Addus HomeCare Corp
Form 10-K
March 18, 2019
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2018

OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to

Commission file number 001-34504

ADDUS HOMECARE CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	20-5340172
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
6801 Gaylord Parkway, Suite 110 Frisco, TX	75034
(Address of principal executive offices)	(Zip Code)

469-535-8200

(Registrant’s telephone number, including area code)

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

Title of each class	Name of each exchange on which registered
Common Stock, par value $0.001	The Nasdaq Stock Market LLC

Securities registered pursuant to Section 12(g) of the Act:

None

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

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

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405) is not contained herein, and will not be contained, to the best of the registrant’s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of “large accelerated filer,” “accelerated filer”, “smaller reporting company” and “emerging growth company” in Rule 12b-2 of the Exchange Act.

Large accelerated filer	Accelerated filer
Non-accelerated filer	Smaller reporting company
	Emerging growth company

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

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

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the registrant, based on the last sale price on The Nasdaq Global Market on June 30, 2018 (the last business day of the registrant’s most recently completed second fiscal quarter) was $443,506,647.

As of March 1, 2019, there were 13,177,598 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Certain portions of the registrant's Definitive Proxy Statement for its 2019 Annual Meeting of Stockholders (which is expected to be filed with the Commission within 120 days after the end of the registrant's 2018 fiscal year) are incorporated by reference into Part III of this Annual Report on Form 10-K.

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SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

When included in this Annual Report on Form 10-K, or in other documents that we file with the Securities and Exchange Commission ("SEC") or in statements made by or on behalf of the Company, words like "believes," "belief," "expects," "plans," "anticipates," "intends," "seeks," "projects," "targets," "estimates," "may," "might," "continue," "would," "will," and similar expressions or variations are intended to identify forward-looking statements as defined by the Private Securities Litigation Reform Act of 1995. These statements are based on the beliefs and assumptions of our management based on information currently available to management. These forward-looking statements involve a variety of risks and uncertainties that could cause actual results to differ materially from those described therein. These risks and uncertainties include, but are not limited to, changes in operational and reimbursement processes and payment structures at the state or federal levels; changes in Medicaid, Medicare, other government program and managed care organizations policies and payment rates; changes in, or our failure to comply with existing, federal and state laws or regulations or our failure to comply with new government laws or regulations on a timely basis; competition in the healthcare industry; the geographical concentration of our operations; changes in the case mix of consumers and payment methodologies; operational changes resulting from the assumption by managed care organizations of responsibility for managing and paying for our services to consumers; the nature and success of future financial and/or delivery system reforms; changes in estimates and judgments associated with critical accounting policies; our ability to maintain or establish new referral sources; our ability to renew significant agreements or groups of agreements; our ability to attract and retain qualified personnel; federal, city and state minimum wage pressure, including any failure of Illinois or any other governmental entity to enact a minimum wage offset and/or the timing of any such enactment; changes in payments and covered services due to the overall economic conditions and deficit spending by federal and state governments; cost containment initiatives undertaken by state and other third party payors; our ability to access financing through the capital and credit markets; our ability to meet debt service requirements and comply with covenants in debt agreements; business disruptions due to natural disasters or acts of terrorism; our ability to integrate and manage our information systems; our expectations regarding the size and growth of the market for our services; the acceptance of privatized social services; our expectations regarding changes in reimbursement rates; eligibility standards and limits on services imposed by state governmental agencies; the potential for litigation; discretionary determinations by government officials; our ability to successfully implement our business model to grow our business; our ability to continue identifying, pursuing and integrating acquisition opportunities and expand into new geographic markets; the impact of acquisitions and dispositions on our business; the effectiveness, quality and cost of our services; our ability to successfully execute our growth strategy; changes in tax rates; the impact of inclement weather or natural disasters; and various other matters, many of which are beyond our control.

Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified, you should not rely on any forward-looking statement as a prediction of future events. We expressly disclaim any obligation or undertaking and we do not intend to release publicly any updates or changes in our expectations concerning the forward-looking statements or any changes in events, conditions or circumstances upon which any forward-looking statement may be based, except as required by law. For a discussion of some of the factors discussed above as well as additional factors, see Part I, Item 1A—"Risk Factors" and Part II, Item 7—"Critical Accounting Policies and Estimates" within "Management's Discussion and Analysis of Financial Condition and Results of Operations".

Unless otherwise provided, "Addus," "we," "us," "our," and the "Company" refer to Addus HomeCare Corporation and our consolidated subsidiaries and "Holdings" refers to Addus HomeCare Corporation. When we refer to 2018, 2017 and 2016, we mean the twelve month period then ended December 31, unless otherwise provided.

A copy of this Annual Report on Form 10-K for the year ended December 31, 2018 as filed with the SEC, including all exhibits, is available on our internet website at http://www.addus.com on the “Investors” page link. Information contained on, or accessible through, our website is not a part of, and is not incorporated by reference into, this Annual Report on Form 10-K.

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PART I

ITEM 1. BUSINESS

Overview

Addus HomeCare Corporation was incorporated in Delaware in 2006 under the name Addus Holding Corporation for the purpose of acquiring Addus HealthCare, Inc. ("Addus HealthCare"). Addus HealthCare was founded in 1979. We are a home care services provider operating in three segments: personal care; hospice; and home health. Our services are principally provided in the home under agreements with federal, state and local government agencies. Our consumers are predominantly "dual eligible," meaning they are eligible to receive both Medicare and Medicaid benefits.

As of December 31, 2018, we provided services to over 39,000 consumers in 24 states through 156 offices. Our payor clients include federal, state and local governmental agencies, managed care organizations, commercial insurers and private individuals. For the years ended December 31, 2018, 2017 and 2016, we served approximately 57,000, 51,000 and 50,000 discrete consumers, respectively. Our personal care segment also includes staffing services, with clients including assisted living facilities, nursing homes and hospice facilities.

A summary of our financial results for 2018, 2017 and 2016 is provided in the table below.

	For the Years Ended December 31,		
	2018	2017 [1]	2016 [1]
	(Amounts in Thousands)		
Net service revenues – continuing operations	$518,119	$425,994	$400,929
Net income from continuing operations	17,377	13,534	12,063
Earnings from discontinued operations	126	147	97
Net income	$17,503	$13,681	$12,160
Total assets	$355,388	$271,691	$232,984

[1] Net service revenues and net income from continuing operations, net income and total assets have been updated to reflect the correction described in Note 2 to the Notes to Consolidated Financial Statements.

Our services and operating model address a number of crucial needs across the healthcare continuum. Care provided in the home generally costs less than facility-based care and is typically preferred by consumers and their families. By providing services in the home to the elderly and others who require long-term care and support with the activities of daily living, we lower the cost of chronic and acute care treatment by delaying or eliminating the need for care in more expensive settings. In addition, our caregivers observe and report changes in the condition of our consumers for the purpose of facilitating early intervention in the disease process, which often reduces the cost of medical services by preventing unnecessary emergency room visits and/or hospital admissions and re-admissions. We coordinate the services provided by our team with those of other healthcare providers and payors as appropriate. Changes in a consumer's conditions are evaluated by appropriately trained managers and may result in a report to the consumer's case manager at a managed care organization or other payor. By providing care in the preferred setting of the home and by providing opportunities to improve the consumer's conditions and allow early intervention as indicated, our

model also is designed to improve consumer outcomes and satisfaction.

We believe our model provides significant value to managed care organizations. States are increasingly implementing managed care programs for Medicaid enrollees, and as a result managed care organizations have been increasingly responsible for the healthcare needs and the related healthcare costs of our consumers. Managed care organizations have an economic incentive to better manage the healthcare expenditures of their members, lower costs and improve outcomes. We believe that our model is well positioned to assist in meeting those goals while also improving consumer satisfaction, and, as a result, we expect increased referrals from managed care organizations.

Beginning January 1, 2019, a final rule of the Centers for Medicare and Medicaid Services ("CMS"), allows Medicare Advantage insurers to offer beneficiaries more options and new benefits. Through this rule, CMS has redefined health-related supplemental benefits to include services that increase health and improve quality of life, including coverage of non-skilled in-home care. This policy change, emphasizing improving quality and reducing costs, aligns with our overall approach to care, and we believe the increased demand for personal care from the Medicare Advantage population represents a significant upside opportunity over the next three to five years.

We utilize Interactive Voice Response ("IVR") systems and smart phone applications to communicate with the majority of our aides. Through these technologies, our aides are able to report changes in health conditions to an appropriate manager for triage and evaluation. In addition, we use these technologies to record basic information about each visit, record start and end times for a

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scheduled shift, track mileage reimbursement, send text messages to the aide and communicate basic payroll information. In addition to our organic growth, we have been growing through acquisitions that have expanded our presence in current markets or facilitated our entry into new markets where the personal care business has primarily been moving to managed care organizations.

In 2013, we sold substantially all of the assets of our then home health skilled nursing business (the "2013 Home Health Business") in Arkansas, Nevada, South Carolina and Pennsylvania, and 90% of the 2013 Home Health Business in California and Illinois. Effective October 1, 2017, we sold our remaining 10% ownership interest in the 2013 Home Health Business in California and Illinois. The results of the 2013 Home Health Business sold are reflected as discontinued operations for all periods presented herein. We maintain licensure as a Medicare home health agency in Ohio and Delaware in connection with providing services in those states. With the purchase of Ambercare Corporation ("Ambercare"), completed in the second quarter of 2018, we now maintain licensure as a Medicare home health and hospice agency in New Mexico.

Our Market and Opportunity

We provide personal care services to the elderly and other infirm adults who require long-term care and assistance with activities of daily living. Personal care services are a significant component of home and community-based services ("HCBS"), which have grown in significance and demand in recent years. Demand for personal care services is expected to continue to grow due to the aging of the U.S. population, increased life expectancy, and improved opportunities for individuals to receive home-based care as an alternative to institutional care. The population over the age of 65 nationally has been growing at a consistent rate for the past five years and the U.S. Census Bureau estimates are that this demographic will more than double by 2050.

Reported federal and state Medicaid expenditures for fee-for-service personal care services amounted to over $29.9 billion in calendar year 2016, the most recent year for which data is available, reflecting an increase of $1.9 billion from 2015.

Many states use both fee-for-service and managed care delivery models for personal care services, and the number of beneficiaries served through managed care continues to grow. As of July 2018, 39 states contracted with risk-based managed care organizations to serve their Medicaid enrollees, with 20 of those states enrolling at least 75% of all elderly beneficiaries or those with disabilities in managed care organizations. In 24 states, some or all long-term services and support is covered through Medicaid managed care arrangements.

In addition to the projected growth of government-sponsored personal care services, the private pay market for our services continues to expand. We offer our private pay consumers the same services that we provide to our government-sponsored personal care consumers.

Historically, there were limited barriers to entry in the personal care services industry. As a result, the personal care services industry developed in a highly fragmented manner, with many small local providers. Few companies have a significant market share across multiple regions or states. The lack of licensure or certification requirements in some states makes it difficult to estimate the number of personal care services agencies.

The personal care services industry has become subject to increased regulation. At the federal level, recent efforts have focused on improved coordination of regulation across the various types of Medicaid programs through which personal care services are offered. For example, the 21st Century Cures Act, as amended, mandates that states implement electronic visit verification ("EVV") by January 1, 2020, which will be used to collect home visit data, such

as when the visit begins and ends. In several states, providers are now required to obtain state licenses or registrations and must comply with laws and regulations governing standards of practice. Providers must dedicate substantial resources to ensure continuing compliance with all applicable regulations and significant expenditures may be necessary to offer new services or to expand into new markets. The failure to comply with regulatory requirements could lead to the termination of rights to participate in federal and state-sponsored programs and the suspension or revocation of licenses. We believe new licensing requirements and regulations, including EVV, the increasing focus on improving health outcomes, the rising cost and complexity of operations, technology and pressure on reimbursement rates due to constrained government resources may discourage new providers and may encourage industry consolidation.

The Medicare-Medicaid Coordination Office ("MMCO") was established within CMS to effectively improve services for consumers who are eligible for both Medicare and Medicaid, also known as dual eligibles, and improve coordination between the federal government and states to enhance access to quality services to which they are entitled. The MMCO works with state Medicaid agencies, other federal and state agencies, physicians and others, to make available technical assistance and educational tools to improve care coordination between Medicare and Medicaid and to reduce costs and improve beneficiary experience while reducing administrative and regulatory barriers between the programs. For example, the Financial Alignment Initiative is a demonstration project that tests capitated models and managed fee-for-service models of integrated care and payment for benefits provided to dual eligibles.

