as well as the other information contained in this Annual Report on Form 10-K. 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 twelve months ended December 31, 2006, we derived approximately 63% 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 - Government Health Care Reimbursement Programs@ 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 Government Health Care Reimbursement Programs@.

We face additional federal requirements that mandate major changes in the transmission and retention of health information. HIPAA was enacted to ensure, first, that employees can retain and at times transfer their health insurance when they change jobs, and second, to simplify health care administrative processes. This simplification includes expanded protection of the privacy and security of personal medical data and requires the adoption of standards for the exchange of electronic health information. Among the standards that the Secretary of Health and Human Services has adopted pursuant to HIPAA are standards for the following: electronic transactions and code sets, unique identifiers for providers, employers, health plans and individuals, security and electronic signatures, privacy and enforcement. Although HIPAA was intended to ultimately reduce administrative expenses and burdens faced within the health care industry, we believe that implementation of this law has resulted and will continue to result in additional costs. Failure to comply with HIPAA could result in fines and penalties that could have a material adverse effect on us. See Item 1, "Business - HIPAA Compliance@.

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.

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 insured 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.

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, and further requiring our independent auditor to attest similarly to such effectiveness. 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, 2006, we perform management services (which include financial services) for 24 such centers and accounting and financial services for an additional 32 such centers. Furthermore, we provide advisory services to NHR, 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.

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, 2006, 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 extend, the charges for services. In addition, we compete with other long-term care providers for customer referrals from hospitals. As a result, a failure to compete effectively with respect to referrals may have an adverse impact on our business. Many of these competing companies have greater financial and other resources than we have. We cannot assure you that increased competition in the future will not adversely affect our financial condition and results of operations.

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

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

We are exposed to market risk due to the fact that outstanding debt and future borrowings are or will be subject to wide fluctuations based on changing interest rates. - Market risk is the risk of loss arising from adverse changes in market rates and prices such as interest rates, foreign currency exchange rates and commodity prices. Our primary exposure to market risk is interest rate risk associated with variable rate borrowings. Although we do not currently have a bank credit facility, we may be in the future as we resume development and acquisitions. Any future credit facility will provide for variable rates and if market interest rates rise, so will our required interest payments on any future borrowings under the credit facility.

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

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

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incr