Addus HomeCare Corp
Form ARS
May 19, 2015
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ADDUS HOMECARE CORPORATION

2014 ANNUAL REPORT

NASDAQ:ADUS

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COMPARISON OF 5-YEAR CUMULATIVE TOTAL RETURN

The following graph compares the performance of our common stock with performance of two market indexes and three peer group indexes. In past years, our market index has been the Center for Research in Security Prices (CRISP) Index for NASDAQ Stock Market (U.S. Companies) (NASDAQ Composite) and one of two peer group indexes has been the CRISP Index for NASDAQ Health Services Stocks (NASDAQ Health Services). As a result of a change in the total return data made available to us through NASDAQ, our performance graphs going forward will use comparable indexes provided by NASDAQ OMX Global Indexes. The market index will be the NASDAQ U.S. Stocks Benchmark index (NASDAQ U.S. Stocks Benchmark), and the peer group index will be the NASDAQ Health Care Providers index (NASDAQ Health Care Providers). In past years, we have also included as the second peer group index a customized peer group index (the Peer Group) of four companies, which include: Almost Family, Inc., Amedisys, Inc., Gentiva Health Services, Inc. and LHC Group, Inc. We do not plan to include this index after this year because the acquisition of one of the companies in February 2015 reduces the comparability of the index. The following graph covers the period from December 31, 2009 through the end of fiscal 2014. The graph assumes that $100 was invested at the closing price on December 31, 2009 in our common stock, the market indexes and the peer group indexes, and that all dividends were reinvested.

	12/31/09	12/31/10	12/31/11	12/31/12	12/31/13	12/31/14
Addus HomeCare	**100.0**	**44.6**	**38.8**	**77.7**	**244.0**	**263.8**
NASDAQ U.S. Stocks Benchmark	**100.0**	**117.5**	**117.9**	**137.3**	**183.3**	**206.1**
NASDAQ Composite	**100.0**	**118.0**	**117.0**	**137.5**	**192.6**	**221.0**
NASDAQ Health Care Providers	**100.0**	**110.5**	**121.5**	**137.5**	**189.8**	**245.2**
NASDAQ Health Services	**100.0**	**120.4**	**113.5**	**136.4**	**176.5**	**212.7**
Peer Group	**100.0**	**84.1**	**28.5**	**38.4**	**48.9**	**73.0**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2014

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.)**

2300 Warrenville Road

Downers Grove, IL 60515

(Address of principal executive offices)

630-296-3400

(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(b) of the Act:

None

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes x No ¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of 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. x

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ¨	Accelerated filer x
Non-accelerated filer ¨ (Do not check if a smaller reporting company)	Smaller reporting company ¨

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

The aggregate market value of 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, 2014 (the last business day of the registrant s most recently completed second fiscal quarter) was $246,868,346.

As of March 1, 2015, there were 11,009,879 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Certain portions of the registrant s Definitive Proxy Statement for its 2015 Annual Meeting of Stockholders (which is expected to be filed with the Commission within 120 days after the end of the registrant s 2014 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, projects, estimate might, would, should and similar expressions are intended to identify forward-looking statements as defined by the Private Securities Litigation Reform Act of 1995. 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 the following: changes in operational and reimbursement processes at the state level, changes in Medicaid, Medicare and other medical payment levels, changes in or our failure to comply with existing federal and state laws or regulations or the inability to comply with new government regulations on a timely basis, competition in the home and community based service industry, 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 home and community based services to consumers, changes in estimates and judgments associated with critical accounting policies, our ability to maintain or establish new referral sources, our ability to attract and retain qualified personnel, changes in payments and covered services due to the overall economic conditions and deficit spending by federal and state governments, future cost containment initiatives undertaken by third party payors, our access to financing due to the volatility and disruption of 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, authorized hours and eligibility standards of state governmental agencies, the potential to settle litigation, and the effect of those changes on our results of operations in 2014 or for periods thereafter, our ability to successfully implement our coordinated care model to grow our business, our ability to attract referrals, our ability to continue identifying and pursuing acquisition opportunities and expand into new geographic markets, the impact of acquisitions on our business, the effectiveness, quality and cost of our services 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 a Holdings refers to Addus HomeCare Corporation. When we refer to 2014, 2013 and 2012, 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, 2014 as filed with the SEC, including all exhibits, is available on our internet website at http://www.addus.com on the Investor Relations 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

We are a provider of comprehensive home and community based services, which are provided primarily in the home, and focused on the dual eligible (Medicare/Medicaid) population. Our services include personal care and assistance with activities of daily living, and adult day care. Our consumers are primarily persons who are at risk of hospitalization or institutionalization, such as the elderly, chronically ill and disabled. Our payor clients include federal, state and local governmental agencies, managed care organizations, commercial insurers and private individuals. We currently provide home and community based services to over 31,000 consumers through 129 locations across 22 states, including 5 adult day centers in Illinois. Over the course of 2014, we served over 43,000 consumers.

A summary of our financial results for 2014, 2013 and 2012 is provided in the table below:

	2014	2013	2012
		(Amounts in Thousands)	
Net service revenues continuing operations	$ 312,942	$ 265,941	$ 244,315
Net service revenues discontinued operations		6,462	38,822
Net income from continuing operations	11,963	11,163	9,288
Earnings (loss) from discontinued operations	280	7,982	(1,653)
Net income	$ 12,243	$ 19,145	$ 7,635
Total assets	$ 180,803	$ 163,934	$ 149,857

Historically our services were provided under agreements with state and local government agencies established to meet the needs of our consumers. Our consumers are predominately dual eligible and as such are eligible to receive both Medicare and Medicaid funded home-based care. As a result of certain legislation enacted by the federal government, states are being incentivized to initiate dual eligible demonstration programs and other managed Medicaid initiatives, which are designed to coordinate the services provided through these two programs, with the overall objective to better coordinate service delivery and over the long term to reduce costs. Increasingly states are implementing these managed care programs and as such are transitioning management of individuals such as our consumers to local and national managed care organizations. Under these arrangements the managed care organizations have an economic incentive to provide home and community based services to consumers as a means to better manage the acute care expenditures of their membership.

The home and community based services we provide include assistance with bathing, grooming, dressing, personal hygiene and medication reminders, and other activities of daily living. We provide these services on a long-term, continuous basis, with an average duration of approximately 20 months per consumer. Our adult day centers provide a comprehensive program of skilled and support services and designated medical services for adults in a community-based group setting. Services provided by our adult day centers include social activities, transportation services to and from the centers, the provision of meals and snacks, personal care and therapeutic activities such as exercise and cognitive interaction.

We utilize a coordinated care model that is designed to improve consumer outcomes and satisfaction as well as lower the cost of acute care treatment and reduce service duplication. We believe this coordinated care model to be especially valuable to managed care organizations that have economic responsibility for both home and community services as well as acute care expenditures. Over the long term, we believe this model will be a differentiator and as a result we expect to receive increased referrals from the managed care organizations.

Through our coordinated care model, we utilize our home care aides to observe and report changes in the condition of our consumers for the purpose of early intervention in the disease process, thereby preventing or

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reducing the cost of medical services by avoiding emergency room visits, and/or reducing the need for hospitalization. We will coordinate the services provided by our team with those of selected health care agencies as appropriate. Changes in consumers condition are evaluated by appropriately trained managers and referred to either appropriate medical personnel including the consumers primary care physicians or managed care organizations for treatment and follow-up. We believe this approach to the provision of care to our consumers and the integration of our services into the broader healthcare continuum are attractive to managed care organizations and others who are ultimately responsible for the healthcare needs and costs of our consumers and over time will increase our business with them.

We are investing in technology based solutions to support and facilitate our coordinated care model. We utilize an Integrated Voice Response, IVR system and smart phones applications to communicate with the homecare aides. Through these applications we are able to identify changes in health conditions with automated alerts forwarded to appropriate management team for triaging and evaluation. In addition, the technology is used to record basic transaction information about each visit including: start and end times to a scheduled shift, mileage reimbursement, text messages to the homecare aide and communication of basic payroll information. Our plans for this technology include development of a web portal to provide the ability to communicate this basic information about individual clients to the managed care organizations.

We are growing through selective acquisitions, based on an overall strategy to expand our presence in current markets and to expand our footprint in markets where the home and community business is moving to managed care organizations. We completed two acquisitions in December 2013 and June 2014 that expanded our presence in two existing markets and provided us with a base of operations in two new targeted managed care states. Effective January 1, 2015, we acquired Priority Home Health Care, Inc., a company headquartered in Cleveland, Ohio that operates six offices in the Cleveland, Akron and Columbus areas. We anticipate these transactions to be accretive to earnings in 2015.

Effective March 1, 2013, we sold substantially all of the assets used in our home health business (the Home Health Business) in Arkansas, Nevada and South Carolina, and 90% of the Home Health Business in California and Illinois, to subsidiaries of LHC Group, Inc. (the Purchasers) for a cash purchase price of approximately $20,000,000. We retained a 10% ownership interest in the Home Health Business in California and Illinois. The assets sold included 19 home health agencies and two hospice agencies in five states. On December 30, 2013, we sold one home health agency in Pennsylvania for approximately $200,000. The results of the Home Health Business sold and one additional agency in Idaho which was closed in November 2012, are reflected as discontinued operations for all periods presented herein. Continuing operations include the results of operations previously included in our home & community segment and three agencies previously included in our home health segment. Following the sale of the Home Health Business, we manage and internally report our business in one segment. Because regulatory requirements in Delaware and Indiana require home and community based services to be provided by a licensed home health agency, we will continue to provide limited home health services reimbursable by Medicare in these agencies in order to maintain these licenses. In addition, Priority Home Health Care maintains enrollment in but does not derive significant revenues from Medicare.

We believe the sale of the Home Health Business substantially positioned us for future growth. The sale allowed us to focus both management and financial resources to address changes in the home and community based services industry and to address the needs of managed care organizations as they become more responsible for the state sponsored programs. We have improved our financial performance by concentrating our efforts on our home and community business that is growing and profitable. We have improved our overall financial position by eliminating our debt and adding to our cash reserves.

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. Our principal executive offices are located at 2300 Warrenville Road, Downers Grove, Illinois 60615. Our telephone number is 630-296-3400. Our internet address is www.addus.com. Through our

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website, 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 as soon as reasonably practicable after we electronically file such material with, or furnish such information to the SEC.

Our Market and Opportunity

We provide home and community based services to the elderly and other adult infirm who need long-term care and assistance with activities of daily living. A report by CMS, in consultation with Truven Health Analytics, from April 28, 2014, estimated total Medicaid expenditures for home and community based services in 2012 (the most recent year in their data set) to be almost $70 billion, representing an annual compound rate of growth of 8.2% over the period from 2007-2012. The report also notes that spending on home and community based services constituted about 50% of total spending in 2012 by Medicaid on the group of programs Medicaid refers to as long-term services and supports (with the remaining 50% being spent on institutional programs, i.e. nursing homes and mental health facilities), up from 18% in 1995 (the earliest year in the data set).

In addition to the projected growth of government-sponsored home and community based services, the private duty market for our services is growing rapidly. We provide our private duty consumers with all of the services we provide to our government-sponsored home and community based consumers.

Historically, there were limited barriers to entry in the home and community based services industry. As a result, the home and community based 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. According to the National Association for Home Care & Hospice, or NAHC, as of 2013, there were over 33,000 homecare and hospice agencies in the United States. Approximately 15,000 were Medicare-certified homecare and hospice agencies, while the remaining 18,000 represent the number of licensed home and community based services agencies in the United States providing services similar to those we provide. In addition, while difficult to estimate, there are many non-licensed, non-certified home and community based services agencies.

More recently, the home and community based services industry has been subject to increased regulation. 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. Any failure to comply with this growing and changing regulatory regime could lead to the termination of rights to participate in federal and state-sponsored programs and the suspension or revocation of licenses. We believe limitations on the availability of new licenses, the increasing focus on improving health outcomes, the rising cost and complexity of operations and pressure on reimbursement rates due to constrained government resources may create barriers for new providers and may encourage industry consolidation.

The Federal Coordinated Health Care Office was established to effectively integrate benefits for consumers who are enrolled in both Medicare and Medicaid, also known as dual eligibles, and improve coordination between the federal and state governments to ensure that dual eligibles have full access to items and services to which they are entitled. Stated goals of the Federal Coordinated Health Care Office are to ensure that the dual eligible population has full access to seamless high quality health care and to make the system as cost-effective as possible. The Federal Coordinated Health Care Office works with the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and other federal and state agencies, as well as physicians and others, to provide technical assistance and educational tools to improve care coordination between Medicare and Medicaid and to reduce costs, improve beneficiary experience and educate dual eligibles regarding care coverage. It also performs policy and program analysis and develops policy and program recommendations regarding dual eligibles.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, both laws are referred to herein as the Health Reform Act), encourages states to integrate

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the state managed Medicaid home and community based programs with managed Medicare programs. The objective of these initiatives is to enhance the coordination of benefits between the two programs and to lower overall costs. The integrated programs are being structured as three year pilots. Nationally, 18 states are currently pursuing financial or administrative alignment for dual eligible beneficiaries, including 6 of the 22 states in which we provide services.