We believe that our personal care program and our technology make us well-suited to partner with managed care organizations to address the needs of the dual eligible population. We believe that our ability to identify changes in our consumers' health and

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condition before acute intervention is required will lower the overall cost of care. We believe this approach to care delivery and the integration of our services into the broader healthcare continuum are particularly attractive to managed care organizations and others who are ultimately responsible for the healthcare needs of our consumers and over time will increase our business with them.

Our Growth Strategy

Our net service revenues growth is closely correlated with the number of consumers to whom we provide our services. Our continued growth depends on our ability to provide consistently high quality care, maintain our existing payor relationships, establish relationships with new payors and increase our referral sources. Our continued growth is also dependent upon the authorization by state agencies of new consumers to receive our services. We believe there are several market opportunities for growth. The U.S. population of persons aged 65 and older is growing, and the U.S. Census Bureau estimates that this population will more than double by 2050. Additionally, we believe the overwhelming majority of individuals in need of care generally prefer to receive care in their homes. Finally, we believe the provision of personal care services is more cost-effective than the provision of similar services in institutional settings for long-term care. We plan to continue our revenue growth and margin improvement and enhance our competitive positioning by executing on the following growth strategies:

Consistently provide high-quality care

We schedule and require our caregivers to perform their services as defined within the individual plan of care. We monitor the performance of our caregivers through regular supervisory visits in the homes of consumers. Our caregivers are provided with pre-service training and orientation and an evaluation of their skills. In many cases, caregivers are also required to attend ongoing in-service education. In certain states, our caregivers are required to complete certified training programs and maintain a state certification. The training provided assists to identify changes in our consumers' health and condition before acute intervention is required, which we believe lowers the overall cost of care.

Drive Organic Growth in Existing Markets

We intend to drive organic growth through several initiatives, including building our sales capabilities, increasing our interaction with referral sources, enhancing our business intelligence capabilities and expanding relationships with payors in our markets. We also expect our organic growth will benefit from an increase in demand for our services by an aging population. We also are prepared to selectively open new offices in existing markets when an opportunity is identified and appropriate.

Market to Managed Care Organizations

As a scaled, national provider of home-based care, we can grow by partnering with managed care organizations, taking advantage of an industry shift away from traditional fee-for-service Medicaid and toward managed care models, which aim to better coordinate care. We expect this shift to lead to narrower provider networks where we can be competitive by offering a larger, more experienced partner to these organizations, as well as by providing more sophisticated technology, electronic visit records and an outcomes-driven approach to service. We believe our coordinated care model and integration of services into the broader healthcare industry are particularly attractive to managed care organizations.

Grow through Acquisitions

In 2018, we completed three acquisitions. Through the Ambercare acquisition, completed in the second quarter of 2018, we acquired the businesses that comprise our hospice and home health segments. Our acquisition pipeline and strong financial position support additional acquisitions. With rising consolidation pressures in the industry, our focus is on identifying growing markets with favorable demographics in states that are fiscally well managed and have a reasonable minimum wage environment and where we have the potential to become one of the leading providers in the state in order to support our managed care organization strategy. We believe our experience identifying and executing on acquisition opportunities, as well as our history of integrating acquisitions, will lead to additional growth.

Grow in Complementary Businesses

In 2018, we expanded and diversified into hospice and home health via our Ambercare acquisition. Entry into these business lines allows us to broaden our range of services in existing markets, while achieving further economies of scale and taking advantage of our home-focused management and operational capabilities. We anticipate having further opportunities to expand these segments by acquisition, with a particular focus on hospice care.

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Our Services

As of December 31, 2018, we delivered services to our consumers in 24 states through 156 individual agencies. Our services, which include non-medical personal care services, are provided to consumers who are unable to independently perform some or all of their activities of daily living. Without our services, many of our consumers would be at increased risk of placement in a long-term care institution. With the acquisition of Ambercare completed during the second quarter of 2018, we began to report our business with two additional segments, hospice and home health. Prior to the Ambercare acquisition, we operated one business segment as a provider of personal care services.

Personal Care

Our personal care segment provides non-medical assistance with activities of daily living, primarily to persons who are at increased risk of hospitalization or institutionalization, such as the elderly, chronically ill or disabled. The services we provide include assistance with bathing, grooming, oral care, assistance with feeding and dressing, medication reminders, meal planning and preparation, housekeeping and transportation services. Many consumers need such services on a long-term basis to address chronic or acute conditions. Each payor client establishes its own eligibility standards, determines the type, amount, duration and scope of services, and establishes the applicable reimbursement rate in accordance with applicable law, regulations or contracts.

Hospice

Our hospice segment provides physical, emotional and spiritual care for people who are terminally ill as well as for their families. The hospice services we provide include palliative nursing care, social work, spiritual counseling, homemaker services and bereavement counseling. Generally, patients receiving hospice services have a life expectancy of six months or less.

Home Health

Our home health segment provides services that are primarily medical in nature to individuals who may require assistance during an illness or after surgery and include skilled nursing and physical, occupational and speech therapy. We generally provide home health services on a short-term, intermittent or episodic basis to individuals, typically to assist patients recovering from an illness or injury.

Our Payors

Our payor clients include federal, state and local governmental agencies, managed care organizations, commercial insurers and private individuals. The federal, state and local programs under which these organizations operate are subject to legislative, budgetary and other risks that can influence reimbursement rates. Managed care organizations that operate as an extension of our state payors are subject to similar economic pressures. Our commercial insurance payor clients are typically for profit companies and are continuously seeking opportunities to control costs.

Most of our services are provided pursuant to agreements with state and local governmental social and aging service agencies. These agreements generally have an initial term of one to two years and may be terminated with 60 days' notice. They are typically renewed for one to five-year terms, provided that we have complied with licensing, certification and program standards, and other regulatory requirements. Reimbursement rates and methods vary by state and service type, but are typically based on an hourly or unit-of-service basis. Managed care organizations are becoming an increasing portion of our personal care segment payor mix as states shift from administering

fee-for-service programs to utilizing managed care models. In our personal care segment during 2018, approximately 58.2% of our net service revenues were derived from state and local government programs, with 35.3% derived from managed care organizations, while approximately 4.1% and 1.3% of net service revenues were derived from private pay consumers and commercial insurance programs, respectively.

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For 2018, 2017 and 2016, our revenue mix by payor type was as follows:

	Years Ended December 31,		
	2018	2017	2016
Personal Care			
State, local and other governmental programs	58.2 %	64.2 %	70.5 %
Managed care organizations	35.3	33.1	26.0
Private pay	4.1	2.1	2.4
Commercial insurance	1.3	0.6	1.1
Other	1.1	—	—
Hospice			
Medicare	93.6 %	— %	— %
Managed care organizations	5.6	—	—
Other	0.8	—	—
Home Health			
Medicare	88.0 %	— %	— %
Managed care organizations	11.0	—	—
Other	1.0	—	—

We derive a significant amount of our net service revenues from our operations in Illinois, New York and New Mexico. The percentages of total revenue for each of these significant states for 2018, 2017 and 2016 were as follows:

	% of Total Revenue for the Years Ended December, 31		
State	2018	2017	2016
Personal Care			
Illinois	47.5 %	52.6 %	53.6 %
New York	13.2	8.8	12.9
New Mexico	12.0	13.7	7.5
All other states	27.3	24.9	26.0
Hospice			
New Mexico	100.0	—	—
Home Health			
New Mexico	100.0	—	—

A significant amount of our net service revenues from our personal care segment are derived from one specific payor client, the Illinois Department on Aging, which accounted for 31.0%, 36.5% and 42.1% of our total net service

revenues for 2018, 2017 and 2016, respectively. The Illinois Department on Aging's payments for non-Medicaid consumers have been delayed in the past and may be delayed in the future in the event of budget disputes. The state of Illinois did not adopt comprehensive budgets for fiscal years 2016 or 2017, ending June 30, 2016 and June 30, 2017, respectively. On July 6, 2017, the state of Illinois passed a budget for state fiscal year 2018, which began on July 1, 2017, authorizing the Illinois Department on Aging to pay for our services rendered to non-Medicaid consumers provided in prior fiscal years. As of December 31, 2018, we have received substantially all such payments. On June 4, 2018, the state of Illinois passed a budget for state fiscal year 2019, which began on July 1, 2018.

In December 2014, the Chicago City Council passed an ordinance that will raise the minimum wage for Chicago workers to $13 per hour by 2019, with increases up to $1 per hour effective on July 1 of each year. The rate is $12 per hour effective July 1, 2018. The wage increase in 2016 did not have a material impact on our financial results because of our existing wage scale. The 2017 wage increase was offset by a reimbursement rate increase. In the budget process for the 2019 fiscal year, a similar provision was proposed but was not included in the final budget. We believe that there is legislative support for a reimbursement rate increase and anticipate that an increase to offset the wage increase could be passed in the first half of 2019. Our financial performance will be impacted in quarters for which a reimbursement rate increase is not in effect.

We also measure the performance of each segment using a number of different metrics. For the personal care segment these include billable hours, billable hours per business day, revenues per billable hour and the number of consumers, or census. For the hospice segment these include admissions, average daily census, average length of stay and revenue per patient day. For the home health segment these include admissions, recertifications, total volume, and number of visits, completed episodes and average revenue per completed episode.

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Competition

Our industry is highly competitive, fragmented and market specific. Each local market has its own competitive profile and no single competitor has significant market share across all of our markets. Our competition consists of personal care service providers, home health providers, private caregivers, larger publicly held companies, privately held companies, privately held single-site agencies, hospital-based agencies, not-for-profit organizations, community-based organizations, managed care organizations and self-directed care programs. In addition, certain governmental payors contract for services with independent providers such that our relationships with these payors are not exclusive. We have experienced, and expect to continue to experience, competition from new entrants into our markets. Increased competition may result in pricing pressures, loss of or failure to gain market share or loss of consumers or payors, any of which could harm our business. In addition, some of our competitors may have greater financial, technical, political and marketing resources, and name recognition with consumers and payors.

Sales and Marketing

We focus on initiating and maintaining working relationships with state and local governmental agencies responsible for the provision of the services we offer. We target these agencies in our current markets and in geographical areas that we have identified as potential markets for expansion. We also seek to identify service needs or changes in the service delivery or reimbursement system of governmental entities and attempt to work with and provide input to the responsible government personnel, provider associations and consumer advocacy groups.

We establish new referral relationships with various managed care organizations that contract with the states for the servicing of the state Medicaid programs. We have met with many contracted managed care organizations in markets where we serve our clients and believe we are building the relationships necessary to ensure continued referrals of new clients.

We receive substantially all of our consumers through third-party referrals, including state departments on aging, rehabilitation, mental health and children’s services, county departments of social services, the Veterans Health Administration and city departments on aging. Generally, family members of potential consumers are made aware of available in-home or alternative living arrangements through a state or local case management system. These systems are operated by governmental or private agencies.

We provide ongoing education and outreach in our target communities in order to inform the community about state and locally-subsidized care options and to communicate our role in providing quality personal care services. We also utilize consumer-directed sales, marketing and advertising programs designed to attract consumers. With respect to our hospice and home health patients, we receive substantially all of our referrals through other health care providers, such as hospitals, physicians, nursing homes and assisted living facilities. We have a team of community liaisons in our hospice and home health operations that educate and develop relationships with other health care providers and the community at large.

Payment for Services

We are reimbursed for substantially all of our services by federal, state and local government programs, such as Medicaid state programs, other state agencies and the Veterans Health Administration. In addition, we are reimbursed by managed care organizations, commercial insurance and private pay consumers. Depending on the type of service, coverage for services may be predicated on a case manager, physician or nurse determination that the care is necessary or on the development of a plan for care in the home. A significant amount of our net service revenues from our

personal care segment are derived from one specific payor client, the Illinois Department on Aging, which accounted for 31.0%, 36.5% and 42.1% of our total net service revenues for 2018, 2017 and 2016, respectively.

