Addus HomeCare Corp
Form ARS
May 06, 2014
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ADDUS HOMECARE CORPORATION

2013 ANNUAL REPORT

NASDAQ:ADUS

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The graph below matches the cumulative 50-Month total return of holders of Addus HomeCare Corporation s common stock with the cumulative total returns of the NASDAQ Composite index, the NASDAQ Health Services index and a customized peer group of four companies that includes: Almost Family Inc., Amedisys Inc., Gentiva Health Services Inc. and LHC Group Inc. The graph assumes that the value of the investment in our common stock, in each index, and in the peer group (including reinvestment of dividends) was $100 on 10/28/2009 and tracks it through 12/31/2013.

	10/09	12/09	3/10	6/10	9/10	12/10	3/11	6/11	9/11
Addus HomeCare Corporation	**100.00**	**108.36**	**71.14**	**70.41**	**46.76**	**48.29**	**59.01**	**63.96**	**47.70**
NASDAQ Composite	**100.00**	**107.12**	**113.13**	**100.35**	**112.60**	**126.20**	**132.48**	**132.65**	**116.24**
NASDAQ Health Services	**100.00**	**112.28**	**119.53**	**99.93**	**98.85**	**114.77**	**127.07**	**120.33**	**92.35**
Peer Group	**100.00**	**114.30**	**121.74**	**104.09**	**73.09**	**95.60**	**98.42**	**74.10**	**37.94**

12/11	3/12	6/12	9/12	12/12	3/13	6/13	9/13	12/13
42.05	**58.30**	**57.83**	**63.02**	**84.19**	**155.36**	**232.51**	**341.22**	**264.43**
126.93	**150.15**	**143.04**	**152.62**	**148.20**	**161.51**	**169.09**	**188.96**	**209.79**
95.64	**106.33**	**109.43**	**118.43**	**107.84**	**119.19**	**131.20**	**145.28**	**158.05**
32.43	**45.09**	**38.82**	**45.56**	**43.64**	**44.46**	**42.41**	**53.48**	**55.58**

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, 2013

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.)**

2401 South Plum Grove Road

Palatine, Illinois 60067

(Address of principal executive offices)

(847) 303-5300

(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. ¨

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 28, 2013 (the last business day of the registrant s most recently completed second fiscal quarter) was $112,336,629.

As of March 10, 2014, there were 10,912,973 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Certain portions of the registrant s Definitive Proxy Statement for its 2014 Annual Meeting of Stockholders (which is expected to be filed with the Commission within 120 days after the end of the registrant s 2013 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 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, 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 economic downturn 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 2013 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 2013, 2012 and 2011, 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, 2013 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 comprehensive provider of home and community based services, which are primarily social in nature and are provided in the home, and focused on the dual eligible population. Our services include personal care and assistance with activities of daily living, and adult day care. Our consumers are individuals with special needs 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, commercial insurers and private individuals. We provide home and community based services through over 121 locations across 21 states to over 26,000 consumers.

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 million. 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 $0.2 million. Through home health agencies, we previously provided physical, occupational and speech therapy, as well as skilled nursing services, to pediatric, adult infirm and elderly patients. 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.

We believe the sale of the Home Health Business substantially positions us for future growth. The sale allows 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 responsible for the state sponsored programs. We completed two acquisitions in 2013 and January 2014 which expand our presence in two existing markets and provide us with a base of operations in two new targeted managed care states. We have improved our financial performance by lowering our administrative costs and concentrating our efforts on the business that is growing and providing all of our profitability and disposing of the business that was unprofitable. We have improved our overall financial position by eliminating our debt and adding substantial amounts in cash reserves to our balance sheet. A summary of our results for 2013, 2012 and 2011, expressed in thousands, are provided in the table below:

	2013	2012	2011
Net service revenues continuing operations	$ 265,941	$ 244,315	$ 230,105
Net service revenues discontinued operations	6,462	38,822	42,995
Net income from continuing operations	11,163	9,288	8,412
Earnings (loss) from discontinued operations	7,982	(1,653)	(10,393)
Net income (loss)	$ 19,145	$ 7,635	$ (1,981)
Total assets	$ 163,934	$ 149,857	$ 154,692

The home and community based services we provide are primarily social in nature and 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 17 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.

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We utilize a coordinated care model that is designed to enhance consumer outcomes and satisfaction as well as lower the cost of acute care treatment and reduce service duplication. 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. These changes in condition are evaluated by appropriately trained managers and referred to appropriate medical personnel including the primary care physicians and managed care plans for treatment and follow-up. We will coordinate the services provided by our team with those of selected health care agencies as appropriate. We believe this 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 providers and others who are ultimately responsible for the healthcare needs of our consumers and over time will increase our business with them.

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 2401 South Plum Grove Road, Palatine, Illinois 60067. Our telephone number is (847) 303-5300. 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 home and community based services to the elderly and other adult infirm who need long-term care and assistance with essential, routine tasks of life. The Kaiser Commission report on Medicaid and the uninsured dated December 2012 estimated total Medicaid expenditures for home and community based services in 2009 to be over $50.0 billion annually, up from $19.4 billion in 2000, with an average annual increase of 11%. Over the same period, participants in Medicaid home and community based services increased from 2.1 million to 3.3 million.

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 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.