We believe that our coordinated care program and our commitment to our technology platform make us well-suited to partner with managed care organizations to address the needs of the dual eligible population. These programs will eliminate service duplication between home and community based programs and traditional Medicare home health. We believe our ability to identify changes in our consumers health and condition before the medical need requires acute intervention will lower the overall cost of care and will be recognized as an added benefit of our services. We believe this approach to the provision of care to our consumers and the integration of our services into the broader healthcare continuum is 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 good care, maintain our existing payor client 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 or community-based settings. Finally, we believe the provision of home and community based services is more cost-effective than the provision of similar services in an institutional setting for long-term care. The following are the key elements of our growth strategy:

Consistently provide high-quality care. We schedule our home care aides to perform their services at times mutually determined by our consumers. The home care aides are required to perform tasks as defined within the individual plan of care. We manage the performance of our home care aides through regular visits while in our consumer homes.

Drive growth in existing markets. We are growing in our existing markets overall by enhancing the breadth of our services, increasing the number of referral sources and leveraging and expanding our payor relationships in each market. We are achieving this growth by continuing to educate referral sources about the benefits of our services.

Market the benefits of our coordinated care model to managed care organizations serving the dual eligible populations. Our coordinated care model provides significant opportunities to effectively market to a wide range of payor clients and referral sources, many of whom are responsible for consumers with both social and medical service needs. We are seeking to partner with managed care organizations to address the needs of the dual eligible population in light of governmental incentives for consumers to enroll in managed care plans. We believe that our approach to the provision of care to our consumers and the integration of our services into the broader healthcare industry is particularly attractive to managed care organizations and others who are ultimately responsible for the healthcare needs of our consumers and over time we believe this approach will increase our business.

***Grow through acquisitions*.** We continue to grow with selective acquisitions. Our strategy is to expand within our existing markets and to enter markets where states are transitioning the management of home and community services to managed care organizations.

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Expand into new markets. We offer our services in geographic markets contiguous to our existing markets through de novo agency development. We also anticipate we will have opportunities to develop new agencies in response to requests from managed care organizations.

Our Services

We deliver services to our consumers through 129 individual agencies located in 22 states and 5 adult day centers in Illinois. Our home and community based services assist consumers, who would otherwise be at risk of placement in a long-term care institution, with activities of daily living.

Services are primarily provided to older adults and younger disabled persons in consumers homes on an as-needed, hourly basis. These services, generally provided by home and community based service aides, include non-medical care such as personal care, home support services and adult day care.

Personal care and home support services are provided to consumers who are unable to independently perform some or all of their activities of daily living. Our services are needed when assistance from family or community members is insufficient or where caregivers respite is needed. Personal care services include bathing, grooming, oral care, skincare, assistance with feeding and dressing and medication reminders. Home support services include 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. The average duration of our provision of home and community based services is approximately 20 months per consumer.

We also operate five adult day centers in Illinois which provide a comprehensive program of skilled and support services and designated health services for adults in a community-based group setting. Services provided by our adult day centers include social activities, transportation services to and from the centers, the provision of meals and snacks, personal care and therapeutic activities such as exercise and cognitive interaction.

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

Most of our services are provided pursuant to agreements with state and local governmental social and aging service agencies. These agreements generally have a 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 payor mix as states shift from the management of their programs to managed care organizations. In 2014, approximately 86.4% of our net service revenues from continuing operations were derived from state and local government programs, with 9.1% derived from managed care organizations, while approximately 4.5% of net service revenues from continuing operations were derived from insurance programs and private duty consumers.

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For 2014, 2013 and 2012, our revenue mix by payor type for continuing operations was as follows:

	Year Ended December 31,		
	2014	2013	2012
State, local and other governmental programs	86.4%	94.1%	94.9%
Managed care organizations	9.1	1.0	0.0
Private duty	3.4	3.9	4.1
Commercial	1.1	1.0	1.0
	100.0%	100.0%	100.0%

We derive a significant amount of our net service revenues from our operations in Illinois, New Mexico, Washington and California. The percentages of total revenue for each of these significant states for 2014, 2013 and 2012 are listed below.

	% of Total Revenue for the Years Ended December, 31		
State	2014	2013	2012
Illinois	60.6%	65.5%	63.7%
New Mexico	8.2	2.1	1.7
Washington	5.0	6.5	7.2
California	4.9	5.8	6.9

A significant amount of our net service revenues from continuing operations are derived from one specific payor client, the Illinois Department on Aging, which accounted for 53.2%, 58.8% and 57.3% of our total net service revenues from continuing operations for the years ended December 31, 2014, 2013 and 2012, respectively.

We also measure the performance of our business through review of our billable hours per client, billable hours per business day, revenues per billable hour and the number of consumers served, or census.

Competition

The home and community based services 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 home and community based 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. This is particularly true in California where the independent provider is an individual who provides services for one consumer and is paid directly by the county where services are delivered. 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.

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We are establishing new referral relationships with various managed care organizations who are contracting with the states for the management of the state Medicaid programs under dual eligible demonstration and similar Medicaid managed care programs. We have met with all contracted managed care organizations in markets where we serve our clients and are building those relationships necessary to insure continued referrals of new clients.

We receive substantially all of our consumers from third-party referrals. 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 receive referrals from 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.

We provide ongoing education and outreach to our target communities, both to inform the community about state and locally-subsidized care options and to communicate our role in providing quality home and community based services. We also utilize consumer-direct sales, marketing and advertising programs designed to attract consumers.

Payment for Services

We are compensated for substantially all of our services by federal, state and local government programs, such as Medicaid funded programs and Medicaid waiver programs, other state agencies, the Veterans Health Administration, commercial and managed care organizations and private duty consumers.

The following table sets forth net service revenues from continuing operations derived from each of our major payors during the indicated periods as a percentage of total net service revenues from continuing operations.

	Year Ended December 31,		
Payor	**2014**	**2013**	**2012**
Illinois Department on Aging	53.2%	58.8%	57.3%
Washington Department of Social and Health Services	4.6	6.6	6.4
United HealthCare of New Mexico	3.4	0.0	0.0
Other federal, state and local payors	25.7	28.7	31.2
Other managed care organizations	8.6	1.0	0.0
Private duty	3.4	3.9	4.1
Commercial insurance	1.1	1.0	1.0
Total	100.0%	100.0%	100.0%

Illinois Department on Aging

We provide home and community based services pursuant to agreements with the Illinois Department on Aging, which is funded by Medicaid and general revenue funds of the State of 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 the program, the 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.

Due to its revenue deficiencies and financing issues, the State of Illinois is currently providing reimbursement on a delayed basis with respect to these agreements. These payment delays could adversely impact our liquidity, and may result in the need to increase borrowings under our credit facility. Other delayed payor reimbursements from the State of Illinois could contribute to an increase in our receivables balances.

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Washington Department of Social and Health Services

We provide home and community based services pursuant to agreements with the Washington Department of Social and Health Services, which is funded by Medicaid and general revenue funds of the State of Washington. Consumers are identified by area Agency on Aging case managers contracted independently with the Washington Department of Social and Health Services. Once a consumer has been evaluated and determined to be eligible for the program, the 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 Washington Department of Social and Health Services. We are reimbursed on an hourly fee for service basis.

United HealthCare of New Mexico

We provide services under contract with United HealthCare of New Mexico (United HealthCare) under the Community Long Term Care Services (CoLTS) program. This is a managed Medicaid program pursuant to which the State of New Mexico has contracted with several commercial insurance payers to manage home and community based services as well as other long-term social services. Under this agreement, consumers are qualified for services and referred to us by United Healthcare. We provide personal care and other in-home support services under this program. Our relationship with United HealthCare is not exclusive as United HealthCare has a network of providers who provide similar services to it. All services are reimbursed on an hourly fee for service basis.

Other Federal, State and Local Payors

Medicaid Funded Programs and Medicaid Waiver 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, 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, subject to federal oversight. Most states cover Medicaid beneficiaries for intermittent home health services, as well as continuous services for children and young adults with complicated medical conditions, and certain states cover home and community-based services.

In an effort to control escalating Medicaid costs, states are increasingly requiring Medicaid beneficiaries to enroll in managed care plans. Under a health reform bill signed into law in January 2012, Illinois set a goal to increase the percentage of Medicaid beneficiaries in Medicaid managed care plans from the then current 8% to 50% by 2015. The State fell just short of that goal, enrolling approximately 1,400,000 of its 3,100,000 Medicaid population in managed care plans as of January 2015. The State plans to enroll an additional 800,000 people in managed care plans in the next few months. Under these managed care programs, states are increasingly requiring Medicaid beneficiaries to work with case managers.

Veterans Health Administration

The Veterans Health Administration operates the nation s largest integrated health care system, with more than 1,800 sites of care, and provides health care benefits, including home and community based 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 by contracting directly with local in-home care providers, and to the aid and attendance pension, which pays veterans for their otherwise

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unreimbursed health and long-term care expenses. We currently have relationships and agreements with the Veterans Health Administration to provide home and community based services in several states, with the largest Veterans Health Administration services being provided in Illinois, Arkansas and California.

Other

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

Other Managed Care Organizations

Many states are moving the administration of their Medicaid home and community based programs to commercially-managed care insurance companies. This transition is due to federal and state initiatives to address the needs of the dual eligible population and an overall desire to better manage the costs of the Medicaid long term care programs. Reimbursement from the managed care organizations is generally on an hourly, fee for service basis with rates consistent with the individual state funded rates.

Private Duty

Our private duty services are provided on an hourly basis. Our rates are established to achieve a pre-determined gross profit margin, and are competitive with those of other local providers. We bill our private duty consumers for services rendered either bi-monthly or monthly, and in certain circumstances we obtain a two- week deposit from the consumer. Other private duty payors include workers compensation programs/insurance, preferred provider organizations and employers.

Commercial Insurance/Long-Term Care Insurance

Most long-term care insurance policies contain benefits for in-home services and adult day care. Policies are generally subject to dollar limitations on the amount of daily, weekly or monthly coverage provided. Depending on the type of service, coverage for services may be predicated on a physician or nurse determination that the care is necessary or on the development of a plan for care in the home.

Exposure for Payments Previously Received

As described above under the caption Business Overview, we sold our Home Health Business effective March 1, 2013, pursuant to an Asset Purchase Agreement, dated as of February 7, 2013 (the Home Health Purchase Agreement), with LHC Group, Inc. and the Purchasers identified therein. Pursuant to the Home Health Purchase Agreement, we retained a 10% ownership interest in the Home Health Business in California and Illinois. In addition, not included in the sale were four home health agencies in Delaware, Idaho, Indiana and Pennsylvania. The home health agency in Pennsylvania was sold on December 30, 2013 and the agency in Idaho was closed in November 2012 and efforts to sell the Idaho agency were abandoned in December 2013.

While we no longer receive substantial payments from Medicare for home health services, pursuant to the Home Health Purchase Agreement, we are obligated 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 consummation of the sale (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

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Closing to meet the requirements of such government programs, or any violation prior to the Closing of any health care 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 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.

Medicare is the U.S. government s health insurance program funded by the Social Security Administration for individuals aged 65 or older, individuals under the age of 65 with certain disabilities and individuals of all ages with end-stage renal disease. Eligibility for Medicare does not depend on income, and coverage is restricted to reasonable and medically-necessary treatment.

Medicare home health rates are based on a Medicare episodic rate set annually through federal legislation. The rate covers a 60-day episode of care. Payment for each patient s episode of care is based on the severity of the consumer s condition, his or her service needs and other factors relating to the cost of providing services and supplies.

In addition, Medicare payments can be adjusted through changes in the payment rate and recoveries of overpayments for, among other things, unusually costly care for a particular consumer, low utilization, transfers to another provider, the level of therapy services required, the number of episodes of care provided, and if the consumer is discharged but readmitted within the same 60-day episodic period. In addition, Medicare can also reduce levels of reimbursement if a provider is unable to produce appropriate billing documentation or acceptable medical authorizations.