Illinois Department on Aging

We provide personal care services pursuant to agreements with the Illinois Department on Aging, which coordinates programs and community-based services intended to improve quality of life and preserve the independence of older individuals. The Illinois Department on Aging is funded by Medicaid and general revenue funds of the state of Illinois, and also receives funding available under the Federal Older Americans Act ("OAA"). The Department on Aging's Community Care Program ("CCP") provides case management, adult day service, emergency home response and homemaker services to individuals age 60 and over. Some of these services are provided through Medicaid waivers granted by CMS. Enrollment in the CCP has grown significantly over the last ten years due to the aging of the population in Illinois.

Consumers are identified by case managers contracted independently with the Illinois Department on Aging. Once a consumer has been evaluated and determined to be eligible for a program, an assigned case manager refers the consumer to a list of authorized providers, from which the consumer selects the provider. We provide our services in accordance with a care plan developed by the case manager and under administrative directives from the Illinois Department on Aging. We are reimbursed on an hourly fee-for-service basis. The state of Illinois's payments for non-Medicaid consumers have been delayed in the past due to budget disputes that began in 2015. The state of Illinois did not adopt a comprehensive budget for fiscal years 2016 or 2017, but did adopt a

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comprehensive budget in 2018 and 2019. On November 6, 2018, Illinois elected a new governor. The new governor is expected to be more aligned with the General Assembly; therefore, the likelihood of a future budget impasse and corresponding delay in payments may be reduced.

Other Federal, State and Local Payors

Medicare

Medicare is a federal program that provides medical services to persons aged 65 or older and other qualified persons with disabilities or end-stage renal disease. Each of our hospice and home care agencies must comply with the extensive conditions of participation in the Medicare program in order to continue receiving Medicare reimbursement.

Medicare beneficiaries who have a terminal illness and a life expectancy of six months or less may elect to receive hospice benefits (i.e., palliative services for management of a terminal illness) in lieu of standard Medicare coverage for treatment. Hospice services are paid under the Medicare Hospice Prospective Payment System ("HPPS"), under which CMS sets a daily rate for each day a patient is enrolled in the hospice benefit. Hospice payment rates increased by 1.8% in federal fiscal year 2019, which reflects a 2.9% market basket update; a negative 0.8% multifactor productivity adjustment; and a negative 0.3% adjustment required by the ACA. Additionally, hospice companies are subject to two specific payment limit caps under the Medicare program each federal fiscal year: the inpatient cap and the aggregate cap. The inpatient cap limits the number of inpatient care days provided to no more than 20% of the total days of hospice care provided to Medicare patients for the year. If a hospice exceeds the number of inpatient care days, the hospice must refund any amounts received for inpatient care that exceed the total of: (i) the product of the total reimbursement paid to the hospice for inpatient care multiplied by the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicare patients; and (ii) the product of the number of actual inpatient days in excess of the limitation multiplied by the limitation by the routine home care rate. The aggregate cap, which is calculated each federal fiscal year, limits the amount of Medicare reimbursement a hospice may receive, based on the number of Medicare patients served. If a hospice's Medicare payments exceed its aggregate cap, it must repay Medicare for the excess amount. In 2019, the aggregate cap is $29,205.

Home health services for homebound patients are paid under the Medicare Home Health Prospective Payment System ("HHPPS"), which is currently based on a 60-day episode of care as a unit of service. The HHPPS permits multiple, continuous episodes per patient. Medicare payment rates for episodes under HHPPS vary based on the severity of the patient's condition as determined by assessment of a patient's Home Health Resource Group score. CMS updates the HHPPS payment rates each calendar year. In 2019, HHPPS rates will increase by 2.2%, which includes a 2.2% home health payment update; a 0.1% increase due to a decrease of the fixed-dollar-loss ratio in order to pay no more than 2.5% of total payments as outlier payments; and a 0.1% reduction due to a new rural add-on policy mandated by the Bipartisan Budget Act of 2018. The Bipartisan Budget Act of 2018 also requires CMS to use a 30-day episode of care and implement the Patient-Driven Groupings Model ("PDGM") beginning in January 1, 2020. The PDGM model will replace the current case-mix system, which uses the number of visits to determine payment, and will classify patients based on clinical characteristics. The PDGM is intended to shift toward a value-based payment system and remove the incentive to overprovide care.

CMS requires both hospice and home health providers to submit quality reporting data each year. Hospice and home health providers that do not comply are subject to a 2% reduction to their market basket update.

Medicaid Programs

Medicaid is a state-administered program that provides certain social and medical services to qualified low-income individuals and is jointly funded by the federal government and individual states. Reimbursement rates and methods vary by state and service type, but are typically based on an hourly or unit-of-service basis. Rates are subject to adjustment based on statutory and regulatory changes, administrative rulings, government funding limitations and interpretations of policy by individual state agencies. Within guidelines established by federal statutes and regulations, and subject to federal oversight, each state establishes its own eligibility standards, determines the type, amount, duration and scope of services, sets the rate of payment for services and administers its own program. States typically cover Medicaid beneficiaries for intermittent home health services as well as continuous services for children and young adults with complicated medical conditions and cover home and community-based services for seniors and people with disabilities.

Many states are moving the administration of their Medicaid and Medicare personal care programs to managed care organizations. This transition is due to an overall desire to better manage the costs of the Medicaid long term care programs. In addition, hospice and home health services are also provided by managed care organizations. Reimbursement from the managed care organizations for personal care services is generally on an hourly, fee-for-service basis with rates consistent with or as a percentage of the individual state funded rates.

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Currently, personal care services and other HCBS are largely reimbursed on a fee-for-service basis. States receive permission from CMS to provide personal care services under waivers of traditional Medicaid requirements. In an effort to control escalating Medicaid costs, states are increasingly requiring Medicaid beneficiaries to enroll in managed care plans for better coordination of HCBS and health care services. A report issued by the Illinois Department on Aging in 2016 indicates that over 60% of the state's Medicaid population is enrolled in a care coordination program, many of which are provided through various managed care entities including managed care organizations. In January 2018, Illinois began transitioning Medicaid beneficiaries to the Health Choice Illinois statewide managed care program, which is serviced by various managed care organizations. The Illinois Department of Healthcare and Family Services expected that managed care would expand through the Health Choice Illinois program to reach approximately 80% of Medicaid enrollees. In March of 2018, the Department of Healthcare and Family Services announced a delay of enrollment for certain Medicaid beneficiaries receiving long term care services. It is unclear at this time when enrollment in HealthChoice Illinois will begin for these beneficiaries.

Veterans Health Administration

The Veterans Health Administration operates the nation's largest integrated healthcare system, with more than 1,900 sites of care, and provides healthcare benefits, including personal care, hospice and home health services, to eligible military veterans. The Veterans Health Administration provides funding to regional and local offices and facilities that support the in-home care needs of eligible aged and disabled veterans. Services are funded by local Veterans Medical Centers and the aid and attendance pension, which reimburses veterans for their otherwise unreimbursed health and long-term care expenses. We currently have relationships and agreements with the Veterans Health Administration to provide personal care services in several states, with the most Veterans Health Administration services being provided to eligible consumers in Illinois, Tennessee and California.

Other

Other sources of funding are available to support personal care, hospice and home health services in different states and localities. In addition, many states appropriate general funds or special use funds through targeted taxes or lotteries to finance personal care services for senior citizens and individuals with disabilities. Depending on the state, these funds may be used to supplement existing Medicaid programs or for distinct programs that serve non-Medicaid eligible consumers.

Commercial Insurance

Most long-term care insurance policies contain benefits for in-home services. Policies are generally subject to dollar limitations on the amount of daily, weekly or monthly coverage provided.

Private Pay

Our private pay services are provided on an hourly or type of services basis. Our rates are established to achieve a pre-determined gross margin, and are competitive with those of other local providers. We bill our private pay consumers for services rendered weekly, bi-monthly or monthly. Other private payors include workers' compensation programs/insurance, preferred provider organizations and employers.

Insurance Programs and Costs

We maintain workers' compensation, general and professional liability, cyber, automobile, directors' and officers' liability, fiduciary liability and excess liability insurance. We offer various health insurance plans to eligible full-time and part-time employees. We believe our insurance coverage and self-insurance reserves are adequate for our current operations. However, we cannot be certain that any potential losses or asserted claims will not exceed such insurance coverage and self-insurance reserves.

Employees

The following is a breakdown of our part- and full-time employees, including the employees in our national support center, as of December 31, 2018:

	Full-time	Part-time	Total
Caregivers	4,597	28,267	32,864
National support centers	278	11	289
	4,875	28,278	33,153

Our caregivers provide substantially all of our services and comprise approximately 95.7% of our total workforce. They undergo a criminal background check and are provided with pre-service training and orientation and an evaluation of their skills. In many cases, caregivers are also required to attend ongoing in-service education. In certain states, our caregivers are required to complete

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certified training programs and maintain a state certification. Approximately 49.0% of our total employees are represented by labor unions. We maintain strong working relationships with these labor unions. We have numerous collective bargaining agreements with the Service Employees International Union ("SEIU"), which are renegotiated from time to time.

Technology

We currently utilize multiple applications to support our various lines of business and locations for patient accounting. For our legacy Addus locations and Ambercare, we utilize the Horizon Homecare software solution ("Horizon"). We recently purchased and implemented HomeCare Homebase to support these lines of business. All locations acquired through our recent purchase of operations of Arcadia Home Care & Staffing ("Arcadia") utilize Continulink for their personal care and staffing business.

Each of these applications support their respective lines of business and locations with administrative, office, clinical and operating information system needs, including assisting with the compliance of our operating systems with the Health Insurance Portability and Accountability Act of 1996, or HIPAA, requirements. Each assists our staff in gathering information to improve the quality of consumer care, optimize financial performance, promote regulatory compliance and enhance staff efficiency. Each application is hosted by the vendor in a secure data center, which provides multiple redundancies for storage, power, bandwidth and security.

In order to comply with current and future state and future federal regulations around EVV use, we utilize several different vendors. In states with an "open" model, we are able to choose our vendor and have standardized Celltrak as our preferred EVV vendor. In states mandating the EVV vendor, a "closed" system, we utilize whichever vendor the state has mandated. In both cases, we have built interfaces between the EVV vendor and the patient accounting system utilized in the respective branch location.

We license the Qlik Business Intelligence platform to provide historical, current, and forward-looking operational performance analysis. We currently have our personal care business managed by Horizon and Continulink integrated into Qlikview to provide a comprehensive view of the business regardless of the application used. Qlik provides high-level historical and current analytical views to measure performance against budget and deliver insight into the various factors driving our execution against our financial, operational, and compliance goals. This analysis is available in summary and detailed views to accommodate user needs from senior management down to the operators in the field.

We also utilize ADP for Talent Management and use their services and products to manage our leave of absence ("LOA") processes, flexible spending account ("FSA") administration, and time and attendance. As of December 31, 2018, we have implemented ADP Vantage for all our acquired businesses. ADP serves as our base Human Resources and Payroll Processing system.

For Financial Management, we utilize Oracle's Planning Budgeting Cloud Service ("PBCS") as our solution for budgeting, forecasting, and financial reporting. Currently we use Sage MAS ERP software but will be converting to Oracle Fusion in the first half of 2019. Oracle Fusion will be our solution for general ledger, accounts payable, and fixed assets.

Government Regulation

Overview

Our business is subject to extensive federal, state and local regulation. Changes in the laws and regulations or new interpretations of existing laws and regulations may have a material impact on the definition of permissible activities, the relative cost of doing business, and the methods and amounts of payment for care by both governmental and other payors. In addition, differences among state laws may impede our ability to expand into certain markets. If we fail to comply with applicable laws and regulations, we could suffer administrative civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal or state programs. In addition, the healthcare industry has experienced, and is expected to continue to experience, extensive and dynamic change. It is difficult to predict the effect of these changes on budgetary allocations for our services. See also “Management’s Discussion and Analysis of Financial Condition and Results of Operations—Overview.”

Medicare and Medicaid Participation

To participate in and qualify for reimbursement under Medicare, our home health agencies and hospices must comply with extensive conditions of participation. Likewise, to participate in Medicaid programs, our personal care services, home health agencies and hospices are subject to various requirements imposed by federal and state authorities. If we were to violate the applicable federal and state regulations governing Medicare or Medicaid participation, we could be excluded from participation in federal and state healthcare programs and be subject to substantial administrative, civil and criminal penalties.

