Addus HomeCare Corp
Form 10-K
March 14, 2018
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2017

OR

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

For the transition period from to

Commission file number 001-34504

ADDUS HOMECARE CORPORATION

(Exact name of registrant as specified in its charter)

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

469-535-8200

(Registrant s telephone number, including area code)

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

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

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

None

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

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

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

Indicate by check mark whether the registrant has submitted electronically 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 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.

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

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

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

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

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the registrant, based on the last sale price on The Nasdaq Global Market on June 30, 2017 (the last business day of the registrant s most recently completed second fiscal quarter) was $287,192,965.

As of March 1, 2018, there were 11,630,888 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Certain portions of the registrant s Definitive Proxy Statement for its 2018 Annual Meeting of Stockholders (which is expected to be filed with the Commission within 120 days after the end of the registrant s 2017 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, estimates, may, might, would, should and similar ex 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, managed care organizations and other government program payment rates, changes in or our failure to comply with existing federal and state laws or regulations or the inability to comply with new government laws or regulations on a timely basis, competition in the personal care service industry, the geographical concentration of our operations, changes in the case mix of consumers and payment methodologies, operational changes resulting from the assumption by managed care organizations of responsibility for managing and paying for personal care services to consumers, the nature and success of future financial and/or delivery system reforms, changes in estimates and judgments associated with critical accounting policies, our ability to maintain or establish new referral sources, our ability to renew significant agreements or groups of agreements, our ability to attract and retain qualified personnel, city and state minimum wage pressure, 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 ability to access financing through the capital and credit markets, our ability to meet debt service requirements and comply with covenants in debt agreements, business disruptions due to natural disasters or acts of terrorism, our ability to integrate and manage our information systems, our expectations regarding the size and growth of the market for our services, the acceptance of privatized social services, our expectations regarding changes in reimbursement rates, eligibility standards and limits on services imposed by state governmental agencies, the potential for litigation, our ability to successfully implement our personal care model to grow our business, our ability to continue identifying, pursuing and integrating acquisition opportunities and expand into new geographic markets, the impact of acquisitions 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 ou consolidated subsidiaries and Holdings refers to Addus HomeCare Corporation. When we refer to 2017, 2016 and 2015, 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, 2017 as filed with the SEC, including all exhibits, is available on our internet website at http://www.addus.com on the Investor 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 operate as one business segment and are a provider of comprehensive personal care services, which are principally provided in the home. Our personal care services provide assistance with activities of daily living. 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. As of December 31, 2017, we provided personal care services to over 34,000 consumers in 24 states through 116 offices. For the years ended December 31, 2017, 2016 and 2015, we served approximately 51,000, 50,000 and 48,000 discrete consumers, respectively.

A summary of our financial results for 2017, 2016 and 2015 is provided in the table below. Total assets has been updated to reflect the correction described in Note 2 of the Notes to Consolidated Financial Statements.

	For the Years Ended December 31,		
	2017	2016	2015
	(Amounts in Thousands)		
Net service revenues	$ 425,715	$ 400,688	$ 336,815
Net income from continuing operations	13,461	11,927	11,353
Earnings from discontinued operations, net of tax	147	97	270
Net income	$ 13,608	$ 12,024	$ 11,623
Total assets	$ 267,110	$ 229,864	$ 184,631

Our services are provided predominantly in the home under federal, state and local government programs. Our consumers are predominately dual eligible, meaning they are eligible to receive both Medicare and Medicaid benefits. The federal government permits states to initiate dual eligible demonstration programs and other managed Medicaid initiatives designed to coordinate the services provided through Medicare and Medicaid, with the overall objective of improving care quality and reducing costs. States are increasingly implementing managed care programs to deliver care for Medicaid enrollees. Managed care organizations have an economic incentive to better manage the healthcare expenditures of their membership, and therefore seek to provide care in a more cost-effective setting, such as a patient s home. Managed care revenues account for 33.1%, 26.1% and 18.3% of our revenue mix for 2017, 2016 and 2015, respectively.

The personal care services we provide include assistance with bathing, grooming, oral care, assistance with feeding and dressing, medication reminders, meal planning and preparation, housekeeping and transportation services and other activities of daily living. We provide these non-medical services on a long-term, continuous basis, with an average duration of approximately 26 months per consumer.