Insurance Programs and Costs

We maintain workers compensation, general and professional liability, 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 assure you 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, as well as the employees in our National Support Center, as of December 31, 2014:

		Full-time	Part-time	Total
Continuing Operations	Home and Community Based Services	3,388	14,501	17,889
National Support Center		138	27	165
		3,526	14,528	18,054

Our home and community based service aides provide substantially all of our services and comprise approximately 96.3% of our total workforce. Our home and community based services aides undergo a criminal background check, and are provided with pre-service training and orientation and an evaluation of their skills. In many cases, home and community based services aides are also required to attend ongoing in-services education. In certain states, our home and community based services aides are required to complete certified training programs and maintain a state certification; however, no state in which we operate requires home and community

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based services aides to maintain a license similar to that of a nurse or therapist. Approximately 61.3% of our total employees are represented by labor unions. We maintain strong working relationships with these labor unions. We have a national agreement with the Service Employees International Union (the SEIU). Wages and benefits are negotiated at the local level at various times throughout the year.

Technology

We have licensed the Horizon Homecare software solution (Horizon Homecare) from McKesson Information Solutions, LLC (McKesson), to address our administrative, office, clinical and operating information system needs, including compliance with the Health Insurance Portability and Accountability Act, or HIPAA, requirements. Horizon Homecare assists our staff in gathering information to improve the quality of consumer care, optimize financial performance, adjust consumer mix, promote regulatory compliance and enhance staff efficiency. Horizon Homecare supports intake, personnel scheduling, office clinical and reimbursement management in an integrated database. The Horizon Homecare software is hosted by McKesson in a secure data center, which provides multiple redundancies for storage, power, bandwidth and security. Using this technology, we are able to standardize the care delivered across our network of locations and effectively monitor our performance and consumer outcomes. We have also leveraged this technology to implement a centralized billing and collections function at our national support center.

During most of 2014, we used an internally developed and customized payroll management system to calculate and produce our payroll. We transitioned all payroll and human resource functions to a commercial human resource and payroll system vendor, provided by Ultimate Software during the fourth quarter of 2014 and the first quarter of 2015. The Ultimate Software solution is a web based provider of integrated human resource and payroll software, which supports our management with the systems and reporting necessary to manage our employees. Both software systems are integrated with Horizon Homecare and other clinical data-management systems, and include features for tax reporting, managing wage assignments and garnishments, on-site check printing, general ledger population and direct-deposit paychecks. Secure management reports are made available centrally and through our internal reporting module.

We utilize commercial vendors for electronic visit verification pursuant to which our home and community based service aids record their beginning and ending times for services provided through either an interactive voice recognition (IVR) system or cell phone based system. We have supplemented these commercial systems with company developed mobile applications that allow our homecare aides the ability to communicate with our support center, to request additional work if available, to monitor or change their schedules and to inquire about payroll information. In addition, our software development includes features to allow our homecare aides to communicate changes in the health condition of our consumers. We utilize this information to support our coordinated care model and to communicate to managed care organizations.

Government Regulation

Overview

Our business is subject to extensive and increasing federal, state and local regulation. Changes in the law or new interpretations of existing laws may have a dramatic effect 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. Departments of the federal government are currently considering how to implement programs and policy changes and mandated demonstration projects in the Health Reform Act. As a result of the Health Reform Act, it is expected that the number of Medicaid beneficiaries will increase (although several states in which we operate have declined to expand Medicaid eligibility) and in addition, there may be additional increases if employers terminate their employee health plans. It is impossible to know at this time what effect, if any, this will have on budgetary allocations for our services. The health care industry has experienced, and is expected to continue to experience, extensive and dynamic change. 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

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civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal or state programs. See also Management s Discussion and Analysis of Financial Condition and Results of Operations Overview.

Medicaid Participation

To participate in and qualify for reimbursement under Medicaid programs, we are subject to various requirements imposed by federal and state authorities. If we were to violate the applicable federal and state regulations, we could be excluded from participation in federal and state healthcare programs and be subject to substantial civil and criminal penalties. New federal regulations took effect on March 17, 2014 setting forth eligibility requirements for home and community based services provided under Medicaid waiver programs. The regulations specify that home and community based settings must be integrated in and support full access to the greater community, selected by individuals from among different setting options, ensure privacy rights of individuals, optimize autonomy and independence in making life choices, and facilitate individual choice regarding services and supports. In addition, the regulations impose several conditions on provider-owned or controlled residential settings. All states are required to submit transition plans to CMS by March 17, 2015, detailing any actions necessary for the state to achieve compliance with the new requirements. Several states have submitted transition plans already or made draft plans available for public comment prior to submission to CMS. Home and community based service providers will face costs associated with compliance with these regulations, but it is difficult to ascertain the impact of these costs at this time and these costs will vary from state to state depending on how the requirements are implemented.

Health Reform Act

The Health Reform Act includes several provisions that may affect reimbursement for our services. The Health Reform Act is broad, sweeping reform, and is subject to change, including through the adoption of related regulations, the way in which its provisions are interpreted and the manner in which it is enforced. Although the Health Reform Act provides for expansion of eligibility for Medicaid enrollment, 21 states, including some in which we do business, have opted not to participate in Medicaid expansion. The Health Reform Act also creates within CMS a Center for Medicare and Medicaid Innovation, or CMMI, to test innovative payment and service delivery systems to reduce program expenditures while maintaining or enhancing quality. Among the issues that are to be addressed by CMMI are: allowing the states to test new models of care for individuals dually eligible for Medicare and Medicaid, supporting continuing care hospitals that offer post-acute care during the 30 days following discharge, funding home health providers that offer chronic care management services, and establishing pilot programs that bundle acute care hospital services with physician services and post-acute care services, including home health services for patients with certain selected conditions. We may have difficulty negotiating for a fair share of the bundled payment. In addition, we may be unfairly penalized if a consumer is readmitted to the hospital within 30 days of discharge for reasons beyond our control.

We cannot assure you that the provisions described above, or that any other provisions of the Health Reform Act or amendment thereto, will not adversely impact our business, results of operations or financial position.

Permits and Licensure

Our home and community based services are authorized and / or licensed under various state and county requirements. Our home and community based aides generally have no licensure requirements, although in certain states, they are required to complete training programs and maintain state certification. We believe we are currently licensed appropriately where required by the laws of the states in which we operate, but additional licensing requirements may be imposed upon us in existing markets or markets that we enter in the future.

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Applicable Federal and State Laws

Anti-Kickback Laws: The federal government enforces the federal law, commonly known as the Anti-Kickback Statute that prohibits the offer, payment, solicitation or receipt of any remuneration to or from any person or entity to induce or in exchange for the referral of patients covered by federal health care programs such as Medicare and Medicaid. The federal Anti-Kickback Statute also prohibits the purchasing, leasing, ordering or arranging for any item, facility or service covered by the government payment programs (or the recommendation thereof) in exchange for such referrals. Many states, including Illinois, Nevada and California also have similar laws proscribing kickbacks, some of which are not limited to services for which government-funded payment may be made. Violations of these provisions are punishable by criminal fines, civil penalties, imprisonment or exclusion from participation in reimbursement programs.

The Stark Law and other Prohibitions on Physician Self-Referral: We may also be affected by the federal law, commonly known as the Stark Law, that prohibits physicians from making a referral for health care items or services, including home health services, if they, or their family members, have a financial relationship with the entity receiving the referral unless certain conditions are met. Violations are punishable by civil monetary penalties on both the person making the referral and the provider rendering the service. Such persons or entities are also subject to exclusion from federal and state healthcare programs. We believe our compensation agreements with physicians who served as medical directors in our home health agencies meet the requirements for the personal services exception and that our operations comply with the Stark Law.

Many states, including Illinois, Nevada and California have also enacted statutes similar in scope and purpose to the Stark Law.

Beneficiary Inducement Prohibition: The federal Civil Monetary Penalties Law (CMPL) imposes substantial penalties for offering remuneration or other inducements to influence federal health care beneficiaries decisions to seek specific governmentally reimbursable items or services, or to choose particular providers. The CMPL also can be used for civil prosecution of the Anti-Kickback Statute. Sanctions under the CMPL include substantial financial penalties as well as exclusion from participation in all federal and state health care programs.

The False Claims Act: Under the federal False Claims Act, the government may fine any person, company or corporation that knowingly submits, or participates in submitting, claims for payment to the federal government which are false or fraudulent, or which contain false or misleading information. Any such person or entity that knowingly makes or uses a false record or statement to avoid paying the federal government may also be subject to fines under the False Claims Act. Private parties may initiate whistleblower lawsuits against any person or entity under the False Claims Act in the name of the government and may share in the proceeds of a successful suit. The penalty for violation of the False Claims Act is a minimum of $5,500 and a maximum of $11,000 for each fraudulent claim plus three times the amount of damages caused to the government as a result of each fraudulent claim. A False Claims Act violation may provide the basis for the imposition of administrative penalties as well as exclusion from participation in governmental health care programs, including Medicare and Medicaid. In addition to the False Claims Act, the federal government may use several criminal statutes to prosecute the submission of false or fraudulent claims for payment to the federal government.

Amendments to the False Claims Act in the Health Reform Act provide that a provider must report and return overpayments within 60 days of identifying the overpayment or the claims for the services that generated the overpayments become false claims subject to the False Claims Act. Overpayments include payments for services for which the provider does not have proper documentation. On February 13, 2015, CMS announced that it will delay finalizing regulations that were intended to clarify when a payment is identified for purposes of the 60-day rule. Notwithstanding the delay, providers are still required to comply with the rule even though there is considerable uncertainty over exactly when the 60-day period begins.

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Many states, including Illinois, Nevada and California have similar false claims statutes that impose additional liability for the types of acts prohibited by the False Claims Act.

Fraud Alerts: 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. We believe, but cannot assure you, that our operations comply with the principles expressed by the Office of the Inspector General (the OIG) in these reports and special fraud alerts.

HIPAA and the HITECH Act: HIPAA privacy regulations contain detailed requirements concerning the use and disclosure of individually identifiable health information by HIPAA covered entities, which includes our company. In addition to the privacy requirements, HIPAA covered entities must implement certain security standards to protect the integrity, confidentiality and availability of certain electronic health information. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) imposes additional privacy and security requirements and breach notification obligations on health care providers and on their business associates. Failure to comply with HIPAA or the HITECH Act could result in fines and penalties that could have a material adverse effect on us.

Most states, including Illinois, Nevada and California also have laws that protect the privacy and security of confidential personal information.

Civil Monetary Penalties: HHS may impose civil monetary penalties upon any person or entity that presents, or causes to be presented, certain ineligible claims for medical items or services. The amount of penalties varies, depending on the offense, from $2,000 to $50,000 per violation plus treble damages for the amount at issue and exclusion from federal health care programs, including Medicare and Medicaid. In addition, 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. Penalties are also applicable in certain other cases, including violations of the federal Anti-Kickback Law, payments to limit certain patient services and improper execution of statements of medical necessity.

Surveys and Audits

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. Violation of the applicable federal and state health care regulations can result in excluding a health care provider from participating in the Medicare and/or Medicaid and other federal and state healthcare programs and can subject the provider to substantial civil and/or criminal penalties.

Pursuant to the Tax Relief and Health Care Act of 2006, HHS created a permanent and national recovery audit program to identify improper Medicare payments made on claims of health care services provided to Medicare beneficiaries. The program uses recovery audit contractors, or RACs, to identify the improper Medicare payments and protect the Medicare Trust Fund from fraud, waste and abuse. Since the start of the program, RACs have identified more than $8 billion in improper payments. RACs are paid a contingent fee based on the improper payments identified. On December 30, 2014, CMS announced a series of changes to the RAC audit program aimed at reducing the burden on providers, enhancing CMS oversight of RACs and increasing program transparency. CMS also instituted Zone Program Integrity Contracts (ZPICs) for additional audit of Medicare providers, including home health agencies.

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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.

ITEM 1A. RISK FACTORS

The risks described below, and 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 and the actual outcome of matters as to which forward-looking statements are 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.

If any of the following risks are actually realized, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected. In that case, the trading price of our common stock could decline.

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.

Changes to Medicaid, Medicaid waiver or other state and local medical and social programs could adversely affect our client caseload, units of service, net service revenues, gross profit and profitability.

For the year ended December 31, 2014, we derived approximately 86.4% of our net service revenues from continuing operations from agreements that are directly or indirectly paid for by state and local governmental agencies, such as Medicaid funded programs and Medicaid waiver programs. Governmental agencies generally condition their agreements with us upon a sufficient budgetary appropriation. If a governmental agency does not receive an appropriation sufficient to cover its contractual obligations with us, it may terminate an agreement or defer or reduce the amount of the reimbursement we receive. Almost all the states in which we operate experience periodic financial pressures and budgetary shortfalls due to changing economic conditions and the rising costs of health care, and as a result, have made, are considering or may consider making changes in their Medicaid, Medicaid waiver or other state and local medical and social programs. The Deficit Reduction Act of 2005 permits states to make benefit cuts to their Medicaid programs, which could affect the services for which states contract with us. Changes that states have made or may consider making to address their budget deficits include:

limiting increases in, or decreasing, reimbursement rates;

redefining eligibility standards or coverage criteria for social and medical programs or the receipt of home and community based services under those programs;

increasing the consumer s share of costs or co-payment requirements;

decreasing the number of authorized hours for recipients;

slowing payments to providers;

increasing utilization of self-directed care alternatives or all inclusive programs; or

shifting beneficiaries to managed care organizations.