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Health Reform

The U.S. Congress and certain state legislatures have passed many laws and regulations in recent years intended to effect major change within the national healthcare system, the most prominent of which is the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, "ACA"). As currently structured, the ACA affects how healthcare services are delivered and reimbursed through the expansion of public and private health insurance coverage, reduction of growth in Medicare and Medicaid program spending, and the establishment and expansion of programs that tie reimbursement to quality and integration. It includes several provisions that may affect reimbursement for our services. However, the future of the ACA is unclear. The law has been subject to legislative and regulatory changes and court challenges, and the current presidential administration and certain members of Congress have stated their intent to repeal or make additional significant changes to the ACA, its implementation or interpretation. For example, in 2017, the President of the United States signed an executive order that directs agencies to minimize "economic and regulatory burdens" of the ACA. Effective January 1, 2019, Congress eliminated the penalty associated with the individual mandate to maintain health insurance. Because the penalty associated with the individual mandate was eliminated, a federal judge in Texas ruled in December 2018 that the entire ACA was unconstitutional. However, the law remains in place pending appeal. These and other changes and court challenges may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased.

The Affordable Care Act, as enacted, requires states to expand Medicaid coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level. However, states may opt out of the expansion without losing existing federal Medicaid funding. Some of the states use or have applied to use Medicaid waivers granted by CMS to implement expansion provisions, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. CMS administrators have indicated that they intend to increase state flexibility in the administration of Medicaid programs and states continue to explore payment and delivery reform initiatives, including beneficiary work requirements, and quality of care incentives. Enrollment in managed Medicaid plans has also increased in recent years, as state governments seek to control the cost of Medicaid programs. Managed Medicaid programs enable states to contract with one or more entities for patient enrollment, care management and claims adjudication. The states usually do not relinquish program responsibilities for financing, eligibility criteria and core benefit plan design.

The Center for Medicare and Medicaid Innovation, or CMMI, tests innovative payment and service delivery systems to reduce program expenditures while maintaining or enhancing quality. For example, the CMMI has supported testing of new models of care for dual eligibles, funding of home health providers that offer chronic care management services, and establishment of pilot programs that bundle acute care hospital services with physician services and post-acute care services, which may include home health services for certain patients. These systems could have a material impact on our business. It is difficult to predict the nature and success of future financial or delivery system reforms implemented by CMMI and other industry participants.

Permits, Licensure and Certificate of Need

Our hospice, home health and personal care services are authorized and/or licensed under various state and county requirements, which cover a variety of topics including standards regarding the provision of medical or care services, clinical records, personnel, infection control and care plans. Additionally health care professionals at our agencies are required to be individually licensed or certified under state law. Although our personal care service caregivers are generally not subject to licensure requirements, certain states require them to complete pre and post-employment training programs, background checks, and, in certain instances, maintain state certification. We believe we are

currently licensed appropriately as required by the laws of the states in which we operate in all material respects, but additional licensing requirements may be imposed upon us in existing markets or markets that we enter in the future.

Some states also require a provider to obtain a certificate of need or permit of approval ("CON") before establishing, constructing, acquiring or expanding certain health services, operations or facilities or making certain capital expenditures. In order to obtain a CON, a state health planning agency must determine that a need exists for the project, with the intent to avoid unnecessary duplication of services.

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Fraud and Abuse Laws

Anti-Kickback Laws: The federal Anti-Kickback Statute prohibits the offering, payment, solicitation or receipt of any remuneration to induce referrals or orders for items or services covered by federal healthcare programs such as Medicare and Medicaid. Courts have interpreted this statute broadly and held that there is a violation if just one purpose of the remuneration is to generate referrals. Knowledge of the law or intent to violate the law is not required. Violations of the federal Anti-Kickback Statute may be punished by criminal fines, imprisonment, significant civil monetary penalties plus damages of up to three times the total amount of remuneration involved and exclusion from participation in federal healthcare programs. In addition, the submission of a claim for services or items generated in violation of the federal Anti-Kickback Statute may be subject to additional penalties under the federal False Claims Act. Many states have similar laws proscribing kickbacks, some of which apply regardless of the source of payment for items or services.

The Stark Law and other Prohibitions on Physician Self-Referral: The federal law commonly known as the “Stark Law” prohibits physicians from referring to an entity that provides certain “designated health services” covered by the Medicare and Medicaid program, including home health services, if they, or their family members, have a financial relationship with the entity receiving the referral, unless an exception applies. The Stark Law also prohibits entities that provide designated health services reimbursable by Medicare or Medicaid from billing these programs for any items or services that result from a prohibited referral and requires the entities to refund amounts received for items or services provided pursuant to a prohibited referral. Violations of the Stark Law may result in denial of payment, civil monetary penalties and exclusion from federal healthcare programs. Failure to refund amounts received as a result of a prohibited referral on a timely basis may constitute a false or fraudulent claim, which may result in additional penalties imposed under the federal False Claims Act. The statute and regulations also provide for a penalty of over $165,000 for a circumvention scheme. We attempt to structure our relationships, including compensation agreements with physicians who serve as medical directors in our home health agencies, to meet an exception to the Stark Law, but we cannot provide assurance that every relationship is fully compliant. Many states have also enacted statutes similar in scope and purpose to the Stark Law, although these laws may apply to all payors or a greater range of services.

The False Claims Act: Numerous state and federal laws govern the submission of claims for reimbursement and prohibit false claims or statements. Under the federal False Claims Act, for example, the government may fine any person, company or corporation that knowingly presents or causes to be presented claims for payment to the federal government that are false or fraudulent, or which contain false or misleading information. “Knowingly” is defined broadly, and includes submission of a claim with reckless disregard to its truth or falsity. The federal False Claims Act can be used to prosecute fraud involving issues such as coding errors and billing for services not provided. Violations of other statutes, such as the federal Anti-Kickback Statute, can also serve as a basis for liability under the federal False Claims Act. Among other potential bases for liability is the knowing and improper failure to report and return overpayments received from Medicare or Medicaid in a timely manner following identification of the overpayment. An overpayment is deemed to be “identified” when a person has, or should have through reasonable diligence, determined that an overpayment was received and quantified the overpayment.

A provider determined to be liable under the False Claims Act may be required to pay three times the amount of actual damages sustained by the federal government, in addition to mandatory civil monetary penalties that may amount to over $20,000 for each false or fraudulent claim. These penalties will be updated annually based on changes to the consumer price index. Private parties may initiate whistleblower lawsuits alleging the defrauding of the federal government by a provider and may receive a share of any settlement or judgment. When a private individual brings an action under the federal False Claims Act, the defendant generally is not made aware of the lawsuit under the federal

government commences its own investigation or determines whether it will intervene.

Every entity that receives at least $5.0 million in Medicaid payments annually must have written policies regarding certain federal and state laws for all employees, contractors and agents. These policies must provide detailed information about false claims, false statements and whistleblower protections.

Many states have similar false claims statutes that impose additional liability for the types of acts prohibited by the False Claims Act.

Other Fraud and Abuse Provisions: Criminal and civil penalties may be imposed under various other federal and state statutes that prohibit various forms of fraud and abuse, such as anti-kickback laws, prohibitions on self-referral, fee-splitting restrictions, insurance fraud laws, and false claims acts, which may extend to services reimbursable by any payer, including private insurers. For example, criminal penalties may be imposed upon any person or entity that knowingly and willfully defrauds a health care benefit plan, willfully obstructing a criminal investigation of a healthcare offense or makes a materially false statement in connection with delivery of or payment for health care services by a health care benefit plan. Further, the federal Civil Monetary Penalties Law (“CMPL”) imposes substantial penalties for offering remuneration or other inducements to influence federal healthcare beneficiaries’ decisions to seek specific governmentally reimbursable items or services or to choose particular providers. It also imposes penalties for contracting with an individual or entity known to be excluded from a federal healthcare program. The CMPL requires a lower burden of proof than some other fraud and abuse laws, including the federal Anti-Kickback Statute. Civil monetary penalties are

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updated annually based on changes to the consumer price index. In addition to the financial penalties, federal enforcement officials are able to exclude from Medicare or Medicaid any individuals or entities convicted of Medicare or Medicaid fraud or other offenses related to the delivery of items or services under those programs. Persons who have been excluded from the Medicare or Medicaid program may not retain ownership in a participating entity. Participating entities that permit continued ownership by excluded individuals, that contract with excluded individuals, and the excluded individuals themselves, may be penalized.

Payment Integrity

We are subject to routine and periodic surveys and audits by various governmental agencies and other payors. From time to time, we receive and respond to survey reports containing statements of deficiencies. Periodic and random audits conducted or directed by these agencies could result in a delay in receipt or an adjustment to the amount of reimbursements due or received under federal or state programs.

Under the Recovery Audit Contractor ("RAC") program, CMS contracts with third parties to identify improper Medicare payments. RACs are paid a contingent fee based on the improper payments identified and corrected. CMS has also instituted Zone Program Integrity Contracts for additional audit of Medicare providers, including home health agencies. By statute, states are required to enter into contracts with RACs to audit payments to Medicaid providers although states are allowed to request waivers of aspects of this requirement. Further, under the Medicaid Integrity Program, CMS employs private contractors, referred to as Medicaid Integrity Contractors, to perform post-payment audits of Medicaid claims and identify overpayments. CMS is transitioning some of its other integrity programs to a consolidated model by engaging Unified Program Integrity Contractors ("UPICs") to perform audits, investigations and other integrity activities.

From time to time, various federal and state agencies, such as the U.S. Department of Health and Human Services ("HHS"), issue pronouncements that identify practices that may be subject to heightened scrutiny, as well as practices that may violate fraud and abuse laws. For example, the Office of the Inspector General issued an Investigative Advisory in 2012 that identified a number of program integrity vulnerabilities in the delivery of personal care services and recommending corrective actions by CMS. In December 2016, CMS issued a bulletin highlighting safeguards that state Medicaid agencies can put in place around personal care services. It has also issued guidance to personal care services agencies and attendants on avoiding improper payments. We believe, but cannot assure you, that our operations comply with the principles expressed by HHS in these reports, advisories and guidance.

HIPAA and Other Privacy and Security Requirements

The HIPAA Administrative Simplification provisions and implementing regulations require the use of uniform electronic data transmission standards and code sets for certain healthcare claims and reimbursement payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the U.S. healthcare industry.

HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and its implementing regulations extensively regulate the use, disclosure, confidentiality, availability and integrity of individually identifiable health information, known as "protected health information," and provide for a number of individual rights with respect to such information. These requirements apply to most healthcare providers, which are known as "covered entities," including our company. Vendors, known as "business associates," that handle protected health information, on behalf of covered entities must also comply with most HIPAA requirements. A covered entity may be subject to penalties as a result of a business associate violating HIPAA, if the business associate is found to be

an agent of the covered entity.

Covered entities must, among other things, maintain privacy and security policies, train workforce members, maintain physical, administrative, and technical safeguards, enter into confidentiality agreements with business associates, and permit individuals to access and amend their protected health information. In addition, covered entities must report breaches of unsecured (unencrypted) protected health information to affected individuals without unreasonable delay, but not to exceed 60 calendar days from the discovery date of the breach. Notification must also be made to HHS and, in certain cases involving large breaches, to the media.

HIPAA violations may result in criminal penalties and significant civil penalties. Our company is also subject to other applicable federal or state laws that are more restrictive than HIPAA, which could result in additional penalties. For example, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions against entities whose inadequate data security programs may expose consumers to fraud, identity theft and privacy intrusions. Various state laws and regulations require entities that maintain individually identifiable information (even if not health-related) to report data breaches to affected individuals and, in some cases, state regulators. We expect compliance with HIPAA and other privacy and security standards to continue to impose significant costs on our business lines.

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Environmental, Health and Safety Laws

We are subject to federal, state and local regulations governing the storage, transport, use and disposal of hazardous materials and waste products. In the event of an accident involving such hazardous materials, we could be held liable for any damages that result, and any liability could exceed the limits or fall outside the coverage of our insurance. We may not be able to maintain insurance on acceptable terms, or at all.

Access to Public Filings

Through our website, www.addus.com, we make available, free of charge, our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and all amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. In addition to our website, the SEC maintains an internet site that contains our reports, proxy and information statements, and other information that we file electronically with the SEC at www.sec.gov.