Our services and model play a number of crucial roles in the overall healthcare continuum. By providing non-medical services in the home to the elderly and others who require long-term service and support with the activities of daily living, we can lower the cost of chronic and acute care treatment, in part by delaying or eliminating the need for care in more expensive settings. We also can reduce service duplication with traditional Medicare home health. In addition,

we utilize home care aides to observe and report changes in the condition of our consumers for the purpose of early intervention in the disease process, with the goal of reducing the cost of medical services by preventing unnecessary emergency room visits and/or hospital admissions and re-admissions. We coordinate the services provided by our team with those of other healthcare agencies as appropriate. Changes in a consumer s conditions are evaluated by appropriately trained managers and may result in a report to the consumer s case manager at a managed care organization or other payor. Our model also is designed to improve consumer outcomes and satisfaction by providing care in the preferred setting of the home and in providing opportunities to improve the consumer s conditions and allow early intervention as indicated.

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We believe that this model makes us a valuable partner to managed care organizations by providing significant value. Our consumers are predominately dual eligible, meaning they are eligible to receive both Medicare and Medicaid benefits. With permission from the federal government, states are increasingly implementing managed care programs to deliver care for Medicaid enrollees, with the result that managed care organizations are increasingly responsible for the healthcare needs and the related healthcare costs of our consumers. These managed care organizations have an economic incentive to better manage the healthcare expenditures of their membership, including the provision of care in lower cost settings and improved outcomes. We believe that our model is very well positioned to assist in meeting those challenges while also improving consumer satisfaction and as a result we expect increased referrals from managed care organizations.

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

In addition to our organic growth, we have been growing through acquisitions that have expanded our presence in current markets or facilitated our entry into new markets where the personal care business has been moving to managed care organizations. We completed six acquisitions during the years ended December 31, 2017, 2016 and 2015.

In 2013, we sold substantially all of the assets of our home health skilled nursing business (the Home Health Business) in Arkansas, Nevada, South Carolina and Pennsylvania, and 90% of the Home Health Business in California and Illinois. Effective October 1, 2017, we sold our remaining 10% ownership interest in the Home Health Business in California and Illinois. The results of the Home Health Business sold are reflected as discontinued operations for all periods presented herein. Following the sale of the Home Health Business, we have managed and internally reported our business in one segment. We maintain licensure as a Medicare home health agency in Ohio and Delaware in connection with providing services in those states.

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 6801 Gaylord Parkway, Suite 110, Frisco, TX 75034. Our telephone number is 469-535-8200. Our internet address is www.addus.com. Through our 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 personal care services to the elderly and other infirm adults who require long-term care and assistance with activities of daily living. Personal care services are a significant component of home and community-based services (HCBS), which have grown in significance and demand in recent years. This trend is expected to continue as a result of the aging of the U.S. population, increased life expectancy, and increased opportunities for individuals to receive home-based care as an alternative to institutionalization.

Reported federal and state Medicaid expenditures for fee-for-service personal care services amounted to over $28.0 billion in calendar year 2015, the most recent year for which data is available, reflecting an increase of $6.2 billion from 2012.

Many states use both fee-for-service and managed care delivery models for personal care services, and the number of beneficiaries served through managed care continues to grow. As of July 2017, 39 states contracted with risk-based managed care organizations to serve their Medicaid enrollees, with 16 of those states enrolling at

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least 75% of all elderly beneficiaries or those with disabilities in managed care organizations. In 23 states, some or all long-term services and support is covered through Medicaid managed care arrangements. As of federal fiscal year 2016, the Centers for Medicare & Medicaid Services (CMS) requires states to identify and estimate their institutional and HCBS expenditures within Medicaid managed care.

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

Historically, there were limited barriers to entry in the personal care services industry. As a result, the personal care services industry developed in a highly fragmented manner, with many small local providers. Few companies have a significant market share across multiple regions or states. The lack of licensure or certification requirements in some states makes it difficult to estimate the number of personal care services agencies. However, projections published by the Centers for Disease Control and Prevention in 2016 indicate that social workers and home health and personal care aides are among the long-term care services occupations that will grow the most by 2030.

The personal care services industry has become subject to increased regulation. At the federal level, recent efforts have focused on improved coordination of regulation across the various types of Medicaid programs through which personal care services are offered. 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 regulatory requirements could lead to the termination of rights to participate in federal and state-sponsored programs and the suspension or revocation of licenses. We believe new licensing requirements and regulations, including Electronic Visit Verification, 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 discourage new providers and may encourage industry consolidation.

The Medicare-Medicaid Coordination Office was established within CMS to effectively improve services for consumers who are eligible for both Medicare and Medicaid, also known as dual eligibles, and improve coordination between the federal and state governments in the delivery of items and services to which they are entitled. The Medicare-Medicaid Coordination Office works with state Medicaid agencies, and other federal and state agencies, as well as physicians and others, to make available technical assistance and educational tools to improve care coordination between Medicare and Medicaid, to reduce costs and improve beneficiary experience while reducing administrative and regulatory barriers between the programs. For example, the Financial Alignment Initiative is a demonstration project that tests capitated models and managed fee-for-service models of integrated care and payment for benefits provided to dual eligibles. Nationally, CMS approved demonstrations in 13 states, including several of the states in which we provide services.