Certain of these measures have been implemented by, or are proposed in, states in which we operate. The Governor of Illinois has proposed a budget that contemplates many of these above-mentioned changes in order to

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control costs in the Illinois. In 2014, we derived approximately 60.6% of our total net service revenues from continuing operations from services provided in Illinois, 8.2% of our total net service revenues from continuing operations in New Mexico, 5.0% of our total net service revenues from continuing operations from services provided in Washington and 4.9% of our total net service revenues from continuing operations from services provided in California. Riverside, California is planning to move substantially all of its Medicaid recipients to a self-directed model for care delivery beginning in July 2015. Because a substantial portion of our business is concentrated in these states, any significant reduction in expenditures that pay for our services in these states and other states in which we do business may have a disproportionately negative impact on our future operating results. Provisions in the Health Reform Act increase eligibility for Medicaid, which may cause a reallocation of Medicaid funding. It is difficult to predict at this time what the effect of these changes would be on our business. If changes in Medicaid policy result in a reduction in available funds for the services we offer, our net service revenues could be negatively impacted.

Under the Health Reform Act, the federal medical assistance percentage (the FMAP) paid by the federal government to states that elect to provide Medicaid coverage to low income adults who were previously ineligible for Medicaid is 100% for calendar years 2014-2016 and gradually decreases to 90% in 2020 and thereafter. Not all states in which we do business may elect to provide coverage to newly eligible individuals. We are not able at this time to determine the impact that these changes will have on our business.

In March 2013, the federal government implemented certain budgetary restrictions, commonly known as sequestration. Although Medicaid is exempt from these automatic cuts, sequestration remains in place and could negatively impact reimbursement or authorizations for services under our federal or state contracts.

A number of states have initiated efforts to combat Medicaid fraud and overpayments. If the number of Medicaid applicants or recipients is significantly reduced as a result of these efforts, the number of consumers we serve could be reduced, which could negatively affect our business and results of operations.

State efforts to transition their home and community based programs to being administered by managed care organizations could adversely affect our net service revenues and our profitability.

Under the Health Reform Act, states are encouraged to integrate the state managed Medicaid home and community based programs with managed Medicare programs. The objective of these initiatives is to enhance the coordination of benefits between the two programs and to lower overall costs.

Nationally, 18 states are currently pursuing financial or administrative alignment for dual eligible beneficiaries, including 6 of the 22 states in which we provide services. However, the timing for implementation of these demonstration projects are unknown at this time. In addition, the final regulations implementing these programs modify the requirements and definitions around home and community-based settings. We cannot assure you that: we will be able to secure favorable contracts with all or some of the managed care organizations; 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. If states in which we provide services transition their home and community based programs to managed care organizations and we are not able to participate through contracts with managed care organization or otherwise, we could lose revenue generated in those states, even in states in which we currently have contracts to provide home and community based services.

In certain states, where the transition to managed care organizations is occurring, operational processes are not well defined. Membership is being assigned by the respective state agency to the managed care organizations, but often communication of the changes is not clear to either the managed care organizations or the consumers. Membership, new referrals and the related authorization for services to be provided are being delayed, resulting in delays in service delivery to our consumers. Payments for services rendered are often delayed due to confusion in membership assignment and the referral processes. To the extent these processes are not improved, revenue growth rates, cash flow and profitability for services provided may be negatively affected.

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The implementation of Accountable Care Organizations (ACOs) may limit our ability to increase our market share and could adversely affect our revenues.

CMS published final ACO regulations in October 2011, which established a shared savings program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. These programs are focused on efforts by hospitals and physician groups to organize and coordinate patient care and are not directed toward home and community based service providers. In addition, several states have implemented, or plan to implement, accountable care models for their Medicaid populations. If we are not included in development of these programs, or if the ACOs establish similar services to include home and community based programs for their participants, we are at risk for losing market share and for a loss of our current business. Other cost savings initiatives may be presented by the government and commercial payors to control costs and reduce hospital admissions / readmissions in which we could be financially at risk. We cannot predict at this time what effect ACOs or like organizations may have on our company.

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

In 2014, we derived approximately 53.2% of our revenue from continuing operations from the Illinois Department on Aging programs. Since 2011, the State of Illinois has undertaken a number of initiatives to reduce the costs of the Illinois Department on Aging program, such as the mandated utilization of an electronic visit verification (EVV) system by all providers. In his budget proposal for 2016, the Governor of Illinois has suggested several measures to reduce the costs of the Illinois Department on Aging, including restrictions on new referrals and reduced authorized hours for new and existing clients. The proposal includes additional changes aimed at reducing expenditures by the Illinois Department on Aging, including an income cap and a higher threshold of need for eligibility in the Community Care Program and elimination of the add-on rate the Illinois Department on Aging had been paying Community Care Program service providers to help those providers pay for employee healthcare. It is difficult to ascertain how significant an impact these initiatives will have on our business. If they impact the eligibility of our consumers, the number of hours authorized or services provided to existing consumers, they would adversely affect our service revenues and profitability.

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

There is generally a delay between the time that we provide services and the time that we receive reimbursement or payment for these services. The majority of the 22 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. Specifically, the State of Illinois is currently reimbursing us on a delayed basis, including with respect to our agreements with the Illinois Department on Aging, our largest payor. Our reimbursements from the State of Illinois could be further delayed because current forecasts indicate higher state deficits in the near future. 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. Because we fund our operations primarily through the collection of accounts receivable, any significant delays in reimbursement could result in the need to increase borrowings under our credit facility.

Our revenue may be negatively impacted by a failure to appropriately document services, resulting delays in reimbursement and related indemnification obligations.

Reimbursement to us is conditioned upon providing the correct administrative and billing codes and properly documenting the services themselves, including the level of service provided, and the necessity for the services. If incorrect or incomplete documentation is provided or inaccurate reimbursement codes are utilized,

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this could result in nonpayment for services rendered and could lead to allegations of billing fraud. This could subsequently lead to civil and criminal penalties, including exclusion from government healthcare programs, such as Medicare and Medicaid. In addition, third-party payors may disallow, in whole or in part, requests for reimbursement based on determinations that certain amounts are not covered, services provided were not medically necessary, or supporting documentation was not adequate. Pursuant to the Home Health Purchase Agreement, we are obligated 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 health care 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 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 or the government for the amount of such adjustments, which could adversely affect our business and financial condition. In addition, timing delays may cause working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in achieving our financial results and maintaining liquidity. It is possible that documentation support, system problems, provider issues or industry trends may extend our collection period, which may materially adversely affect our working capital, and our working capital management procedures may not successfully mitigate this risk.

The implementation or expansion of self-directed care programs in states in which we operate may limit our ability to increase our market share and could adversely affect our revenue.

Self-directed care programs are funded by Medicaid and state and local agencies and allow the consumer to exercise discretion in selecting home and community based service providers. Consumers may hire family members, friends or neighbors to provide services that might otherwise be provided by a home and community based service agency provider, such as our company. Most states and the District of Columbia have implemented self-directed care programs, to varying degrees and for different types of consumers. States are under pressure from the federal government and certain advocacy groups to expand these programs. CMS has provided states with specific Medicaid waiver options for programs that offer person-centered planning, individual budgeting or self-directed services and support as part of the CMS Independence Plus initiative introduced in 2002 under an Executive Order of the President. Certain private foundations have also granted resources to states to develop and study programs that provide financial accounts to consumers for their long-term care needs, and counseling services to help prepare a plan of care that will help meet those needs. Expansion of these self-directed programs may erode our Medicaid consumer base and could adversely affect our net service revenues.

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

In 2014, we derived approximately 53.2% of our net service revenues from continuing operations under agreements with the Illinois Department on Aging, 4.6% of our net service revenues from continuing operations under an agreement with the State of Washington and 3.4% of our net service revenues from continuing operations under an agreement with United HealthCare of New Mexico. Each of our agreements is generally in effect for a specific term. For example, the services we provide to the Illinois Department on Aging are provided under a number of agreements that expire at various times through 2015.

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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, with limited barriers to entry.

We compete with home and community based 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 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, particularly in California. Some of our competitors 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. Consumers or referral sources may perceive that local service providers and not-for-profit agencies deliver higher quality services or are more responsive. These competitive advantages may limit our ability to attract and retain referrals in local markets and to increase our overall market share.

There are limited barriers to entry in providing home-based social and medical services, and the trend has been for states to eliminate many of the barriers that historically existed. For example, Illinois changed the way in which it procures home and community based service providers in 2009, allowing all providers that are willing and capable to obtain state approval and provide services. This may increase competition in that state, and because we derived approximately 60.6% of our net service revenues from continuing operations from services provided in Illinois in 2014, this increased competition could negatively impact our business.

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.

Our profitability could be negatively affected by a reduction in reimbursement from payors.

States such as Illinois are experiencing large budget deficits, which may result in lower payments. The Governor of Illinois has proposed a budget for the State s fiscal year 2016 which has certain provisions that would limit the budget and related services provided by the Illinois Department on Aging. While not yet passed by the State, if enacted these changes could affect the number of clients we serve and our growth in the State. To the extent the State continues to have fiscal issues, reimbursement from the State may be negatively impacted. In addition, private payors, including commercial insurance companies, could also reduce reimbursement. Any reduction in reimbursements or imposition of copayments that dissuade the use of our services, or any reduction in reimbursement from private payors, could materially adversely affect our profitability.

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We are subject to extensive government regulation. Changes to the laws and regulations governing our business could negatively impact our profitability and any failure to comply with these regulations could adversely affect our business.

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 consumers and the public. These requirements include matters related to:

licensure and certification;

adequacy and quality of services;

qualifications and training of personnel;

confidentiality, maintenance and security issues associated with medical records and claims processing;

the use and disclosure of protected health information;

relationships with physicians and other referral sources;

operating policies and procedures;

addition of facilities and services; and

billing for services.

These laws and regulations, including the Health Reform Act, and their interpretations, are subject to frequent change. These changes could reduce our profitability by increasing our liability, increasing our administrative and other costs, increasing or decreasing mandated services, forcing us to restructure our relationships with referral sources and providers or requiring us to implement additional or different programs and systems. Failure to comply could lead to the termination of rights to participate in federal and state-sponsored programs, the suspension or revocation of licenses and other civil and criminal penalties and a delay in our ability to bill and collect for services provided. We cannot assure you that the provisions described above will not adversely impact our business, results of operations or financial results. Further, we may be unable to mitigate any adverse effects resulting from the Health Reform Act.

The Health Reform Act amended the False Claims Act to provide that a provider must report and return overpayments within 60 days of identifying the overpayment or the claims for the services that generated the overpayments become false claims subject to the False Claims Act. Overpayments include payments for services for which the provider does not have proper documentation. If we were to identify documentation failures that could not be corrected we could be required to return payments received for those claims within the mandated 60-day time period. If we fail to identify and return overpayments within the required 60-day period we could be subject to suits under the False Claims Act by the government or relators (whistleblowers). On February 13, 2015, CMS announced that it will delay finalizing regulations that were intended to clarify when a payment is identified for purposes of the 60-day rule. Notwithstanding the delay, providers are still required to comply with the rule even though there is considerable uncertainty over exactly when the 60-day period begins. These requirements could have a material adverse impact on our business and operations. During an internal evaluation of billing processes, we discovered documentation errors in a number of claims that we had submitted to Medicare and consistent with applicable law, in March 2014, we voluntarily remitted approximately $1,800,000 to the government. See Note 7 to the Consolidated Financial Statements, Details of Certain Balance Sheet Accounts, included elsewhere herein for more information.

As noted in Business-Overview section above, new federal regulations took effect on March 17, 2014 setting forth eligibility requirements for home and community based services provided under Medicaid waiver programs. Home and community based service providers will face costs associated with compliance with these regulations, but it is difficult to ascertain the impact of these costs at this time and these costs will vary from state to state depending on how the requirements are implemented.