ITEM 1A. RISK FACTORS

Any of the risks described below, and the risks described elsewhere in this Form 10-K, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows, cause the trading price of our common stock to decline and cause the actual outcome of matters to differ materially from our current expectations as reflected in forward-looking statements made in this Form 10-K. The risk factors described below and elsewhere in this Form 10-K are not the only risks we face. Our business and consolidated financial condition, results of operations and cash flows may also be materially adversely affected by factors that are not currently known to us, by factors that we currently consider immaterial or by factors that are not specific to us, such as general economic conditions.

You should refer to the explanation of the qualifications and limitations on forward-looking statements under "Special Caution Concerning Forward-Looking Statements." All forward-looking statements made by us are qualified by the risk factors described below.

Risks Related to Our Business and Industry

We could face a variety of risks by expanding into new lines of business.

In 2018, we expanded our lines of business to include hospice and home health with the acquisition of Ambercare and we acquired facility staffing operations as part of our Arcadia transaction. Risks of our entry into the hospice and home health segments and adding facility staffing operations to our home care segment include, without limitation, difficulties integrating new businesses with our ongoing operations, potential diversion of management's time and other resources from our existing personal care business, the need for additional capital and other resources to expand into these new lines of business, and inefficient integration of operational and management systems and controls. In addition, new businesses that we acquire may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare and other laws and regulations, professional liabilities, workers' compensation liabilities, and tax liabilities. Although we generally attempt to exclude significant liabilities from our acquisitions in the case of acquisitions structured as asset sales and seek indemnification from sellers or insurance protection, we may nevertheless have material liabilities for past activities of acquired businesses. Entry into a new line of business may also subject us to new laws and regulations with which we are not familiar and may lead to increased litigation and regulatory risk.

Our hospice operations are subject to annual Medicare caps. If we exceed the caps, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Overall payments made by Medicare to each hospice provider number (generally corresponding to each of our hospice agencies) are subject to an overall payment cap amount, which is calculated and published by the Medicare fiscal intermediary on an annual basis for each federal fiscal year. If payments received under any of our hospice provider numbers exceed these caps, we may be required to reimburse Medicare such excess amounts, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Reductions in reimbursement and other changes to Medicare, Medicaid, and other federal, state and local medical and social programs could adversely affect our consumer caseload, units of service, net service revenues, gross profit and profitability.

A significant portion of our caseload and net service revenues are derived from government healthcare programs, primarily Medicare and Medicaid. For the year ended December 31, 2018, we derived approximately 59.9% of our net service revenues from state and local governmental agencies, primarily through Medicaid. However, changes in government healthcare programs may decrease the reimbursement we receive or limit access to, or utilization of, our services. As federal healthcare expenditures continue to increase and state governments face budgetary shortfalls, federal and state governments have made, and may continue to make,

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significant changes to the Medicare and Medicaid programs and reimbursement received for services rendered to beneficiaries of such programs. For example, the Budget Control Act of 2011 requires automatic spending reductions to reduce the federal deficit, including Medicare spending reductions of up to 2% per fiscal year, with a uniform percentage reduction across all Medicare programs. CMS began imposing a 2% reduction on Medicare claims in April 2013, and these reductions have been extended through 2027.

The Medicaid program, which is jointly funded by the federal and state governments, is often a state's largest program. Governmental agencies generally condition their agreements upon a sufficient budgetary appropriation. Almost all of the states in which we operate have experienced periodic financial pressures and budgetary shortfalls due to challenging economic conditions and the rising costs of healthcare. Reductions to federal support for state Medicaid or other programs could also result in budgetary shortfalls. As a result, many states have made, are considering or may consider making changes in their Medicaid or other state and local medical and social programs, including enacting legislation designed to reduce Medicaid expenditures.

Changes that may occur at the federal or state level to address budget deficits or otherwise contain costs include:

- limiting increases in, or decreasing, reimbursement rates;
- redefining eligibility standards or coverage criteria for social and medical programs or the receipt of services under those programs;
- increasing consumer responsibility, including through increased co-payment requirements;
- decreasing benefits, such as limiting the number of hours of personal care services that will be covered;
- changing reimbursement methodology and program participation eligibility;
- slowing payments to providers;
- increasing utilization of self-directed care alternatives or "all inclusive" programs;
- shifting beneficiaries to managed care organizations; and
- implementing demonstration projects and alternative payment models.

Certain of these measures have been implemented by, or are proposed in, states in which we operate. In 2018, we derived approximately 47.5% of our total net service revenues from services provided in Illinois, 13.2% of our total net service revenues in New York and 12.0% of our total net service revenues in New Mexico. Because a substantial portion of our business is concentrated in these states, any significant reduction in expenditures that pay for our services or other significant changes in these states may have a disproportionately negative impact on our future operating results. Illinois, in particular, operated without a state budget for fiscal years 2016 and 2017. The Illinois legislature has enacted comprehensive state budgets for fiscal years 2018 and 2019. However, there is no certainty that Illinois will pass budgets in subsequent years.

The ACA made significant changes to Medicare and Medicaid policy and funding, among other broad changes across the healthcare industry, promoting a shift toward value-based care, including implementation of alternative payment models. The ACA also resulted in expanded Medicaid eligibility in many states and the establishment of various demonstration projects and Medicaid programs under which states may apply to test new or existing approaches to payment and delivery of Medicaid benefits. CMS has indicated that it will look to states to drive innovation and value through such waivers and has taken steps to update program management, the waiver and state plan amendment approval process, and quality reporting, but the extent and effect of these changes remains uncertain. Future health reform efforts or efforts to repeal or significantly change the ACA will likely impact both federal and state programs.

If changes in Medicare, Medicaid or other state and local medical and social programs result in a reduction in available funds for the services we offer or a reduction in the number of beneficiaries eligible for our services or a

reduction in the number of hours or amount of services that beneficiaries eligible for our services may receive, then our net service revenues and profitability could be negatively impacted. Our profitability depends principally on the levels of government-mandated payment rates and our ability to manage the cost of providing services. In some cases, commercial insurance companies and other private payors rely on government payment systems to determine payment rates. As a result, changes to government healthcare programs that reduce Medicare, Medicaid or other payments may negatively impact payments from private payors, as well. Any reduction in reimbursements or imposition of copayments that dissuade the use of our services, or any reduction in reimbursement from private payors, could also materially adversely affect our profitability.

Federal and state regulation may impair our ability to consummate acquisitions or open new agencies.

Federal laws or regulations may adversely impact our ability to acquire home health agencies or open new start-up home health agencies. For example, a Medicare regulation known as the “36 Month Rule” prohibits buyers of home health agencies from assuming the Medicare billing privileges of the acquired agency if the acquired agency either enrolled in Medicare or underwent a change in

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majority ownership fewer than 36 months prior to the acquisition, subject to certain exceptions. Instead, the buyer must enroll the acquired home health agencies as new providers with Medicare. The 36 Month Rule can increase competition for acquisition targets that are not subject to the rule and may cause significant Medicare billing delays for the purchases of home health agencies that are subject to the rule. Further, CMS has implemented a moratorium on enrolling new home health agencies in Texas, Michigan, Florida and Illinois. On July 29, 2018, CMS extended the moratorium for an additional 6 months. If a moratorium is imposed on enrollment of new providers in a geographic area we desire to service, our ability to expand operations may be impacted.

Our ability to expand operations in a state will depend on our ability to obtain a state license to operate, and where required, CON approval. States may limit the number of licenses they issue. The failure to obtain any required CON or license could impair our ability to operate or expand our business.

The implementation of alternative payment models and the transition of Medicaid and Medicare beneficiaries to managed care organizations may limit our market share and could adversely affect our revenues.

Many government and commercial payors are transitioning providers to alternative payment models that are designed to promote cost-efficiency, quality and coordination of care. For example, accountable care organizations (“ACOs”) incentivize hospitals, physician groups, and other providers to organize and coordinate patient care while reducing unnecessary costs. Several states have implemented, or plan to implement, accountable care models for their Medicaid populations. If we are not included in these programs, or if ACOs establish programs that overlap with our services, we are at risk for losing market share and for a loss of our current business.

We may be similarly impacted by increased enrollment of Medicare and Medicaid beneficiaries in managed care plans, shifting away from traditional fee-for-service models. Under the managed Medicare program, also known as Medicare Advantage, the federal government contracts with private health insurers to provide Medicare benefits. Insurers may choose to offer supplemental benefits and impose higher plan costs on beneficiaries. Approximately one third of Medicare beneficiaries were enrolled in a Medicare Advantage plan in 2018, a figure that continues to grow. While hospice services are currently reimbursed as a traditional fee-for-service program under Medicare Part A, hospice services may eventually be offered under Medicare Advantage plans, which could result in reduced reimbursement, limited utilization, and increased competition for managed care contracts.

Enrollment in managed Medicaid plans is also growing, as states are increasingly relying on managed care organizations to deliver Medicaid program services as a strategy to control costs and manage resources. We may experience increased competition for managed care contracts due to state regulation and limitations. For instance, effective October 2018, New York limits the number of home care providers with which a managed Medicaid plan can contract. We cannot assure you that we will be successful in our efforts to be included in plan networks, that we will be able to secure favorable contracts with all or some of the managed care organizations, that our reimbursement under these programs will remain at current levels, that the authorizations for services will remain at current levels or that our profitability will remain at levels consistent with past performance. In addition, operational processes may not be well defined as a state transitions beneficiaries to managed care. For example, membership, new referrals and the related authorization for services to be provided may be delayed, which may result in delays in service delivery to consumers or in payment for services rendered. Difficulties with operational processes may negatively affect our revenue growth rates, cash flow and profitability for services provided.

Other alternative payment models may be presented by the government and commercial payors to control costs that subject our Company to financial risk. We cannot predict at this time what effect alternative payment models may have on our Company.

Our revenues are concentrated in a small number of states which will make us particularly sensitive to regulatory and economic changes in those states.

Our revenues are particularly sensitive to regulatory and economic changes in states in which we generate a significant portion of our revenues including Illinois, New York and New Mexico. Accordingly, any change in the current demographic, economic, competitive or regulatory conditions in these states could have an adverse effect on our business, financial condition or results of operations. Changes to the Medicaid programs in these states could also have a disproportionately adverse effect on our business, financial condition, results of operations or cash flows.

Efforts to reduce the costs of the Illinois Department on Aging programs could adversely affect our service revenues and profitability.

For the years ended December 31, 2018 and 2017, we derived approximately 31.0% and 36.5%, respectively, of our revenue from the Illinois Department on Aging programs. Previous state government officials have attempted to reduce government spending by proposing changes aimed at reducing expenditures by this department. On November 6, 2018, Illinois elected a new governor. The new Democratic governor is expected to be more aligned with the General Assembly. It is expected that initiatives to reduce costs in Illinois, such as shifting services to managed care organizations and implementing a CCP Medicaid Initiative to enroll eligible

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individuals in Medicaid will continue. The nature and extent of any future cost reduction initiatives is unknown. If future reforms impact the eligibility of consumers for services, the number of hours authorized or otherwise restrict services provided to existing consumers, our service revenues and growth may be adversely affected.

Delays in reimbursement due to state budget deficits may increase in the future, adversely affecting our liquidity.

There is a delay between the time that we provide services and the time that we receive reimbursement or payment for these services. Many of the states in which we operate are operating with budget deficits for their current fiscal year. These and other states may in the future delay reimbursement, which would adversely affect our liquidity. In addition, from time to time, procedural issues require us to resubmit claims before payment is remitted, which contributes to our aged receivables. Additionally, unanticipated delays in receiving reimbursement from state programs due to changes in their policies or billing or audit procedures may adversely impact our liquidity and working capital. We fund operations primarily through the collection of accounts receivable.

Failure to renew a significant agreement or group of related agreements may materially impact our revenue.

In 2018, we derived approximately 31.0% of our net service revenues under agreements with the Illinois Department on Aging. Each of our agreements is generally in effect for a specific term.

Even though our agreements are for a specific term, they are generally terminable with 60 days' notice. Our ability to renew or retain our agreements depends on our quality of service and reputation, as well as other factors over which we have little or no control, such as state appropriations and changes in provider eligibility requirements. Additionally, failure to satisfy any of the numerous technical renewal requirements in connection with our proposals for agreements could result in a proposal being rejected even if it contains favorable pricing terms. Failure to obtain, renew or retain agreements with major payors may negatively impact our results of operations and revenue. We can give no assurance these agreements will be renewed on commercially reasonable terms or at all.