We believe that our personal care program and our technology make us well-suited to partner with managed care organizations to address the needs of the dual eligible population. These programs reduce service duplication between personal care programs and traditional Medicare home health. We believe that our ability to identify changes in our consumers health and condition before acute intervention is required will lower the overall cost of care. We believe this approach to care delivery and the integration of our services into the broader healthcare continuum are particularly attractive to managed care organizations and others who are ultimately responsible for the healthcare needs of our consumers and over time will increase our business with them.

Our Growth Strategy

Our net service revenues growth is closely correlated with the number of consumers to whom we provide our services. Our continued growth depends on our ability to provide consistently high quality care, maintain our existing payor relationships, establish relationships with new payors and increase our referral sources. Our continued growth is also dependent upon the authorization by state agencies of new consumers to receive our

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services. We believe there are several market opportunities for growth. The U.S. population of persons aged 65 and older is growing, and the U.S. Census Bureau estimates that this population will more than double by 2050. Additionally, we believe the overwhelming majority of individuals in need of care generally prefer to receive care in their homes. Finally, we believe the provision of personal care services is more cost-effective than the provision of similar services in institutional settings for long-term care. 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 determined by our consumers. The home care aides are required to perform tasks as defined within the individual plan of care. We monitor the performance of our home care aides through regular supervisory visits in the homes of consumers.

Drive growth in existing markets. We have grown in our existing markets by enhancing the breadth of our services, increasing the number of referral sources and leveraging and expanding our payor relationships in our markets. We have achieved this growth by educating referral sources about the benefits of our services.

Market the benefits of our personal care model to managed care organizations serving the dual eligible populations. Our personal 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 seek to partner with managed care organizations to address the needs of the dual eligible population. We believe that our approach to the provision of care to our consumers and the integration of our services into the broader healthcare industry are particularly attractive to managed care organizations and others who are ultimately responsible for both the healthcare needs and related costs of our consumers.

Grow through acquisitions**.** Our strategy is to expand within our existing markets and to enter new markets through acquisitions.

Our Services

As of December 31, 2017, we delivered services to our consumers in 24 states through 116 individual agencies. Our services, which include non-medical personal care services, are provided to consumers who are unable to independently perform some or all of their activities of daily living. Without our services, many of our consumers would be at risk of placement in a long-term care institution.

Personal care services are primarily provided to older adults and younger disabled persons in their homes on an as-needed, hourly basis. Typically provided by home care aides, our services are needed when assistance from family or community members is insufficient or when caregivers need respite. Personal care services include assistance with bathing, grooming, oral care, assistance with feeding and dressing, medication reminders, meal planning and preparation, housekeeping and transportation services and other activities of daily living. Many consumers need such services on a long-term basis to address chronic or acute conditions. Each payor client establishes its own eligibility standards, determines the type, amount, duration and scope of services, and establishes the applicable reimbursement rate in accordance with applicable law, regulations or contracts. We provide personal care services for an average duration of approximately 26 months per consumer.

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

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Most of our services are provided pursuant to agreements with state and local governmental social and aging service agencies. These agreements generally have an initial term of one to two years and may be terminated with 60 days notice. They are typically renewed for one to five-year terms, provided that we have complied with licensing, certification and program standards, and other regulatory requirements. Reimbursement rates and methods vary by state and service type, but are typically based on an hourly or unit-of-service basis. Managed care organizations are becoming an increasing portion of our payor mix as states shift from the management of their programs to managed care organizations. In 2017, approximately 64.2% of our net service revenues were derived from state and local government programs, with 33.1% derived from managed care organizations, while approximately 2.7% of net service revenues were derived from commercial insurance programs and private pay consumers.