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On October 6, 2014, CMS issued a proposed rule that would revise the Medicare and Medicaid conditions of participation for home health agencies. The proposed rule would require home health agencies to develop, implement and maintain an agency-wide, data-driven quality assessment and improvement program and a system of communication and integration to identify patient needs and coordinate care. The proposed rule also aims to clarify and expand current patient rights requirements and contains several other clarifications and updates largely focused on creating a more patient-centered, data-driven, outcome-oriented process for patient care. While we sold our Home Health Business, as discussed in Business-Overview above, we retain some limited Medicare business as a result of our acquisition of Priority Home Health Care, Inc. and otherwise. If the proposed rule is finalized, we expect to face costs associated with compliance with such changes.

On December 11, 2014, CMS proposed a star rating methodology for home health agencies to meet the Health Reform Act s call for more transparent, public information on provider quality. All Medicare-certified home health agencies would be eligible to receive a star rating (from one to five stars) based on a number of quality measures, such as timely initiation of care, drug education provided to patients, fall risk assessment, depression assessments, improvements in bed transferring and bathing, among others. Ratings would be available on the Home Health Compare website. CMS is currently soliciting feedback from stakeholders on the proposed program and has set an implementation target of Summer 2015. It is not clear at this time what impact, if any, the proposed rating system would have on our remaining home health business.

In October 2013, California enacted the Home Care Services Consumer Protection Act. The act establishes a licensing program for home care organizations, and requires background checks, basic training, and tuberculosis screening for the aides that are employed by home care organizations. Home care organizations and aides will have until January 1, 2016 to comply with the new licensing and background check requirements. Although we sold the bulk of our home health business in California in March 2013, we continue to operate in California. The requirements of the act are expected to impose additional costs on us.

We are subject to various other federal and state regulations and laws, including anti-referral laws, the Anti-Kickback Statute, the Stark Law, the False Claims Act, Fraud Alerts, HIPPA and the HITECH Act as described in the Section Government Regulation . Failure to comply with these regulations or violations of these laws could lead to fines and exclusions or other sanctions that could have a material effect on our business.

We are subject to federal and state laws that govern our employment practices. Failure to comply with these laws, or changes to these laws that increase our employment-related expenses, could adversely impact our operations.

We are required to comply with all applicable federal and state laws and regulations relating to employment, including occupational safety and health requirements, wage and hour requirements, employment insurance and equal employment opportunity laws. These laws can vary significantly among states 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 or state laws or regulations requiring employers to provide specified benefits 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, 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.

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 $10,000 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.

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Under the Health Reform Act, we are required to provide a minimum level of coverage for 70 percent of our full-time employees in 2015 or be subject to an annual penalty. For 2016, coverage must extend to 95% of our full-time employees. Approximately 22% of our employees are not provided any medical coverage. We are evaluating our options to minimize our exposure as a result of this requirement. If we determine that we will provide medical coverage for these employees, the costs could be material and have a significant effect on our profitability. If we determine not to offer medical coverage, we could be assessed fines or penalties for individuals who seek medical coverage through federal and state health exchanges. Depending on the number of employees who seek coverage in this manner, the penalties could be material and have a significant effect on our profitability.

In September 2013, the United States Department of Labor (the Department of Labor) announced the adoption of a rule that extended the minimum wage and overtime pay requirements of federal law to most direct care workers, such as home health aides, personal care aides and certified nursing assistants. These employees have been exempt from federal wage laws since 1974. The new rule was slated to take effect on January 1, 2015, (though the Department of Labor announced on October 7, 2014 that it would delay enforcement of the rule until June 30, 2015). However, two decisions from the United States District Court for the District of Columbia, handed down on December 22, 2014 and January 14, 2015, invalidated key provisions in the rule, effectively restoring the status quo in which home care agencies and other third party employers can utilize the companionship services exemption to the minimum wage and overtime requirements of the Fair Labor Standards Act. The applicability of the rule remains uncertain, however, as the Department of Labor filed a notice of appeal of these rulings with the United States Court of Appeals for the District of Columbia on January 23, 2015.

A number of states already require that direct care workers receive state-mandated minimum wage and/or overtime pay. Opponents say that the new protections will make in-home care more expensive for government programs such as Medicaid that pay for such services, and that the new rule could result in a reduction in covered services. We will continue to evaluate the effect of the new rule on our operations.

We are subject to reviews, compliance audits and investigations that could result in adverse findings that negatively affect our net service revenues and profitability.

As a result of our participation in Medicaid, Medicaid waiver, Medicare programs, 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, 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. Pursuant to the Home Health Purchase Agreement, we are obligated 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 health care 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 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. Payments we receive in respect of Medicaid and Medicare can be retroactively adjusted after a new examination during the

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claims settlement process or as a result of pre- or post-payment audits. Federal, state and local government payors may disallow our requests for reimbursement based on determinations that certain costs are not reimbursable because proper documentation was not provided or because certain services were not covered or deemed necessary. In addition, other third-party payors may reserve rights to conduct audits and make reimbursement adjustments in connection with or exclusive of audit activities. Significant adjustments as a result of these audits could adversely affect our revenues and profitability.

If we fail to meet any of the conditions of participation or coverage with respect to state licensure or our participation in Medicaid, Medicaid waiver, 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, the imposition of fines or other sanctions, damage to our reputation, cancellation of our agreements, suspension or revocation of our licenses or disqualification from federal and state reimbursement programs. These actions may adversely affect our ability to provide certain services, to receive payments from other payors and to continue to operate. Additionally, actions taken against one of our locations may subject our other locations 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 locations 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.

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 studies mandated by Congress in the Health Reform Act to make public quality measures are implemented and if our quality measures 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.

In addition, in connection with the sale of our Home Health Business, we granted a license to the Purchasers that allows them to use certain of our intellectual property, including the Addus name, for the provision of skilled nursing and related physical therapy healthcare services to individuals in their homes and hospice services in California, Illinois, Arkansas, South Carolina and Nevada. Although the use of the intellectual property is required to be consistent and at least equal to the level of quality and brand perception prior to the sale, we do not have operational control over the Purchasers. As a result, home health agencies operated by the Purchasers may not be operated in a manner consistent with the standards we uphold at our agencies. If such agencies do not maintain operational standards consistent with the standards we demand of our agencies, the image and brand reputation of Addus may suffer and our business may be materially affected.

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 will place significant demands on our management team, systems, internal controls and financial and professional

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resources. In addition, we will need to further develop our financial controls and reporting systems to accommodate 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. For example, we were unable to fully integrate one acquired business because we were unable to procure a necessary government endorsement. The failure to effectively integrate future acquisitions could have an adverse impact on our operations.

We have grown our business through de novo locations and we may in the future open new locations in existing and new markets. De novo locations 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 locations 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, 2014 and December 31, 2013, we had cash balances of $13,363,000 and $15,565,000, respectively. As of December 31, 2014, we had no outstanding debt on our credit facility. After giving effect to the amount drawn on our credit facility, approximately $15,464,000 of outstanding letters of credit and borrowing limits based on an advanced multiple of adjusted EBITDA, we had $39,536,000 available for borrowing under the credit facility as of December 31, 2014. Since our credit facility provides for borrowings based on a multiple of an EBITDA ratio, any declines experienced 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 would be dilutive to existing shareholders. In addition, our credit facility prohibits us from consummating more than three acquisitions in any calendar year, and, in any event, does not permit the purchase price for any one acquisition to exceed $2,000,000, in each case without the consent of the lenders. The consideration we paid in connection with 12 of the 15 acquisitions we completed exceeded $2,000,000. In addition, 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.

Access to additional capital and credit markets, at a reasonable cost, may be necessary for us to fund our operations, including potential acquisitions and working capital requirements. We currently rely on one financial

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institution for funding under our credit facility and any instability in the financial markets or the negative impact of local, national and worldwide economic conditions on that financial institution could impact our short and long-term liquidity needs to meet our business requirements.

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 health care 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 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, 2014, approximately 61.3% of our workforce was represented by two national unions, including the Service Employees International Union, which is our largest union. We have a national agreement with the SEIU. Wages and benefits are negotiated at the local level at various times throughout the year. 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 home and community based 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. Because we operate in this industry, 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

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are transporting or from employees driving to or from home visits. We operate five adult day centers which provide transportation for our elderly and disabled consumers. Each of our vehicles transports 7 to 14 passengers to and from our locations. The concentration of consumers in one vehicle increases the risk of larger claims being brought against us in the event of an accident.

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 False Claims Act or other federal and state whistleblower statutes designed to combat fraud and abuse in our industry. These 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. For example, we have a $350,000 deductible per person/per occurrence under our workers compensation insurance program. 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 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, our corporate headquarters and a number of our agencies are located in the midwestern United States and California, increasing our exposure to blizzards and other major snowstorms, ice storms, tornados, flooding and earthquakes. Future inclement weather or natural disasters may adversely affect our business and consolidated financial condition, results of operations and cash flows.

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, 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 locations and monitor our performance and consumer outcomes. To the extent that McKesson fails to support the software or systems, or if we lose our license with McKesson, our operations could be negatively affected.

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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, Ultimate Software, to provide continual maintenance, upgrading and enhancement of our primary human resource and payroll systems. To the extent that Ultimate Software fails to support the software or systems, or any of the related support services provided by them, our internal operations could be negatively affected.

Because of the confidential health information and consumer records we store and transmit, loss of electronically-stored information for any reason could expose us to a risk of regulatory action, litigation and liability.

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 support center become inoperable as a result of a natural disaster or terrorist acts, it would take substantial amount of time and resources to restore our business to the current state of operation. This risk is becoming even more critical as we are centralizing more of our business operations. The disruption to the business would be material and would affect our operational and financial performance.

We rely on several vendors for telecommunication and internet access, with a high percentage of our agencies supported by one vendor. To the extent services are interrupted, our individual offices may lose basic telephone service and access to our centralized computer systems. To the extent these delays are frequent, or impact a large number of offices, or occur for extended periods of time, it could disrupt our business and would have a negative effect on our ability to serve our clients and potentially have a negative impact on our financial performance.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other events or developments could result in compromises or breaches of our security systems and consumer data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in our services or operations. The Internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the Internet. Computer viruses could be introduced into our systems which could disrupt our operations or make our systems inaccessible. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of consumers if security breaches are not prevented.

In addition, we are required to comply with the privacy and security laws and regulations of HIPAA and the HITECH Act. If our privacy and security practices are not in compliance with HIPAA and/or if we fail to satisfy the breach notification requirements of the HITECH Act in the event of a security breach, we could be subject to significant fines and penalties. Penalties under the HIPAA (as increased by the HITECH Act) can be as high as $50,000 per violation (with an annual maximum of $1,500,000) depending on the degree of culpability.

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The agreements that govern our credit facility contain various covenants that limit our discretion in the operation of our business.

Our credit facility agreement requires us to comply with customary financial and non-financial covenants. The financial covenants require us to maintain a maximum fixed charge ratio and a maximum leverage ratio, and limit our capital expenditures. Our credit facility also includes non-financial covenants including restrictions on our ability to:

- transfer assets, enter into mergers, make acquisitions or experience fundamental changes;
- make investments, loans and advances;
- incur additional indebtedness and guarantee obligations;
- create liens on assets;
- enter into affiliate transactions;
- enter into transactions other than in the ordinary course of business;
- incur capital lease obligations;
- make capital expenditure; and
- pay dividends.

Our current principal stockholders 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 Eos Partners SBIC III, L.P., or the Eos Funds, together beneficially own approximately 36.5% of our outstanding common stock as of December 31, 2014. 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, 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, train and retain qualified personnel.

We must attract and retain qualified 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. Competition may be greater for skilled personnel, 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.

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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 officers and other key employees.

Our success depends upon the continued employment of certain members of our senior management team. We also depend upon the continued employment of the individuals that manage several of our key functional areas, including operations, business development, accounting, finance, human resources, marketing, information systems, contracting and compliance. The departure of any member of our senior management team may materially adversely affect our operations.

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. 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 $64,220,000 of goodwill and $10,347,000 of intangible assets recorded on our consolidated balance sheet at December 31, 2014.

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.

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 health care 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;

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we have a small base of registered shares of common stock consisting of the 5,400,000 shares we issued in our initial public offering (IPO), which represents approximately 49.0% of our total common shares outstanding, 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 the perception that sales could occur;

investor perception of our business and our prospects;

developments relating to litigation or governmental investigations;

changes or proposed changes in health care laws or regulations or enforcement of these laws and regulations, or announcements relating to these matters; 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 litigation has often been brought against companies following periods of volatility in the market price of their respective securities. We have been and may become involved in this type of litigation in the future. Litigation of this type is often expensive to defend and may divert our management team s attention as well as resources from the operation of our business.

We do not anticipate paying dividends on our common stock in the foreseeable future and, consequently, your ability to achieve a return on your investment will depend solely on appreciation in the price of our common stock.