Our industry is highly competitive, fragmented and market-specific.

We compete with personal care service providers, hospice providers, home health providers, private caregivers, larger publicly held companies, privately held companies, privately held single-site agencies, hospital-based agencies, not-for-profit organizations, community-based organizations and self-directed care programs. Some of our competitors may have greater financial, technical, political and marketing resources, name recognition or a larger number of consumers and payors than we do. In addition, some of these organizations offer more services than we do in the markets in which we operate. These competitive advantages may limit our ability to attract and retain referrals in local markets and to increase our overall market share.

In many states, there are limited barriers to entry in providing personal care services. However, some states require entities to obtain a license before providing home care services. Licensure is generally required of agencies providing home health and hospice services, though requirements vary by state. Economic changes such as increases in minimum wage and changes in Department of Labor rules can also impact the ease of entry into a market. These factors may affect competition in our states.

Often our contracts with payors are not exclusive. Local competitors may develop strategic relationships with referral sources and payors. This could result in pricing pressures, loss of or failure to gain market share or loss of consumers or payors, any of which could harm our business. In addition, existing competitors may offer new or enhanced services that we do not provide, or be viewed by consumers as a more desirable local alternative. The introduction of

new and enhanced service offerings, in combination with the development of strategic relationships by our competitors, could cause a decline in revenue, a loss of market acceptance of our services and a negative impact on our results of operations.

If we fail to comply with the laws and extensive regulations governing our business, we could be subject to penalties or be required to make changes to our operations, which could negatively impact our profitability.

The federal government and the states in which we operate regulate our industry extensively. The laws and regulations governing our operations, along with the terms of participation in various government programs, impose certain requirements on the way in which we do business, the services we offer, and our interactions with providers and consumers. These requirements include matters related to:

- licensure and certification and enrollment with government programs;
- eligibility for services;
- appropriateness and necessity of services provided;
- adequacy and quality of services;
- qualifications and training of personnel;

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- confidentiality, maintenance, data breach, identity theft and security issues associated with health-related and personal information and medical records;
- environmental protection, health and safety;
- relationships with physicians, other referral sources and recipients of referrals;
- operating policies and procedures;
- addition of facilities and services;
- adequacy and manner of documentation for services provided;
- billing and coding for services;
- timely and proper handling of overpayments; and
- debt collection and communications with consumers.

These laws include, but are not limited to the federal Anti-Kickback Statute, the federal Stark law, the federal False Claims Act, the federal Civil Monetary Penalties Law, other federal and state fraud and abuse, insurance fraud, and fee-splitting laws, which may extend to services reimbursable by any payer, including private insurers; and federal and state laws governing the security and privacy of health information.

We currently have contractual relationships with current and potential referral sources and recipients, including hospitals and health systems, skilled nursing facilities and certain physicians who provide medical director services to our Company. Federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts throughout the healthcare industry. While we endeavor to comply with applicable laws and regulations, we cannot assure you that our practices are fully compliant or that courts or regulatory agencies will not interpret those laws and regulations in ways that will adversely affect our practices. The laws and regulations governing our business are subject to change, interpretations may evolve and enforcement focus may shift. These changes could subject us to allegations of impropriety or illegality, require restructuring of relationships with referral sources and recipients or otherwise require changes to our operations. Failure to comply with applicable laws and regulations could lead to civil sanctions and criminal penalties, the termination of rights to participate in federal and state healthcare programs, exclusion from federal healthcare programs, the suspension or revocation of licenses and nonpayment or delays in our ability to bill and collect for services provided, any of which could adversely affect our business, results of operations, or financial results.

In addition, as a result of our participation in Medicaid, Medicare and Veterans Health Administration programs and other state and local governmental programs, and pursuant to certain of our contractual relationships, we are subject to various reviews, compliance audits and investigations by governmental authorities and other third parties to verify our compliance with these programs and agreements as well as applicable laws, regulations and conditions of participation. Each of our home care and hospice agencies must comply with the extensive conditions of participation in the Medicare program. If any of our agencies fail to meet any of the conditions of participation or coverage with respect to state licensure or our participation in Medicaid, Medicare programs, Veterans Health Administration programs and other state and local governmental programs, we may receive a notice of deficiency from the applicable surveyor or authority. Failure to institute a plan of action to correct the deficiency within the period provided by the surveyor or authority could result in civil or criminal penalties, damage to our reputation, cancellation of our agreements, suspension or revocation of our licenses, requirements to repay amounts received, disqualification from federal and state healthcare programs and other negative consequences. These actions may adversely affect our ability to provide certain services, to receive payments from other payors and to continue to operate. Additionally, failure to comply with the conditions of participation related to enrollment could result in a deactivation or revocation of billing privileges. To the extent that billing privileges are revoked, there is a mandated one to three-year bar to re-enrollment. Similarly, we could face liability under the False Claims Act if we submit claims to Medicare or Medicaid while not in compliance with certain conditions of participation. Further, actions taken against one of our offices may subject our other offices to adverse consequences. We may also fail to discover all instances of noncompliance by our

acquisition targets, which could subject us to adverse remedies once those acquisitions are complete. Any termination of one or more of our offices from any federal, state or local program for failure to satisfy such program's conditions of participation could adversely affect our net service revenues and profitability.

Delays in reimbursement may cause liquidity problems.

There are delays in reimbursement from the time we provide services to the time we receive reimbursement or payment for these services. Delays may result from changes by payors to data submission requirements or requests by fiscal intermediaries for additional data or documentation, among other issues. If we have information system problems or issues that arise with Medicare or Medicaid, we may encounter delays in our payment cycle. Such timing delays may cause working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in our results of operations and liquidity. System problems, Medicare or Medicaid issues or industry trends may extend our collection period, adversely impact our working capital. Our working capital management procedures may not successfully negate this risk. There are often timing delays when

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attempting to collect funds from Medicaid programs. Delays in receiving reimbursement or payments from these programs may adversely impact our working capital.

We are and have been subject to routine and periodic surveys, audits and investigations by various governmental agencies. In addition to surveys to determine compliance with the conditions of participation, CMS has engaged a number of contractors (including Medicare Administrative Contractors, Recovery Audit Contractors, Zone Program Integrity Contractors, Unified Program Integrity Contractors and Medicaid Integrity Contractors) to conduct audits to evaluate billing practices and identify overpayments. These audits can result in recoupments by Medicare and other payors of amounts previously paid to us. In addition to audits by CMS contractors, individual states are implementing similar integrity programs using Medicaid Recovery Audit Contractors. We are unable to predict what additional government regulations, if any, affecting our business may be enacted in the future, how existing or future laws and regulations might be interpreted or whether we will be able to comply with such laws and regulations either in the markets in which we presently conduct, or wish to commence, business. In June 2016, CMS announced its plans to implement a three-year “Pre-Claim Review Demonstration of Home Health Services” in certain states, including Illinois. The demonstration, which involved clinical documentation requirements, sought to improve identification, investigation, and prosecution of Medicare fraud among home health agencies and to reduce expenditures while maintaining or improving quality of care. The demonstration began in Illinois in August 2016, but CMS paused it in April 2017. We are currently unable to predict what impact, if any, this program may have on our result of operations or financial position when and if resumed.

We are subject to federal, state and local laws and regulations that govern our employment practices, including minimum wage, living wage, and paid time-off requirements. Failure to comply with these laws and regulations, or changes to these laws and regulations that increase our employment-related expenses, could adversely impact our operations.

We are required to comply with all applicable federal, state and local laws and regulations relating to employment, including occupational safety and health requirements, wage and hour and other compensation requirements, employee benefits, providing leave and sick pay, employment insurance, proper classification of workers as employees or independent contractors, immigration and equal employment opportunity laws. These laws and regulations can vary significantly among jurisdictions and can be highly technical. Costs and expenses related to these requirements are a significant operating expense and may increase as a result of, among other things, changes in federal, state or local laws or regulations, or the interpretation thereof, requiring employers to provide specified benefits or rights to employees, increases in the minimum wage and local living wage ordinances, increases in the level of existing benefits or the lengthening of periods for which unemployment benefits are available. We may not be able to offset any increased costs and expenses. Furthermore, any failure to comply with these laws requirements, including even a seemingly minor infraction, can result in significant penalties which could harm our reputation and have a material adverse effect on our business.

Since our operations are concentrated in Illinois, New York and New Mexico, we are particularly sensitive to changes in laws and regulations in these states. For example, in December 2014, the Chicago City Council passed an ordinance that will raise the minimum wage for Chicago workers to $13 per hour by 2019, with increases up to $1 per hour effective on July 1 of each year. The rate is $12 per hour effective July 1, 2018. The wage increase in 2016 did not have a material impact on us because of our existing wage scale. The 2017 wage increase was offset by a reimbursement rate increase. In the budget process for the 2019 fiscal year, a similar provision was proposed but was not included in the final budget. We believe that there is legislative support for a reimbursement rate increase and anticipate that an increase to offset the wage increase could be passed in the first half of 2019. Our financial performance will be impacted in quarters for which a reimbursement rate increase is not in effect.

In addition, certain individuals and entities, known as excluded persons, are prohibited from receiving payment for their services rendered to Medicaid, Medicare and other federal and state healthcare program beneficiaries. If we inadvertently hire or contract with an excluded person, or if any of our current employees or contractors becomes an excluded person in the future without our knowledge, we may be subject to substantial civil penalties, including up to $20,000 for each item or service furnished by the excluded individual to a federal or state healthcare program beneficiary, an assessment of up to three times the amount claimed and exclusion from the program.

Each of our subsidiaries that employ an average of at least 50 full-time employees in a calendar year are required to offer a minimum level of health coverage for 95% of our full-time employees in 2018 or be subject to an annual penalty.

Our business may be adversely impacted by healthcare reform efforts, including repeal of or significant modifications to the ACA.

In recent years, the U.S. Congress and certain state legislatures have considered and passed a large number of laws intended to result in significant change to the healthcare industry. However, there is significant uncertainty regarding the future of the ACA, the most prominent of these reform efforts. The law has been subject to legislative and regulatory changes and court challenges, and the current presidential administration and certain members of Congress have stated their intent to repeal or make additional significant changes to, the ACA, its implementation or its interpretation. In 2017, the Tax Cuts and Jobs Acts was enacted, which, among other things, removes penalties for not complying with ACA's individual mandate to carry health insurance. Because the individual mandate

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was eliminated, a federal court in Texas ruled in December 2018 that the entire ACA was unconstitutional. However, the law remains in place pending appeal. In addition, the president has signed an executive order that directs agencies to minimize "economic and regulatory burdens" of the ACA. Effective January 1, 2019, Congress eliminated the penalty associated with the individual mandate to maintain health insurance. Because the penalty associated with the individual mandate was eliminated, a federal judge in Texas ruled in December 2018 that the entire ACA was unconstitutional. However, the law remains in place pending appeal. These changes and court challenges may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased. The presidential administration and the U.S. Congress may take further action regarding the ACA, including, but not limited to, repeal or replacement. Additionally, all or a portion of the ACA and related subsequent legislation may be modified, repealed or otherwise invalidated through further legislation or judicial challenge, which could result in lower numbers of insured individuals, and reduced coverage for insured individuals. Further legislation or regulation could be passed that could harm our business, financial condition and results of operations. For example, the Budget Control Act of 2011 included aggregate reductions to Medicare payments to providers of 2% per fiscal year, which went into effect beginning in 2013 and have been extended through 2027. The American Taxpayer Relief Act of 2012 further reduced Medicare payments to several types of providers, including hospitals, imaging centers and cancer treatment centers, and increased the statute of limitations period for the government to recover non-fraudulent overpayments to providers from three to five years.

There is uncertainty regarding whether, when, and how the ACA will be further changed, what alternative provisions, if any, will be enacted, and the impact of alternative provisions on providers and other healthcare industry participants. Government efforts to repeal or change the ACA or to implement alternative reform measures could cause our net revenues to decrease. Some members of Congress have proposed expanding government-funded coverage, including single payor proposals. Furthermore, we are unable to predict the nature and success of future financial or delivery system reforms that may be implemented by other, non-governmental industry participants.

The industry trend toward value-based purchasing may negatively impact our revenues.