For 2017, 2016 and 2015, our revenue mix by payor type was as follows:

	Year Ended December 31,		
	2017	2016	2015
State, local and other governmental programs	64.2%	70.4%	77.7%
Managed care organizations	33.1	26.1	18.3
Private pay	2.1	2.4	3.0
Commercial insurance	0.6	1.1	1.0
	100.0%	100.0%	100.0%

We derive a significant amount of our net service revenues from our operations in Illinois, New York and New Mexico. The percentages of total revenue for each of these significant states for 2017, 2016 and 2015 were as follows:

	% of Total Revenue for the Years Ended December, 31		
State	2017	2016	2015
Illinois	52.6%	53.6%	59.5%
New York	13.7	12.9	
New Mexico	8.8	7.5	8.5

A significant amount of our net service revenues are derived from one specific payor client, the Illinois Department on Aging, which accounted for 36.6%, 42.1% and 48.8% of our total net service revenues for 2017, 2016 and 2015, 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 personal care 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 personal care service providers, home health providers, private caregivers, larger publicly held companies, privately held companies, privately held single-site agencies, hospital-based agencies, not-for-profit organizations, community-based organizations, managed care organizations and self-directed care programs. In addition, certain governmental payors contract for services with independent providers such that our relationships with

these payors are not exclusive. We have experienced, and expect to continue to experience, competition from new entrants into our markets. Increased competition may result in pricing pressures, loss of or failure to gain market share or loss of consumers or payors, any of which could harm our business. In addition, some of our competitors may have greater financial, technical, political and marketing resources, and name recognition with consumers and payors.

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Sales and Marketing

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

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

We receive substantially all of our consumers through third-party referrals. 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 in our target communities in order to inform the community about state and locally-subsidized care options and to communicate our role in providing quality personal care services. We also utilize consumer-directed sales, marketing and advertising programs designed to attract consumers.

Payment for Services

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

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

	Year Ended December 31,		
Payor	**2017**	**2016**	**2015**
Illinois Department on Aging	36.6%	42.1%	48.8%
Other federal, state and local payors	27.6	28.3	28.9
Managed care organizations	33.1	26.1	18.3
Private pay	2.1	2.4	3.0
Commercial insurance	0.6	1.1	1.0
Total	100.0%	100.0%	100.0%

Illinois Department on Aging

We provide personal care services pursuant to agreements with the Illinois Department on Aging, which coordinates programs and community-based services intended to improve quality of life and preserve the independence of older persons. The Illinois Department on Aging is funded by Medicaid and general revenue funds of the State of Illinois, and also receives funding available under the Federal Older Americans Act (OAA). OAA is coordinated through 13 Area Agencies on Aging, and the delivery of services is privatized

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through senior centers and other social service agencies. The Department on Aging s Community Care Program provides adult day services, in-home services, emergency home response and case management to individuals age 60 and over. Some of these services are provided through Medicaid waivers granted by CMS. Enrollment in the Community Care Program has grown significantly over the last ten years.

Consumers are identified by case managers contracted independently with the Illinois Department on Aging. Once a consumer has been evaluated and determined to be eligible for a program, 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.

The State of Illinois s payments for non-Medicaid consumers have been delayed in the past and may continue to be delayed in the future due to budget disputes that began in 2015. The State of Illinois did not adopt a comprehensive budget for fiscal years 2016 or 2017. On July 6, 2017, the State of Illinois passed a state budget for fiscal year 2018, which began on July 1, 2017. This budget authorized the Illinois Department on Aging to pay for services the Company rendered to non-Medicaid consumers in prior fiscal years. The Company began receiving the delayed payments in July 2017.

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, and subject to federal oversight, each state establishes its own eligibility standards, determines the type, amount, duration and scope of services, sets the rate of payment for services and administers its own program. States typically cover Medicaid beneficiaries for intermittent home health services as well as continuous services for children and young adults with complicated medical conditions, and certain states cover home and community-based services for seniors and people with disabilities.

Currently, personal care services and other HCBS are largely reimbursed on a fee-for-service basis. States receive permission from CMS to provide personal care services under waivers of traditional Medicaid requirements. In an effort to control escalating Medicaid costs, states are increasingly requiring Medicaid beneficiaries to enroll in managed care plans for better coordination of HCBS and health care services. A report issued by the Illinois Department on Aging in 2016 indicates that over 60% of the state s Medicaid population is enrolled in a care coordination program, many of which are provided through various managed care entities including managed care organizations. Beginning January 1, 2018, Illinois is transitioning Medicaid beneficiaries to the HealthChoice Illinois statewide managed care program, which is serviced by various managed care organizations. The Illinois Department of Healthcare and Family Services expects that managed care will expand through the HealthChoice Illinois program to reach approximately 80% of Medicaid enrollees.

Veterans Health Administration

The Veterans Health Administration operates the nation s largest integrated healthcare system, with more than 1,700 sites of care, and provides healthcare benefits, including personal care services, to eligible military veterans. The

Veterans Health Administration provides funding to regional and local offices and facilities that support the in-home care needs of eligible aged and disabled veterans. Services are funded by local Veterans Medical Centers and the aid and attendance pension, which reimburses veterans for their otherwise unreimbursed health and long-term care expenses. We currently have relationships and agreements with the Veterans Health Administration to provide personal care services in several states, with the most Veterans Health Administration services being provided to eligible consumers in Illinois, Arkansas and California.