We do not pay dividends on our shares of common stock and intend to retain all future earnings to finance the continued growth and development of our business and for general corporate purposes. In addition, we do not anticipate paying cash dividends on our common stock in the foreseeable future. Any future payment of cash dividends will depend upon our financial condition, capital requirements, credit facility limitations, earnings and other factors deemed relevant by our board of directors.

If securities or industry analysts fail to publish research or reports about our business or publish negative research or reports, or our results are below analysts estimates, our stock price and trading volume could decline.

The trading market for our common stock may depend in part on the research and reports that industry or securities analysts publish about us or our business. We do not have any control over these analysts. If analysts fail to publish reports on us regularly or at all, we could fail to gain visibility in the financial markets, which in turn could cause our stock price or trading volume to decline. If one or more analysts do cover us and downgrade their evaluations of our stock or our results are below analysts estimates, our stock price would likely decline. In addition, due to the small number of analysts covering us, a single comment or report from one of the analysts whether positive or negative, could result in a significant increase or decrease in our stock price.

Provisions in our organizational documents and Delaware law could delay or prevent a change in control of our company, which could adversely affect the price of our common stock.

Provisions in our amended and restated certificate of incorporation and bylaws and anti-takeover provisions of the Delaware General Corporation Law, could discourage, delay or prevent an unsolicited change in control of our company, which could adversely affect the price of our common stock. These provisions may also have the

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effect of making it more difficult for third parties to replace our current management without the consent of the board of directors. Provisions in our amended and restated certificate of incorporation and bylaws that could delay or prevent an unsolicited change in control include:

- a staggered board of directors;
- limitations on persons authorized to call a special meeting of stockholders; and
- the authorization of undesignated preferred stock, the terms of which may be established and shares of which may be issued without stockholder approval.

As a Delaware corporation, we are subject to Section 203 of the Delaware General Corporation Law. This section generally prohibits us from engaging in mergers and other business combinations with stockholders that beneficially own 15% or more of our voting stock, or with their affiliates, unless our directors or stockholders approve the business combination in the prescribed manner. However, because the Eos Funds acquired their shares prior to our IPO, Section 203 is currently inapplicable to any business combination with the Eos Funds or their affiliates. In addition, our amended and restated bylaws require that any stockholder proposals or nominations for election to our board of directors must meet specific advance notice requirements and procedures, which make it more difficult for our stockholders to make proposals or director nominations.

If we fail to achieve and maintain effective internal control over financial reporting, our business and stock price could be adversely impacted.

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 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.

As a result of our increased stock price and overall market value as of the end of the second quarter of 2013, we became subject to the requirements of Section 404 of Sarbanes-Oxley. Accordingly, we are now required to have an audit of our internal controls over financial reporting.

If we fail to satisfy the requirements of Section 404 on a timely basis, we could be subject to regulatory scrutiny and sanctions, our ability to raise capital could be impaired, investors may lose confidence in the accuracy and completeness of our financial reports and our stock price could be adversely affected.

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 the Company to increase their efforts to remain compliant, may reduce the authorizations for services to be provided, 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 there-under, the Sarbanes-Oxley Act and SEC regulations, have created uncertainty for public companies and

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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.

Declines in earnings could create future liquidity problems.

The availability of funds under the revolving credit portion of our credit facility, is based on the lesser of (i) the product of adjusted EBITDA, as defined in the credit agreement, for the most recent 12-month period for which financial statements have been delivered under the credit agreement multiplied by the specified advance multiple, up to 3.25, less the outstanding senior indebtedness and letters of credit, and (ii) $55,000,000 less the outstanding revolving loans and letters of credit. Interest on the revolving line of credit may be payable at (i) a floating rate equal to the one-month LIBOR, plus a margin of 3.5%, (ii) the LIBOR rate for term periods of one, two or three months, plus a margin of 3.5% or (iii) the base rate, plus a margin of 1.6%, where the base rate is equal to the greatest of (a) the rate of interest last quoted by The Wall Street Journal as the prime rate, (b) the sum of the federal funds rate, plus a margin of 0.5% and (c) the sum of the adjusted LIBOR that would be applicable to a loan with a one month interest period advanced on such day, plus a margin of 3%. We pay a fee equal to 0.5% per annum of the unused portion of the revolving portion of the credit facility. Issued stand-by letters of credit are charged at a rate of 2.0% per annum payable monthly. We did not have any amounts outstanding under the credit facility as of December 31, 2014, and the total availability under the revolving credit loan facility was $39,536,000 as of December 31, 2014.

The current federal and state economic and reimbursement environments and state budgetary pressures to decrease or eliminate services we provide could negatively affect our future earnings. This decrease in earnings would reduce the availability of funds under our credit facility which could have a negative impact on our future operating results.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

We do not own any real property. As of December 31, 2014, we operated at 130 leased properties including our National Support Center. Home and community based services are operated out of 129 of these facilities. As part of the sale of the Home Health Business, a portion of 10 of the facilities are currently subleased to the Purchasers. We lease approximately 59,000 square feet of office space in Downers Grove, Illinois, which serves as our corporate headquarters.

ITEM 3. LEGAL PROCEEDINGS

From time to time, we are subject to claims and suits arising in the ordinary course of our business, including claims for damages for personal injuries. In our management s opinion, the ultimate resolution of any of these pending claims and legal proceedings will not have a material adverse effect on our financial position or results of operations.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

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PART II

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

Market Information

Our common stock has been trading on The NASDAQ Global Market under the symbol ADUS since our IPO on October 27, 2009. Prior to that time, there was no public market for our common stock. The holders of our common stock are entitled to one vote per share on any matter to be voted upon by stockholders. All shares of common stock rank equally as to voting and all other matters. The table below sets forth the high and low sales prices for our common stock, as reported by The NASDAQ Global Market, for each of the periods indicated.

	High	Low
2014		
Fourth Quarter	$ 24.29	$ 24.00
Third Quarter	23.50	23.24
Second Quarter	24.32	23.51
First Quarter	29.45	28.56
2013		
Fourth Quarter	$ 32.40	$ 21.13
Third Quarter	29.94	17.62
Second Quarter	20.72	11.17
First Quarter	14.07	7.12

Holders

As of December 31, 2014, 38.6% of our shares were held by Company insiders. An additional 47.6% of the stock was held by 95 institutional investors. As of February 23, 2015, Addus HomeCare Corporation had approximately 2,200 shareholders, including 32 shareholders of record.

Dividends

Historically, we have not paid dividends on our common stock, and we currently do not intend to pay any dividends on our common stock. We currently plan to retain any earnings to support the operation, and to finance the growth, of our business rather than to pay cash dividends. Payments of any cash dividends in the future will depend on our financial condition, results of operations and capital requirements as well as other factors deemed relevant by our board of directors. Our credit facility restricts our ability to declare or pay any dividend or other distribution unless no default then exists or would occur as a result thereof, and we are in pro forma compliance with the financial covenants contained in our credit facility after giving effect thereto.

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Equity Compensation Plan

The following table presents securities authorized for issuance under our equity compensation plans at December 31, 2014.

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (1)	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights (2)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in the First Column) (3)
Equity Compensation Plans Approved by Security Holders	684,370	$ 11.43	1,389,387
Equity Compensation Plans Not Approved by Security Holders			
Total	684,370	$ 11.43	1,389,387

(1) Includes both grants of stock options and unvested share awards.

(2) Includes weighted-average exercise price of outstanding stock options only.

(3) Represents shares of common stock that may be issued pursuant to our 2006 stock incentive plan (the 2006 Plan) or our 2009 stock incentive plan (the 2009 Plan). We do not plan on issuing any further grants under the 2006 Plan. There are 825,583 shares of common stock that may be issued pursuant to the 2009 Plan.

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ITEM 6. SELECTED FINANCIAL DATA

The following table sets forth selected financial information derived from our consolidated financial statements for the periods and at the dates indicated. The information is qualified in its entirety by and should be read in conjunction with the consolidated financial statements and related notes included elsewhere in this Annual Report on Form 10-K.

	For the Years Ended December 31,				
	2014	2013	2012	2011	2010
	(Amounts In Thousands, Except Per Share Data)				
Consolidated Statements of Income Data:					
Net service revenues (1)	$ 312,942	$ 265,941	$ 244,315	$ 230,105	$ 230,099
Cost of service revenues	229,207	198,202	180,264	168,632	170,376
Gross profit	83,735	67,739	64,051	61,473	59,723
General and administrative expenses	61,834	50,118	46,362	45,858	47,042
Revaluation of contingent consideration (4)				(469)	
Gain on sale of agency			(495)		
Depreciation and amortization	3,830	2,160	2,521	3,167	3,408
Total operating expenses	65,664	52,278	48,388	48,556	50,450
Operating income from continuing operations	18,071	15,461	15,663	12,917	9,273
Interest income (5)	(18)	(188)	(155)	(2,263)	(155)
Interest expense	698	674	1,723	2,524	3,159
Total interest expense, net	680	486	1,568	261	3,004
Income from continuing operations before income taxes	17,391	14,975	14,095	12,656	6,269
Income tax expense	5,428	3,812	4,807	4,244	1,902
Net income from continuing operations	11,963	11,163	9,288	8,412	4,367
Discontinued Operations					
Net income (loss) from Home Health Business (3)	280	(980)	(1,653)	(10,393)	1,661
Gain on sale of Home Health Business, net of tax		8,962			
Earnings (losses) from discontinued operations	280	7,982	(1,653)	(10,393)	1,661
Net income (loss)	$ 12,243	$ 19,145	$ 7,635	$ (1,981)	$ 6,028
Basic income (loss) per common share:					
Continuing operations	$ 1.10	$ 1.03	$ 0.86	$ 0.78	$ 0.41
Discontinued operations	0.02	0.74	(0.15)	(0.96)	0.16
Basic income (loss) per common share:	$ 1.12	$ 1.77	$ 0.71	$ (0.18)	$ 0.57
Diluted income (loss) per common share:					
Continuing operations	$ 1.08	$ 1.01	$ 0.86	$ 0.78	$ 0.41
Discontinued operations	0.02	0.72	(0.15)	(0.96)	0.16
Diluted income (loss) per common share:	$ 1.10	$ 1.73	$ 0.71	$ (0.18)	$ 0.57
Weighted average number of common shares and potential common shares outstanding:					
Basic	10,900	10,826	10,764	10,752	10,604
Diluted	11,114	11,075	10,784	10,752	10,606

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	For the Years Ended December 31,				
	2014	2013	2012	2011	2010
	(Actual Numbers, Except Adjusted EBITDA and Billable Hours in Thousands)				
Key Metrics:					
General:					
Adjusted EBITDA (2)	$ 23,759	$ 18,796	$ 18,525	$ 16,415	$ 12,936
States served at period end	22	21	19	19	19
Locations at period end	129	121	96	96	107
Employees at period end	18,054	16,585	13,836	12,463	11,716
Operational Data:					
Average billable census	31,019	26,802	25,104	23,877	23,743
Billable hours	18,335	15,621	14,388	13,504	13,599
Average billable hours per census per month	49	49	48	47	48
Billable hours per business day	71,903	59,850	55,126	51,938	52,103
Revenues per billable hour	$ 17.07	$ 17.02	$ 16.98	$ 17.04	$ 16.92
Percentage of Revenues by Payor:					
State, local and other governmental	87%	94%	95%	94%	93%
Managed care organizations	9	1			
Private duty	3	4	4	5	6
Commercial	1	1	1	1	1

	As of December 31,				
	2014	2013	2012	2011	2010
	(Amounts In Thousands)				
Consolidated Balance Sheet Data:					
Cash	$ 13,363	$ 15,565	$ 1,737	$ 2,020	$ 816
Accounts receivable, net of allowances	68,333	61,354	71,303	72,368	70,954
Goodwill and intangibles	74,567	68,788	56,906	58,739	77,500
Total assets	180,803	163,934	149,857	154,692	166,924
Total debt	3,663		16,458	31,527	45,185
Stockholders equity	127,956	113,856	94,417	86,441	88,091

(1) Acquisitions completed in 2014 accounted for $7,536,000 of growth in net service revenues from continuing operations for the year ended December 31, 2014. Acquisitions completed in 2013 accounted for $21,945,000 and $1,692,000 of growth in net service revenues from continuing operations for the years ended December 31, 2014 and 2013, respectively.

(2) We define Adjusted EBITDA as earnings before discontinued operations, interest expense, taxes, depreciation, amortization, stock-based compensation expense and M&A expense. Adjusted EBITDA is a performance measure used by management that is not calculated in accordance with generally accepted accounting principles in the United States (GAAP). It should not be considered in isolation or as a substitute for net income, operating income or any other measure of financial performance calculated in accordance with GAAP.