The trend in the healthcare industry toward value-based purchasing of healthcare services is growing among both government and commercial payors. Value-based purchasing programs emphasize quality of outcome and efficiency of care provided, rather than quantity of care provided. For example, Medicare requires hospices and home health agencies to report certain quality data in order to receive full reimbursement. Failure to report quality data or poor performance may negatively impact the amount of reimbursement received. CMS currently has a value-based purchasing program affecting home health providers in a number of pilot states, whereby providers receive payment bonuses or penalties based on their achievement of specified performance measures. CMS may expand this program and establish new programs affecting a broader range of providers. In addition, CMS publishes hospice quality measure data online to allow consumers and others to search and compare data for Medicare-certified hospice providers.

Other initiatives aimed at improving quality and cost of care include alternative payment models, including ACOs and bundled payment arrangements. It is unclear whether alternative models will successfully coordinate care and reduce costs or whether they will decrease overall reimbursement. Additionally, commercial payors have expressed intent to shift toward value-based reimbursement arrangements.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. While we believe we are adapting our business strategies to compete in a value-based reimbursement environment, we are unable at this time to predict how this trend will affect our results of operations. If we perform at a level below the outcomes

demonstrated by our competitors, are unable to meet or exceed quality performance standards under any applicable value-based purchasing program, or otherwise fail to effectively provide or coordinate the efficient delivery of quality healthcare services, our reputation in the industry may be negatively impacted, we may receive reduced reimbursement amounts and we may owe repayments to payors, causing our revenues to decline.

Negative publicity or changes in public perception of our services may adversely affect our ability to receive referrals, obtain new agreements and renew existing agreements.

Our success in receiving referrals, obtaining new agreements and renewing our existing agreements depends upon maintaining our reputation as a quality service provider among governmental authorities, physicians, hospitals, discharge planning departments, case managers, nursing homes, rehabilitation centers, advocacy groups, consumers and their families, other referral sources and the public. While we believe that the services that we provide are of high quality, if our quality measures, which are published online by CMS, are deemed to be not of the highest value, our reputation could be negatively affected. Negative publicity, changes in public perceptions of our services or government investigations of our operations could damage our reputation and hinder our ability to receive referrals, retain agreements or obtain new agreements. Increased government scrutiny may also contribute to an increase in compliance costs and could discourage consumers from using our services. Any of these events could have a negative effect on our business, financial condition and operating results.

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Our growth strategy depends on our ability to manage growing and changing operations and we may not be successful in managing this growth.

Our business plan calls for significant growth in business over the next several years through the expansion of our services in existing markets and the establishment of a presence in new markets. This growth would place significant demands on our management team, systems, internal controls and financial and professional resources. In addition, we will need to further develop our financial controls and reporting systems to accommodate any such future growth. This could require us to incur expenses for hiring additional qualified personnel, retaining professionals to assist in developing the appropriate control systems and expanding our information technology infrastructure. Our inability to effectively manage growth could have a material adverse effect on our financial results.

Future acquisitions or growth initiatives may be unsuccessful and could expose us to unforeseen liabilities.

Our growth strategy includes geographical expansion into new markets and the addition of new services in existing markets through the acquisition of local service providers. These acquisitions involve significant risks and uncertainties, including difficulties assimilating acquired personnel and other corporate cultures into our business, the potential loss of key employees or consumers of acquired providers, and the assumption of liabilities and exposure to unforeseen liabilities of acquired providers. In the past, we have made acquisitions that have not performed as expected or that we have been unable to successfully integrate with our existing operations. In addition, our due diligence review of acquired businesses may not successfully identify all potential issues. The failure to effectively integrate future acquisitions could have an adverse impact on our operations.

We have grown our business through de novo offices and we may in the future selectively open new offices in existing and new states. De novo offices involve risks, including those relating to accreditation, hiring new personnel, establishing relationships with referral sources and delays or difficulty in installing our operating and information systems. We may not be successful in establishing de novo offices in a timely manner due to generating insufficient business activity and incurring higher than projected operating cost that could have a material adverse effect on our financial condition, results of operations and cash flows.

We may be unable to pursue acquisitions or expand into new geographic regions without obtaining additional capital or consent from our lenders.

At December 31, 2018 and December 31, 2017, we had cash balances of $70.4 million and $53.8 million, respectively. As of December 31, 2018 and 2017, we had $20.0 million and $44.4 million outstanding debt on our credit facility, respectively. After giving effect to the amount drawn on our credit facility, approximately $10.8 million and $11.8 million of outstanding letters of credit at December 31, 2018 and 2017 and borrowing limits based on an advanced multiple of adjusted EBITDA, we had $142.9 million and $105.1 million available for borrowing under our credit facility as of December 31, 2018 and 2017, respectively. Since our credit facility provides for borrowings based on a multiple of an EBITDA ratio, any declines in our EBITDA would result in a decrease in our available borrowings under our credit facility.

We cannot predict the timing, size and success of our acquisition efforts, our efforts to expand into new geographic regions or the associated capital commitments. If we do not have sufficient cash resources or availability under our credit facility, our growth could be limited unless we obtain additional equity or debt financing. In the future, we may elect to issue additional equity securities in conjunction with raising capital, completing an acquisition or expanding into a new geographic region. Such issuances could be dilutive to existing shareholders. In addition, our ability under our credit facility to consummate acquisitions is restricted if we exceed certain Total Net Leverage Ratio (as defined

in the New Credit Agreement (as defined below)) thresholds, without the consent of the lenders. Further, our credit facility requires, among other things, that we are in pro forma compliance with the financial covenants set forth therein and that no event of default exists before and after giving effect to any proposed acquisition. Our ability to expand in a manner consistent with historic practices may be limited if we are unable to obtain such consent from our lenders.

As a result of the indemnification provisions of the Home Health Purchase Agreement pursuant to which we sold Home Health Business, we may incur expenses and liabilities related to periods up to the date of sale or pursuant to our other indemnification obligations thereunder.

As a result of the indemnification provisions of the Home Health Purchase Agreement pursuant to which we sold the Home Health Business, we have agreed to indemnify the Purchasers for, among other things, (i) penalties, fines, judgments and settlement amounts arising from a violation of certain specified statutes, including the False Claims Act, the Civil Monetary Penalties Law, the federal Anti-Kickback Statute, the Stark Law or any state law equivalent in connection with the operation of the Home Health Business prior to the Closing, and (ii) any liability related to the failure of any reimbursement claim submitted to certain government programs for services rendered by the Home Health Business prior to the Closing to meet the requirements of such government programs, or any violation prior to the Closing of any healthcare laws. Such liabilities include amounts to be recouped by, or repaid to, such government programs as a result of improperly submitted claims for reimbursement or those discovered as a result of audits by investigative agencies. All services that we have provided that have been or may be reimbursed by Medicare are subject to retroactive

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adjustments and/or total denial of payments received from Medicare under various review and audit provisions included in the program regulations. The review period is generally described as six years from the date the services are provided but could be expanded to ten years under certain circumstances if fraud is found to have existed at the time of original billing. In the event that there are adjustments relating to the period prior to the Closing, we may be required to reimburse the Purchasers for the amount of such adjustments, which could adversely affect our business and financial condition.

In addition, pursuant to the Home Health Purchase Agreement, we are obligated to indemnify the Purchasers for breaches of representations, warranties and covenants, certain taxes and liabilities related to the pre-Closing period (other than specifically identified assumed liabilities). Any liability we have to the Purchasers under the Home Health Purchase Agreement could adversely affect our results of operations.

Our business may be harmed by labor relations matters.

We are subject to a risk of work stoppages and other labor relations matters because our hourly workforce is highly unionized. As of December 31, 2018, approximately 49.0% of our workforce was represented by the SEIU. We have numerous agreements with local SEIU affiliates which are renegotiated from time to time. These negotiations are often initiated when we receive increases in our hourly rates from various state agencies. Upon expiration of these collective bargaining agreements, we may not be able to negotiate labor agreements on satisfactory terms with these labor unions. A strike, work stoppage or other slowdown could result in a disruption of our operations and/or higher ongoing labor costs, which could adversely affect our business. Labor costs are the most significant component of our total expenditures and, therefore, an increase in the cost of labor could significantly harm our business.

Our operations subject us to risk of litigation.

Operating in the personal care services industry exposes us to an inherent risk of wrongful death, personal injury, professional malpractice and other potential claims or litigation brought by our consumers and employees. From time to time, we are subject to claims alleging that we did not properly treat or care for a consumer that we failed to follow internal or external procedures that resulted in death or harm to a consumer or that our employees mistreated our consumers, resulting in death or harm. We are also subject to claims arising out of accidents involving vehicle collisions brought by consumers whom we are transporting, from employees driving to or from home visits or other affected individuals.

In addition, regulatory agencies may initiate administrative proceedings alleging violations of statutes and regulations arising from our services and seek to impose monetary penalties on us. We could be required to pay substantial amounts to respond to regulatory investigations or, if we do not prevail, damages or penalties arising from these legal proceedings. We also are subject to potential lawsuits under the federal False Claims Act or other federal and state whistleblower statutes designed to combat fraud and abuse in our industry including the federal False Claims Act litigation discussed in Part I, Item 3 hereof “Legal Proceedings.” This and other similar lawsuits can involve significant monetary awards or penalties which may not be covered by our insurance. If our third-party insurance coverage and self-insurance coverage reserves are not adequate to cover these claims, it could have a material adverse effect on our business, results of operations and financial condition. Even if we are successful in our defense, civil lawsuits or regulatory proceedings could distract us from running our business or irreparably damage our reputation.

Our insurance liability coverage may not be sufficient for our business needs.

Although we maintain insurance consistent with industry practice, the insurance we maintain may not be sufficient to satisfy all claims made against us. We cannot assure you that claims will not be made in the future in excess of the limits of our insurance, and any such claims, if successful and in excess of such limits, may have a material adverse effect on our business or assets. We utilize historical data to estimate our reserves for our insurance programs. If losses on asserted claims exceed the current insurance coverage and accrued reserves, our business, results of operations and financial condition could be adversely affected. Changes in our annual insurance costs and self-insured retention limits depend in large part on the insurance market, and insurance coverage may not continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms.

Inclement weather or natural disasters may impact our ability to provide services.

Inclement weather or natural disasters may prevent our employees from providing authorized services. We are not paid for authorized services that are not delivered due to these weather events. Furthermore, prolonged inclement weather or the occurrence of natural disasters in the markets in which we operate could disrupt our relationships with consumers, employees and referral sources located in affected areas and, in the case of our corporate office, our ability to provide administrative support services, including billing and collection services. For example, one of our support centers and a number of our agencies are located in the Midwestern United States, New York and California, increasing our exposure to blizzards and other major snowstorms, ice storms, tornadoes, flooding, wildfires and earthquakes. The impact of disasters and similar events is inherently uncertain. Future inclement weather or natural disasters may adversely affect our reputation, business and consolidated financial condition, results of operations and cash flows.

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Our business depends on our information systems. Our operations may be disrupted if we are unable to effectively integrate, manage and maintain the security of our information systems.

Our business depends on effective and secure information systems that assist us in, among other things, gathering information to improve the quality of consumer care, optimizing financial performance, adjusting consumer mix, monitoring regulatory compliance and enhancing staff efficiency. We rely on an external service provider, McKesson Information Solutions, LLC ("McKesson"), to provide continual maintenance, upgrading, and enhancement of our primary information systems used for our operational needs. The software we license from McKesson supports intake, personnel scheduling, office clinical and centralized billing and receivables management in an integrated database, enabling us to standardize the care delivered across our network of offices and monitor our performance and consumer outcomes. In addition, we also utilize Horizon to support our personal care business for branches acquired through our acquisition of AmberCare in the second quarter of 2018. These locations also provide Home Health and Hospice services. We recently purchased and implemented HomeCare Homebase to support these lines of business. All locations acquired through our recent purchase of Arcadia utilize Continulink for their home care and staffing business. To the extent providers fail to support the software or systems, or if we lose our licenses, our operations could be negatively be affected. Our business also depends on a comprehensive payroll and human resources system for basic payroll functions and reporting, payroll tax reporting, managing wage assignments and garnishments. We rely on an external service provider, ADP, to provide continual maintenance, upgrading and enhancement of our primary human resource and payroll systems. To the extent that ADP fails to support the software or systems, or any of the related support services provided by them, our internal operations could be negatively affected.