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Other

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

Managed Care Organizations

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

Commercial Insurance

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

Private Pay

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

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 (the Purchasers). We held a 10% ownership interest in the Home Health Business in California and Illinois from March 1, 2013 to October 1, 2017, when we sold our interest to the Purchasers. In addition, not included in the sale were four home health agencies in Delaware, Idaho, Indiana and Pennsylvania. Subsequently, Idaho, Indiana and Pennsylvania were either closed or sold to another purchaser.

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 Closing to meet the requirements of such government programs, or any violation prior to the Closing of any healthcare laws. Such liabilities include amounts to be recouped by, or repaid to, such government programs as a result of improperly submitted claims for reimbursement or those discovered as a result of audits by investigative agencies. All services that we have provided that have been or may be reimbursed by Medicare are subject to retroactive 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.

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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, including the employees in our national support center, as of December 31, 2017:

	Full-time	Part-time	Total
Personal care services	3,203	22,673	25,876
National support centers	214	7	221
	3,417	22,680	26,097

Our home care aides provide substantially all of our services and comprise approximately 97.1% of our total workforce. They undergo a criminal background check and are provided with pre-service training and orientation and an evaluation of their skills. In many cases, home care aides are also required to attend ongoing in-services education. In certain states, our home care aides are required to complete certified training programs and maintain a state certification. Approximately 60.4% of our total employees are represented by labor unions. We maintain strong working relationships with these labor unions. We have a national relationship with the Service Employees International Union (the SEIU), as well as numerous agreements with local SEIU unions which are renegotiated from time to time.

Technology

We license 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 assisting with the compliance of our operating systems with the Health Insurance Portability and Accountability Act of 1996, 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. Horizon Homecare is hosted by McKesson in a secure data center, which provides multiple redundancies for storage, power, bandwidth and security. Using this technology, we are working to standardize the care delivered across our network of offices and monitor our performance and consumer outcomes.

We license the QlikView Business Intelligence software to provide historical, current, and forward-looking operational performance to identify and create or improve our current business strategies. This software has been integrated with our Horizon platform to provide high level historical and current analytical views to measure performance and better understand the factors that are driving our key metrics in a real-time manner. We are also disseminating detailed visit information to local management to optimize their servicing needs.

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To address our human resources and payroll processing needs, we converted our payroll system from the Ultipro system by Ultimate Software to ADP on July 1, 2017. ADP provides integrated human resource and payroll software, which supports our management with the systems and reporting necessary to manage our employees. Additionally, through ADP, we added significant electronic support systems to our recruiting, human resources, payroll and accounting support functions. ADP aids our efforts to comply with state and regulatory requirements, supplies self-service capabilities to various levels within the Company and easily interfaces new entities into the ADP systems. ADP is integrated with Horizon 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.

In some states, we utilize commercial vendors for electronic visit verification pursuant to which our personal care service aides record their beginning and ending times for services provided through either an IVR system or cell phone based system. All Company-provided mobile devices to CellTrak for all mobile and IVR traffic unless otherwise mandated by a state to utilize a specific technology.

Government Regulation

Overview

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

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 administrative, civil and criminal penalties. Federal regulations set forth eligibility requirements for personal care services provided under Medicaid.

Health Reform

The U.S. Congress and certain state legislatures have passed many laws and regulations in recent years intended to effect major change within the national healthcare system, the most prominent of which is the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, ACA). As currently structured, the ACA affects how healthcare services are delivered and reimbursed through the expansion of public and private health insurance coverage, reduction of growth in Medicare and Medicaid program spending, and the establishment and expansion of programs that tie reimbursement to quality and integration. It includes several provisions that may affect reimbursement for our services. However, the future of the ACA is unclear. The current presidential administration and certain members of Congress have stated their intent to repeal or make significant changes to the ACA, its implementation or interpretation, which may result in changes to Medicaid. Some of the states

use or have applied to use Medicaid

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waivers grated by CMS to implement expansion provisions, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. CMS administrators have indicated that they intend to increase state flexibility in the administration of Medicaid programs.

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

Permits and Licensure

Our personal care services are authorized and/or licensed under various state and county requirements. Although our home care aides are generally not subject to licensure requirements, certain states require them to complete training programs and maintain state certification. We are currently licensed appropriately as 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.

Fraud and Abuse Laws

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

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

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