Management believes that Adjusted EBITDA is useful to investors, management and others in evaluating our operating performance for the following reasons:

By reporting Adjusted EBITDA, we believe that we provide investors with insight and consistency in our financial reporting and present a basis for comparison of our business operations between current, past and future periods. Adjusted EBITDA allows management, investors and others to evaluate and compare our core operating results, including return on capital and operating efficiencies, from period to period, by removing the impact of our capital structure (interest expense), asset base (amortization

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and depreciation), tax consequences and non-cash stock-based compensation expense from our results of operations, M&A expense and also facilitates comparisons with the core results of our public company peers.

We believe that Adjusted EBITDA is a measure widely used by securities analysts, investors and others to evaluate the financial performance of other public companies, and therefore may be useful as a means of comparison with those companies, when viewed in conjunction with traditional GAAP financial measures.

We adopted Accounting Standards Codification (ASC) Topic 718 Share-Based Payment, on September 19, 2006, the effective date of our 2006 Stock Incentive Plan (the 2006 Plan), and recorded stock-based compensation expense of $827,000, $515,000, $341,000, $331,000 and $255,000 for the years ended December 31, 2014, 2013, 2012, 2011 and 2010, respectively. By comparing our Adjusted EBITDA in different periods, our investors can evaluate our operating results without stock-based compensation expense, which is a non-cash expense that is not a key measure of our operations.

In addition, management has chosen to use Adjusted EBITDA as a performance measure because the amount of non-cash expenses, such as depreciation, amortization and stock-based compensation expense, may not directly correlate to the underlying performance of our business operations, and because such expenses can vary significantly from period to period as a result of new acquisitions, full amortization of previously acquired tangible and intangible assets or the timing of new stock-based awards, as the case may be. This facilitates internal comparisons to historical operating results, as well as external comparisons to the operating results of our competitors and other companies in the home and community based services industry. Because management believes Adjusted EBITDA is useful as a performance measure, management uses Adjusted EBITDA:

as one of our primary financial measures in the day-to-day oversight of our business to allocate financial and human resources across our organization, to assess appropriate levels of marketing and other initiatives and to generally enhance the financial performance of our business;

in the preparation of our annual operating budget, as well as for other planning purposes on a quarterly and annual basis, including allocations in order to implement our growth strategy, to determine appropriate levels of investments in acquisitions and to endeavor to achieve strong core operating results;

to evaluate the effectiveness of business strategies, such as the allocation of resources, the mix of organic growth and acquisitive growth and adjustments to our payor mix;

as a means of evaluating the effectiveness of management in directing our core operating performance, which we consider to be performance that can be affected by our management in any particular period through their allocation and use of resources that affect our underlying revenue and profit-generating operations during that period;

for the valuation of prospective acquisitions, and to evaluate the effectiveness of integration of past acquisitions into our company; and

in communications with our board of directors concerning our financial performance.

Although Adjusted EBITDA is frequently used by investors and securities analysts in their evaluations of companies, Adjusted EBITDA has limitations as an analytical tool, and you should not consider it in isolation or as a substitute for analysis of our results of operations as reported under GAAP. Some of these limitations include:

Adjusted EBITDA does not reflect our cash expenditures or future requirements for capital expenditures or other contractual commitments;

Adjusted EBITDA does not reflect changes in, or cash requirements for, our working capital needs;

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Adjusted EBITDA does not reflect interest expense or interest income;

Adjusted EBITDA does not reflect cash requirements for income taxes;

although depreciation and amortization are non-cash charges, the assets being depreciated or amortized will often have to be replaced in the future, and Adjusted EBITDA does not reflect any cash requirements for these replacements;

Adjusted EBITDA does not reflect any goodwill and intangible asset impairment charges;

Adjusted EBITDA does not reflect any revaluation of contingent consideration;

Adjusted EBITDA does not reflect any stock based compensation; and

other companies in our industry may calculate Adjusted EBITDA differently than we do, limiting its usefulness as a comparative measure.

Management compensates for these limitations by using GAAP financial measures in addition to Adjusted EBITDA in managing the day-to-day and long-term operations of our business. We believe that consideration of Adjusted EBITDA, together with a careful review of our GAAP financial measures, is the most informed method of analyzing our company.

The following table sets forth a reconciliation of net income, the most directly comparable GAAP measure, to Adjusted EBITDA:

	Year Ended December 31,				
	2014	2013	2012	2011	2010
	(Amounts In Thousands)				
Reconciliation of Adjusted EBITDA to net income (loss):					
Net income (loss)	$ 12,243	$ 19,145	$ 7,635	$ (1,981)	$ 6,028
Less: (Earnings) loss from discontinued operations, net of tax	(280)	(7,982)	1,653	10,393	(1,661)
Net income from continuting operations	11,963	11,163	9,288	8,412	4,367
Interest expense, net	680	486	1,568	261	3,004
Income tax expense from continuing operations	5,428	3,812	4,807	4,244	1,902
Depreciation and amortization	3,830	2,160	2,521	3,167	3,408
M&A expenses	1,031	660			
Stock-based compensation expense	827	515	341	331	255
Adjusted EBITDA (1)	$ 23,759	$ 18,796	$ 18,525	$ 16,415	$ 12,936

(1) The selected historical Consolidated Statements of Income data for the fiscal years ended December 31, 2014, 2013, 2012, 2011 and 2010, were derived from our audited consolidated financial statements included in the Annual Report on Form 10-K for the applicable year.

(3) During December 2012, in anticipation of the sale of the Home Health Business we reported the operating results of our Home Health Business as discontinued operations. On February 7, 2013, we entered into the Home Health Purchase Agreement with the Purchasers. In

2011, we determined that all of the $15,989,000 allocated to goodwill and intangible assets for our home health reportable unit was impaired and recorded an impairment loss of $15,989,000.

(4) Adjusted EBITDA for 2011 includes a $469,000 non-cash gain for the revaluation of contingent consideration originally estimated for the purchase of assets from Advantage Health Systems, Inc.

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(5) Legislation enacted in Illinois entitles designated service program providers to receive a prompt payment interest penalty based on qualifying services approved for payment that remain unpaid after a designated period of time. As the amount and timing of the receipt of these payments are not certain, the interest income is recognized when received. We recorded no prompt payment interest income for the year ended December 31, 2014 and $185,000, $155,000, $2,263,000 and $155,000 in prompt payment interest for the years ended December 31, 2013, 2012, 2011 and 2010, respectively.

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ITEM 7. MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

You should read the following discussion together with our consolidated financial statements and the related notes included elsewhere in this Annual Report on Form 10-K. This discussion contains forward-looking statements about our business and operations. Our actual results may differ materially from those we currently anticipate as a result of the factors we describe under Risk Factors and elsewhere in this Annual Report on Form 10-K.

Overview

We are a provider of comprehensive home and community based services, which are provided primarily in the home, and focused on the dual eligible (Medicare/Medicaid) population. Our services include personal care and assistance with activities of daily living, and adult day care. Our consumers are primarily persons who are at risk of hospitalization or institutionalization, such as the elderly, chronically ill and disabled. Our payor clients include federal, state and local governmental agencies, managed care organizations, commercial insurers and private individuals. We currently provide home and community based services to over 31,000 consumers through 129 locations across 22 states, including 5 adult day centers in Illinois. Over the course of 2014, we served over 43,000 consumers.

A summary of our financial results for 2014, 2013 and 2012 is provided in the table below:

	2014	2013	2012
		(Amounts in Thousands)	
Net service revenues continuing operations	$ 312,942	$ 265,941	$ 244,315
Net service revenues discontinued operations		6,462	38,822
Net income from continuing operations	11,963	11,163	9,288
Earnings (loss) from discontinued operations	280	7,982	(1,653)
Net income	$ 12,243	$ 19,145	$ 7,635
Total assets	$ 180,803	$ 163,934	$ 149,857

Historically our services were provided under agreements with state and local government agencies established to meet the needs of our consumers. Our consumers are predominately dual eligible and as such are eligible to receive both Medicare and Medicaid funded home-based care. As a result of certain legislation enacted by the federal government, states are being incentivized to initiate dual eligible demonstration programs and other managed Medicaid initiatives, which are designed to coordinate the services provided through these two programs, with the overall objectives to better coordinate service delivery and over the long term to reduce costs. Increasingly states are implementing these managed care programs and as such are transitioning management of individuals such as our consumers to local and national managed care organizations. Under these arrangements the managed care organizations have an economic incentive to provide home and community based services to consumers as a means to better manage the acute care expenditures of their membership.

The home and community based services we provide include assistance with bathing, grooming, dressing, personal hygiene and medication reminders, and other activities of daily living. We provide these services on a long-term, continuous basis, with an average duration of approximately 20 months per consumer. Our adult day centers provide a comprehensive program of skilled and support services and designated medical services for adults in a community-based group setting. Services provided by our adult day centers include social activities, transportation services to and from the centers, the provision of meals and snacks, personal care and therapeutic activities such as exercise and cognitive interaction.

We utilize a coordinated care model that is designed to improve consumer outcomes and satisfaction, as well as lower the cost of acute care treatment and reduce service duplication. We believe this coordinated care model to be especially valuable to managed care organizations that have economic responsibility for both home

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and community services as well as acute care expenditures. Over the long term, we believe this model will be a differentiator and as a result we expect to receive increased referrals from the managed care organizations.

Through our coordinated care model, we utilize our home care aides to observe and report changes in the condition of our consumers for the purpose of early intervention in the disease process, thereby preventing or reducing the cost of medical services by avoiding emergency room visits, and/or reducing the need for hospitalization. We will coordinate the services provided by our team with those of other health care agencies as appropriate. Changes in consumers conditions are evaluated by appropriately trained managers and referred to either appropriate medical personnel including the consumers primary care physicians or managed care organizations for treatment and follow-up. We believe this approach to the care to our consumers and the integration of our services into the broader healthcare continuum are attractive to managed care organizations and others who are ultimately responsible for the healthcare needs and costs of our consumers and over time will increase our business with them.

We are investing in technology based solutions to support and facilitate our coordinated care model. We utilize an Integrated Voice Response, IVR system and smart phones applications to communicate with the homecare aides. Through these applications we are able to identify changes in health conditions with automated alerts forwarded to appropriate management team for triaging and evaluation. In addition, the technology is used to record basic transaction information about each visit including: start and end times to a scheduled shift, mileage reimbursement, text messages to the homecare aide and communication of basic payroll information. Our plans for this technology include development of a web portal to provide the ability to communicate this basic information about individual clients to the managed care organizations.

We are growing through selective acquisitions, based on an overall strategy to expand our presence in current markets and to expand our footprint in markets where the home and community business is moving to managed care organizations. We completed two acquisitions in December 2013 and June 2014 that expanded our presence in two existing markets and provided us with a base of operations in two new targeted managed care states. Effective January 1, 2015, we acquired Priority Home Health Care, Inc., a company headquartered in Cleveland, Ohio and operating six offices in the Cleveland, Akron and Columbus areas. We anticipate these transactions to be accretive to earnings in 2015.

Effective March 1, 2013, we sold substantially all of the assets used in our home health business (the Home Health Business) in Arkansas, Nevada and South Carolina, and 90% of the Home Health Business in California and Illinois, to subsidiaries of LHC Group, Inc. (the Purchasers) for a cash purchase price of approximately $20,000,000. We retained a 10% ownership interest in the Home Health Business in California and Illinois. The assets sold included 19 home health agencies and two hospice agencies in five states. Effective December 30, 2013, we sold one home health agency in Pennsylvania for approximately $200,000. The results of the Home Health Business sold and one additional agency in Idaho which was closed in November 2012, are reflected as discontinued operations for all periods presented herein. Continuing operations include the results of operations previously included in our home & community segment and three agencies previously included in our home health segment. Following the sale of the Home Health Business, we manage and internally report our business in one segment. Because regulatory requirements in Delaware and Indiana require home and community based services to be provided by a licensed home health agency, we will continue to provide limited home health services reimbursable by Medicare in these agencies in order to maintain these licenses. In addition, Priority Home Health Care maintains enrollment in but does not derive significant revenues from Medicare.

We believe the sale of the Home Health Business substantially positioned us for future growth. The sale allowed us to focus both management and financial resources on changes in the home and community based services industry and to address and the needs of managed care organizations as they become more responsible for state sponsored programs. We have improved our financial performance by concentrating our efforts on our home and community business that is growing and profitable. We have improved our overall financial position by eliminating our debt and adding to our cash reserves.

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Business

The results of the Home Health Business sold are reflected as discontinued operations for all periods presented herein. Continuing operations include the results of operations previously included in our home and community segment and three agencies previously included in our home health segment. Following the sale of the Home Health Business, we manage and internally report our business in one segment. As of December 31, 2014, we provided our home and community based services through 129 locations across 22 states including 5 adult day centers in Illinois.