Our business also supports the use of EVV to collect visit submission information through our delivery of home care services. Our solution uses a combination of IVR and GPS enabled smartphones to capture time in and time out, mileage and travel time, as well as the completed care plan tasks. We license this software through CellTrak along with partnering with states who utilize Authenticare, SanData, and HealthStar. We rely on these providers to provide continual maintenance, enhancements, as well as security of any protected data. To the extent that our EVV vendors fail to support these processes, our internal operations could be negatively affected.

Under the 21st Century Cures Act, as amended, states have until January 1, 2020 to establish standards for EVV for Medicaid-funded personal care services. States that fail to meet this deadline will lose an escalating amount of their funding. To the extent that the states fail to properly implement EVV, our internal operations could be negatively affected.

If we experience a reduction in the performance, reliability, or availability of our information systems, our operations and ability to process transactions and produce timely and accurate reports could be adversely affected. If we experience difficulties with the transition and integration of information systems or are unable to implement, maintain, or expand our systems properly, we could suffer from, among other things, operational disruptions, regulatory problems, and increases in administrative expenses.

We have full backup of our key information systems. Should our main datacenter become inoperable because of a natural disaster or terrorist acts, our operations would failover to our geographically separate disaster recovery datacenter with a quick return to operations for all sites and systems. All of our sites and branch offices have redundant connections to our primary and backup datacenters using data lines and cellular connections through VPN or MPLS.

The key business functions for our main sites also have redundancies with key functions geographically split between our two main facilities, should one not be available due to the above mentioned scenarios.

While we believe these measures are reasonable, no system of information security is able to eliminate the risk of business disruptions.

A cyber-attack or security breach could cause a loss of confidential consumer data, give rise to remediation and other expenses, expose us to liability under HIPAA, consumer protection laws, common law and other legal theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

We rely extensively on our computer systems to manage clinical and financial data, to communicate with our consumers, payors, vendors and other third parties, and to summarize and analyze our operating results. In spite of our policies, procedures and other security measures used to protect our computer systems and data, occasionally, we have experienced breaches that have required us to notify affected consumers and the government, and we have worked with consumers and the government to resolve such issues. While these past breaches have not had a significant adverse impact on our business or results of operations, there can be no assurance that we will not be subject to additional and/or more severe cyber-attacks or security breaches in the future. Such attacks or breaches could result in loss of protected patient medical data or other information subject to privacy laws or disrupt our information technology systems or business, potentially exposing us to regulatory action, litigation and liability. We continue to prioritize cyber-security and the development of practices and controls to protect our systems and data. We utilize sophisticated firewalls to mitigate external threats and attacks through daily security content updates and intrusion prevention policies. In addition, all email is scanned for threats and viruses as well as Domain Keys Identified Mail keys authentication and Sender Policy Framework records are utilized

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to mitigate spoofing and phishing attempts. Outgoing email is encrypted based on content and HIPAA regulations. In addition, we are required to comply with the privacy and security laws and regulations of HIPAA as amended by HITECH. If our privacy and security practices are not in compliance with HIPAA and/or if we fail to satisfy applicable breach notification requirements in the event of a security breach, we could be subject to significant fines, penalties, lawsuits and reputational harm.

Our current principal stockholders could have significant influence over us, and they could delay, deter or prevent a change of control or other business combination or otherwise cause us to take action with which you might not agree.

Eos Capital Partners III, L.P. and its affiliates (the "Eos Funds"), together beneficially own approximately 20.7% of our outstanding common stock as of December 31, 2018. As a result, the Eos Funds have the ability to significantly influence all matters submitted to our stockholders for approval, including:

- changes to the composition of our board of directors, which has the authority to direct our business and appoint and remove our officers;
- proposed mergers, consolidations or other business combinations; and
- amendments to our certificate of incorporation and bylaws which govern the rights attached to our shares of common stock.

In addition, Mark First, one of our directors is affiliated with the Eos Funds.

This concentration of ownership of shares of our common stock could delay or prevent proxy contests, mergers, tender offers, open-market purchase programs or other purchases of shares of our common stock that might otherwise give you the opportunity to realize a premium over the then-prevailing market price of our common stock. The interests of the Eos Funds may not always coincide with the interests of the other holders of our common stock. This concentration of ownership may also adversely affect our stock price.

We may not be able to attract and retain qualified personnel or we may incur increased costs in doing so.

We must attract and retain qualified non-executive personnel in the markets in which we operate in order to provide our services. We compete for personnel with other providers of social and medical services as well as companies in other service-based industries. This competition has increased significantly as the unemployment rate has decreased in recent years. Increased competition for trained personnel or general inflationary pressures may require that we enhance our pay and benefits packages to compete effectively for such personnel. We may not be able to offset such added costs by increasing the rates we charge for our services. An increase in personnel costs could negatively impact our business. In addition, if we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations effectively would be harmed.

Competition may be greater for managers, such as regional and agency directors. Our ability to attract and retain personnel depends on several factors, including our ability to provide employees with attractive assignments and competitive benefits and salaries. The loss of one or more of the members of the executive management team or the inability of a new management team to successfully execute our strategies may adversely affect our business. If we are unable to attract and retain qualified personnel, we may be unable to provide our services, the quality of our services may decline, and we could lose consumers and referral sources.

We may be more vulnerable to the effects of a public health catastrophe than other businesses due to the nature of our consumers.

The majority of our consumers are older individuals with complex medical challenges, many of whom may be more vulnerable than the general public during a pandemic or in a public health catastrophe. Our employees are also at greater risk of contracting contagious diseases due to their increased exposure to vulnerable consumers. For example, if a flu pandemic were to occur, we could suffer significant losses to our consumer population or a reduction in the availability of our employees and, at a high cost, be required to hire replacements for affected workers. Accordingly, certain public health catastrophes could have a material adverse effect on our financial condition and results of operations.

We depend on the services of our executive team members.

Our success depends upon the continued employment of certain members of our executive team to manage several of our key functional areas, including operations, business development, accounting, finance, human resources, marketing, information systems, contracting and compliance. In 2016 and 2017, we changed a majority of the members of senior management, beginning with our CEO. The departure of any member of our executive team may materially adversely affect our operations.

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If we were required to write down all or part of our goodwill and/or our intangible assets, our net earnings and net worth could be materially adversely affected.

Goodwill and intangible assets with finite lives represent a significant portion of our assets. Goodwill represents the excess of cost over the fair market value of net assets acquired in business combinations. For example, if our market capitalization drops significantly below the amount of net equity recorded on our balance sheet, it might indicate a decline in our fair value and would require us to further evaluate whether our goodwill has been impaired. If as part of our annual review of goodwill and intangibles, we were required to write down all or a significant part of our goodwill and/or intangible assets, our net earnings and net worth could be materially adversely affected, which could affect our flexibility to obtain additional financing. In addition, if our assumptions used in preparing our valuations for purposes of impairment testing differ materially from actual future results, we may record impairment charges in the future and our financial results may be materially adversely affected. We had $135.4 million and $90.3 million of goodwill and $23.8 million and $16.6 million of intangible assets recorded on our Consolidated Balance Sheets at December 31, 2018 and 2017, respectively.

It is not possible at this time to determine if there will be any future impairment charge, or if there is, whether such charges would be material. We will continue to review our goodwill and other intangible assets for possible impairment. We cannot be certain that a downturn in our business or changes in market conditions will not result in an impairment of goodwill or other intangible assets and the recognition of resulting expenses in future periods, which could adversely affect our results of operations for those periods.

Ineffective internal control over financial reporting could adversely impact our business and stock price.

Section 404 of the Sarbanes-Oxley Act of 2002, or the Sarbanes-Oxley Act, requires our management to report on, and requires our independent registered public accounting firm to attest to, the effectiveness of our internal controls over financial reporting. Compliance with SEC regulations adopted pursuant to Section 404 of the Sarbanes Oxley Act requires annual management assessments of the effectiveness of our internal control over financial reporting. Compliance with Section 404(b) of the Sarbanes-Oxley Act has increased our legal and financial compliance costs making some activities more difficult, time-consuming or costly and may also place strain on our personnel, systems and resources.

Accordingly, we are required to have an audit of our internal controls over financial reporting. As described under Item 9A. “Controls and Procedures” below, our management has determined that a material weakness in internal controls existed as of December 31, 2018. The assessment was based on the framework in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

To the extent that we now or in the future have deficiencies in our internal controls over financial reporting that are not remediated, our ability to accurately and timely report our financial position, results of operations, cash flows or key operating metrics could be impaired, which could result in a material misstatement in our financial statements, late filings of our annual and quarterly reports under the Exchange Act, restatements of our consolidated financial statements or other corrective disclosures, or other material adverse effects on our business, reputation, results of operations, financial condition or liquidity and could create a perception that our financial results do not fairly state our financial condition or results of operations, any of which could have an adverse effect on the value of our stock.

Compliance with changing regulations including specific program compliance, corporate governance and public disclosure will result in additional expenses and pose challenges for our management team.

The state agencies that contract for our services require our compliance with various rules and regulations affecting the services we provide. We have a compliance officer who monitors and reports on our efforts for achieving the desired results. State agencies are recommending increased rules and regulations in an effort to control the growth of these programs and their overall costs. The implementation of these changes may require us to increase our efforts to remain compliant, may reduce the authorizations for services to be provided, and may result in certain consumers no longer being eligible for our services all of which may result in lower revenues and increased costs, reducing our operating performance and profitability. If we continue to serve our consumers without addressing these increased regulations we are at risk for non-compliance with program requirements and potential penalties.

Changing laws, regulations and standards relating to corporate governance and public disclosure, including the Dodd-Frank Wall Street Reform and Consumer Protection Act and the rules and regulations promulgated thereunder, the Sarbanes-Oxley Act and SEC regulations, have created uncertainty for public companies and significantly increased the costs and risks associated with accessing the U.S. public markets. We are committed to maintaining high standards of internal controls over financial reporting, corporate governance and public disclosure. As a result, we intend to continue to invest appropriate resources to comply with evolving standards, and this investment has resulted and will likely continue to result in increased general and administrative expenses and a diversion of management time and attention from revenue-generating activities to compliance activities.

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Restrictive covenants in the agreements governing our indebtedness may adversely affect us.

Our credit facility contains various covenants that limit our ability to take certain actions, including our ability to:

- make, create, incur, assume or suffer to exist any lien;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- merge, consolidate, sell or otherwise dispose of all or substantially all our assets;
- make restricted payments, including paying dividends and making certain loans and investments;
- create, incur, assume, permit to exist, or otherwise become or remain directly or indirectly liable with respect to any additional indebtedness;
- enter into transactions with affiliates;
- engage in any line of additional line of business;
- amend our organization documents;
- make a change in accounting treatment or reporting practices, change our name or change our jurisdiction of organization or formation;
- make any payment or prepayment of certain subordinated indebtedness;
- enter into agreements that restrict dividends and certain other payments from subsidiaries;
- engage in a sale leaseback or similar transaction; and
- make certain capital expenditures.

In addition, our credit facility contains restrictive covenants and requires us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet these restrictive covenants and financial ratios and tests may be affected by events beyond our control, and we cannot assure you that we will meet those tests.

A breach of any of these covenants could result in a default under our credit facility. Upon the occurrence of an event of default under our credit facility, all amounts outstanding under our credit facility may become immediately due and payable and all commitments under our credit facility to extend further credit may be terminated. The acceleration of any such indebtedness will result in an event of default under all of our other long-term indebtedness.

Risks Related to Our Common Stock

The market price of our common stock may be volatile and this may adversely affect our stockholders.

The price at which our common stock trades may be volatile. The stock market has recently experienced significant price and volume fluctuations that have affected the market prices of all securities, including securities of healthcare companies. The market price of our common stock may be influenced by many factors, including:

- our operating and financial performance;
- variances in our quarterly financial results compared to expectations;
- the depth and liquidity of the market for our common stock;
- we have a relatively small base of registered shares of common stock that could result in significant stock price movements upward or downward based on low levels of trading volume in our common stock;
- future sales of common stock or debt or the perception that sales could occur;
- investor perception of our business and our prospects;
- developments relating to the occurrence of risks impacting our company, including any of the risk factors set forth herein; or
- general economic and stock market conditions.

In addition, the stock market in general has experienced price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of homecare companies. These broad market and industry factors may materially reduce the market price of our common stock, regardless of our operating performance. In the past, securities class-action litigat