Our payor clients are principally federal, state and local governmental agencies and, increasingly, managed care organizations. The federal, state and local programs under which the agencies operate are subject to legislative, budgetary and other risks that can influence reimbursement rates. We are beginning to experience and anticipate a further transition of business from government payors to managed care organizations with which we are seeking to grow our business given our emphasis on coordinated care and the prevention of acute care. Managed care organizations are commercial insurance carriers who are under contract with various federal and state governmental agencies to manage the provision of home and community based services. Their objective is to lower total health care costs by integrating the provision of home and community based services with those benefit programs responsible for the provision of acute care services to their consumers. We are also seeking to grow our private duty business. Our commercial insurance carrier payor clients are typically for-profit companies and are continuously seeking opportunities to control costs.

For the year ended December 31, 2014, 2013 and 2012, our payor revenue mix for continuing operations was:

	Year Ended December 31,		
	2014	**2013**	**2012**
State, local and other governmental programs	86.4%	94.1%	94.9%
Managed care organizations	9.1	1.0	0.0
Private duty	3.4	3.9	4.1
Commercial	1.1	1.0	1.0
	100.0%	100.0%	100.0%

We derive a significant amount of our net service revenues from our continuing operations in Illinois, which represented 60.6%, 65.5% and 63.7% and of our total net service revenues from continuing operations for the years ended December 31, 2014, 2013 and 2012, respectively.

A significant amount of our net service revenues from continuing operations are derived from one payor client, the Illinois Department on Aging, which accounted for 53.2%, 58.8% and 57.3% of our total net service revenues from continuing operations for the years ended December 31, 2014, 2013 and 2012, respectively.

We also measure the performance of our business using a number of different metrics. We consider billable hours, billable hours per business day, revenues per billable hour and the number of consumers, or census.

Components of our Statements of Income

Net Service Revenues

We generate net service revenues from continuing operations by providing our services directly to consumers. We receive payment for providing such services from our payor clients, including federal, state and local governmental agencies, commercial insurers and private consumers.

Net service revenues from continuing operations are typically generated based on services rendered and reimbursed on an hourly basis. Our net service revenues from continuing operations were generated principally through reimbursements by state, local and other governmental programs which are partially funded by Medicaid

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programs, managed care organizations and to a lesser extent from private duty and insurance programs. Net service revenues from continuing operations are principally provided based on authorized hours, determined by the relevant agency, at an hourly rate, which is either contractual or fixed by legislation or contract, and recognized as net service revenues at the time services are rendered.

Cost of Service Revenues

We incur direct care wages, payroll taxes and benefit-related costs from continuing operations in connection with providing our services. We also provide workers compensation and general liability coverage for these employees.

Employees are also reimbursed for their travel time and related travel costs.

General and Administrative Expenses

Our general and administrative expenses from continuing operations consist of expenses incurred in connection with our activities and as part of our central administrative functions.

Our general and administrative expenses from continuing operations consist principally of supervisory personnel, care coordination and office administration costs. These expenses include wages, payroll taxes and benefit-related costs; facility rent; operating costs such as utilities, postage, telephone and office expenses; and bad debt expense. We have initiated efforts to centralize administrative tasks currently conducted at the branch locations. The costs related to these initiatives are included in the general and administrative expenses from continuing operations. Other centralized expenses from continuing operations include administrative departments of accounting, information systems, human resources, billing and collections and contract administration, as well as national program coordination efforts for marketing and private duty. These expenses primarily consist of compensation, including stock-based compensation, payroll taxes, and related benefits; legal, accounting and other professional fees; rents and related facility costs; and other operating costs such as software application costs, software implementation costs, travel, general insurance and bank account maintenance fees.

Depreciation and Amortization Expenses

We amortize our intangible assets with finite lives, consisting of customer and referral relationships, trade names, trademarks and non-compete agreements, principally using accelerated methods based upon their estimated useful lives. Depreciable assets consist principally of furniture and equipment, network administration and telephone equipment, and operating system software. Depreciable and leasehold assets are depreciated or amortized on a straight-line method over their useful lives or, if less and if applicable, their lease terms.

Interest Income

Legislation enacted in Illinois entitles designated service program providers to receive a prompt payment interest penalty based on qualifying services approved for payment that remain unpaid after a designated period of time. As the amount and timing of the receipt of these payments are not certain, the interest income is recognized when received and reported in the statement of operations as interest income. While we may be owed additional prompt payment interest, the amount and timing of receipt of such payments remains uncertain and we have determined that we will continue to recognize prompt payment interest income when received.

Interest Expense

Interest expense from continuing operations consists of interest costs on our credit facility, capital lease obligations and other debt instruments.

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Income Tax Expense

All of our income from continuing operations is from domestic sources. We incur state and local taxes in states in which we operate. The differences from the federal statutory rate of 34.5% and 35.0% in 2014 and 2013, respectively, are principally due to the inclusion of state taxes and the use of federal employment tax credits that lower our effective tax rate.

Discontinued Operations

Discontinued operations consists of the results of operations, net of tax for our Home Health Business that was sold effective March 1, 2013 and the results of operations for an agency in Pennsylvania that was sold on December 30, 2013 and an agency in Idaho that was closed in November 2012.

Results of Operations

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

The following table sets forth, for the periods indicated, our consolidated results of operations.

	2014		2013		Change	
	Amount	Net Service Revenues	Amount	Net Service Revenues	Amount	%
	(Amounts In Thousands, Except Percentages)					
Net service revenues	$ 312,942	100.0%	$ 265,941	100.0%	$ 47,001	17.7%
Cost of service revenues	229,207	73.2	198,202	74.5	31,005	15.6
Gross profit	83,735	26.8	67,739	25.5	15,996	23.6
General and administrative expenses	61,834	19.8	50,118	18.8	11,716	23.4
Depreciation and amortization	3,830	1.2	2,160	0.8	1,670	77.3
Total operating expenses	65,664	21.0	52,278	19.8	13,386	25.6
Operating income from continuing operations	18,071	5.8	15,461	5.8	2,610	16.9
Interest income	(18)		(188)	(0.1)	170	(90.4)
Interest expense	698	0.2	674	0.3	24	3.6
Total interest expense, net	680	0.2	486	0.2	194	39.9
Income from continuing operations before income taxes	17,391	5.6	14,975	5.6	2,416	16.1
Income tax expense	5,428	1.7	3,812	1.4	1,616	42.4
Net income from continuing operations	11,963	3.8	11,163	4.2	800	7.2
Discontinued operations:						
Earnings from Home Health Business, net of tax	280	0.1	7,982	3.0	(7,702)	(96.5)
Net income	$ 12,243	3.9%	$ 19,145	7.2%	$ (6,902)	(36.1)%
Business Metrics (Actual Numbers, Except Billable Hours in Thousands)						
Average billable census	31,019		26,802		4,217	15.7%
Billable hours	18,335		15,621		2,714	17.4
Average billable hours per census per month	49		49			
Billable hours per business day	71,903		59,850		12,053	20.1

Revenues per billable hour	$ 17.07	$ 17.02	$ 0.05	0.3%

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Net service revenues from state, local and other governmental programs accounted for 86.4% and 94.1% of net service revenues for 2014 and 2013, respectively. Managed care organizations accounted for 9.1% and 1.0% of net serve revenues in 2014 and 2013 respectively, with private duty and commercial payors accounting for the remainder of net service revenues.

Net service revenues increased $47,001,000 or 17.7%, to $312,942,000 for 2014 compared to $265,941,000 for the same period in 2013. The increase was primarily due to a 15.7% increase in average billable census, of which 45.6% is same store census growth and 54.4% is related to acquisitions.

Gross profit, expressed as a percentage of net service revenues, increased to 26.8% for 2014, from 25.5% in 2013. The increase was primarily due to lower than anticipated workers compensation expense and recent acquisitions with higher margins.

General and administrative expenses, expressed as a percentage of net service revenues increased to 19.8% for 2014, from 18.8% in 2013. General and administrative expenses increased to $61,834,000 in 2014 as compared to $50,118,000 in 2013. The increase in general and administrative expenses was due to an increase in expenses related to our acquisitions, transaction costs for acquisitions and increased expenditures related to information technology, Sarbanes-Oxley compliance efforts and legal and consulting fees for the year ended December 31, 2014 as compared to 2013.

Depreciation and amortization, expressed as a percentage of net service revenues, increased to 1.2 % from 0.8 % for the year ended December 31, 2014 and 2013, respectively. Amortization of intangibles, which are principally amortized using accelerated methods, totaled $2,414,000 and $1,346,000 for the year ended December 31, 2014 and 2013, respectively.

Interest Income

Legislation enacted in Illinois entitles designated service program providers to receive a prompt payment interest penalty based on qualifying services approved for payment that remain unpaid after a designated period of time. As the amount and timing of the receipt of these payments are not certain, the interest income is recognized when received and reported in the income statement caption, interest income . We received no prompt payment interest in 2014 and $185,000 in 2013. We are not anticipating being owed additional prompt payment interest for the state s fiscal year ending June 30, 2014. While we may be owed additional prompt payment interest in the future, the amount and timing of receipt of such payments remains uncertain and we have determined that we will continue to recognize prompt payment interest income when received. The state amended its prompt payment interest terms, effective July 1, 2011, which changed the measurement period for outstanding invoices from a 60-day to a 90-day outstanding period.

Interest Expense, Net

Interest expense, net, increased to $680,000 from $486,000 for the year ended December 31, 2014 as compared to December 31, 2013. The increase is primarily as a result of the capital lease agreements entered into on July 12 and September 11, 2014 as described in the Notes to Consolidated Financial Statements 8. *Long-Term Debt*.

Income Tax Expense

Our effective tax rates from continuing operations for 2014 and 2013 were 31.2% and 25.5%, respectively. The principal difference between the federal and state statutory rates and our effective tax rate is the use of federal employment opportunity tax credits.

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Discontinued Operations

Effective March 1, 2013, we sold substantially all of the assets used in our Home Health Business as described in Item 1. Therefore, we have segregated the Home Health Business operating results and presented them separately as discontinued operations for all periods presented (see note 2 Discontinued Operations of the Notes to the Consolidated Financial Statements included elsewhere herein).

The table below summarizes the results of discontinued operations.

	2014	2013
	(Amounts In Thousands)	
Net service revenues	$	$ 6,462
Cost of service revenues		3,692
Gross profit		2,770
General and administrative expenses	(470)	4,442
Depreciation and amortization		
Operating income (loss) from discontinued operations	470	(1,672)
Income tax (benefit)	190	(692)
Earnings (loss) from discontinued operations	$ 280	$ (980)

No revenues were recorded for the year ended December 31, 2014 related to the Home Health Business because that business was sold. We retained the working capital of our Home Health Business when it was sold. The net earnings from discontinued operations for the year ended December 31, 2014 represents the final settlement of previously estimated working capital amounts. The losses for the year ended December 31, 2013 were primarily due to the wind down of our Home Health Business.

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Results of Operations

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

The following table sets forth, for the periods indicated, our consolidated results of operations.

	2013		2012		Change	
	Amount	% of Net Service Revenues	Amount	% of Net Service Revenues	Amount	%
	(Amounts In Thousands, Except Percentages)					
Net service revenues	$ 265,941	100.0%	$ 244,315	100.0%	$ 21,626	8.9%
Cost of service revenues	198,202	74.5	180,264	73.8	17,938	10.0
Gross profit	67,739	25.5	64,051	26.2	3,688	5.8
General and administrative expenses	50,118	18.8	46,362	19.0	3,756	8.1
Gain on sale of agency			(495)	(0.2)	495	*
Depreciation and amortization	2,160	0.8	2,521	1.0	(361)	(14.3)
Total operating expenses	52,278	19.7	48,388	19.8	3,890	8.0
Operating income from continuing operations	15,461	5.8	15,663	6.4	(202)	(1.3)
Interest income	(188)	(0.1)	(155)	(0.1)	(33)	21.3
Interest expense	674	0.3	1,723	0.7	(1,049)	(60.9)
Total interest expense, net	486	0.2	1,568	0.6	(1,082)	(69.0)
Income from continuing operations before income taxes	14,975	5.6	14,095	5.8	880	6.2
Income tax expense	3,812	1.4	4,807	2.0	(995)	(20.7)
Net income from continuing operations	11,163	4.2	9,288	3.8	1,875	20.2
Discontinued operations:						
Earnings (loss) from home health business, net of tax	7,982	3.0	(1,653)	(0.7)	9,635	(582.9)
Net income	$ 19,145	7.2%	$ 7,635	3.1%	$ 11,510	150.8%

Business Metrics (Actual Numbers, Except Billable Hours i