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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 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, 34 states have initiated, or plan to initiate, efforts to pursue these programs, including 15 of the 21 states in which we provide services.

We believe that our coordinated care program makes us well-suited to partner with managed care providers 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 medical 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 industry is particularly attractive to managed care providers 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 ability to grow our net service revenues is closely correlated with the number of consumers to whom we provide our services. Our continued growth depends on our ability to maintain our existing payor client relationships, establish relationships with new payors, enter into new contracts 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:

Drive growth in existing markets. We intend to drive growth 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 each market. We expect to achieve this growth by continuing to educate referral sources about the benefits of our services and maintaining our emphasis on high quality care for our consumers. To take advantage of the growing demand for quality and reputable home and community based services from private duty consumers, we are focusing on increasing and enhancing the private pay services we provide to consumers in all of our locations. By providing private duty services, we expect to increase our net service revenues without a corresponding increase in our operating costs.

Expand our coordinated care model. 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 intend to extend this model to all of our

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markets. We are also seeking to partner with managed care providers to address the needs of the dual eligible population in light of governmental incentives for consumers to enroll in managed care plans. 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 providers and others who are ultimately responsible for the healthcare needs of our consumers and over time we believe will increase our business with them.

Growth through acquisitions. We intend to continue to grow with selective acquisitions. While entering new markets is a priority for our acquisitions, we are also looking for opportunities to expand within our existing markets.

Expand into new markets organically. We intend to 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 121 individual agencies located in 21 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 in consumers homes on an as-needed, hourly basis, mostly to older adults and younger disabled persons. These services, generally provided by home and community based service aides, are of a social rather than medical nature and include 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. The average duration of our provision of home and community based services is approximately 17 months per consumer.

We also operate 5 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.

Most of our services are provided pursuant to agreements with state and local governmental social and aging service agencies. These agreements generally have a stated term of one to two years and may be terminated by the counterparty upon 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. In 2013, approximately 94.1% of our net service revenues from continuing operations were derived from state and local government programs, while approximately 5.9% of net service revenues from continuing operations were derived from insurance programs and private duty consumers.

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The following table presents our locations, setting forth acquisitions, start-ups, divestitures and closures for the period December 31, 2011 to December 31, 2013. The table excludes locations associated with discontinued operations.

	Total
Total December 31, 2011	107
Closed/Merged	(3)
Total at December 31, 2012	104
Acquired	16
Start-up	2
Closed/Merged	(1)
Total at December 31, 2013	121

Our payor clients are principally federal, state and local governmental agencies. The federal, state and local programs under which they operate are subject to legislative, budgetary and other risks that can influence reimbursement rates. Our commercial insurance carrier payor clients are typically for profit companies and are continuously seeking opportunities to control costs. We are seeking to grow our private duty business.

For 2013, 2012 and 2011, our revenue mix by payor type for continuing operations was as follows:

	Year Ended December 31,		
	2013	2012	2011
State, local and other governmental programs	94.1%	94.9%	93.5%
Commercial	2.0	1.0	1.3
Private duty	3.9	4.1	5.2
	100.0%	100.0%	100.0%

We derive a significant amount of our net service revenues from our operations in Illinois and California, which represented 66% and 6%; 64% and 7% and 58% and 8% of our total net service revenues for the years ended December 31, 2013, 2012 and 2011, respectively.

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 59%, 57% and 51% of our total net service revenues from continuing operations for the years ended December 31, 2013, 2012 and 2011, respectively.

We also measure the performance of our business through review of our billable hours, 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. 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, name recognition on a larger number of consumers and payors than we do.

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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.

In many states there is a need to establish new referral relationships with various managed care plans who are contracting with the states for the management of the state Medicaid programs. We have met with all contracted managed care plans in markets where we serve our clients and are beginning to build 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 residents 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 insurers 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 Group	**2013**	**2012**	**2011**
Illinois Department on Aging	58.8%	57.3%	51.2%
Washington Department of Social and Health Services	6.6	6.4	6.7
Riverside County Department of Public Social Services, CA	3.8	3.9	4.5
Nevada Medicaid	3.4	3.9	5.1
Private duty	3.9	4.1	5.2
Commercial insurance	2.0	1.0	1.3
Other federal, state and local payors	21.5	23.4	26.0
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.

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Due to its revenue deficiencies and financing issues, the State of Illinois is currently reimbursing us on a delayed basis with respect to these agreements. These payment delays have adversely impacted, and may further 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 have also contributed to the increase in our receivables balances.

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.

Riverside County Department of Public Social Services

We provide services pursuant to an agreement with the County of Riverside, California under its In-Home Support Services Program. Under this agreement, we serve consumers referred to us by county-employed social workers in accordance with the term and conditions of a Quality Assurance Work Plan. We provide personal care and other assistance with activities of daily living under this program. All services are reimbursed on an hourly fee for service basis. The current agreement has a one year term beginning July 1, 2013. The County has offered a one year extension beginning July 1, 2014, which is subject to approval by the County department that oversees our agreement.

Our contract relationship with the County of Riverside, California may change before the end of the term of our agreement, including any renewal terms, as the State of California and Riverside County are planning to enter into managed care demonstration plans whereby the services we provide to consumers in the county would become the responsibility of the contracted managed care plans. The transition of consumers to managed care is expected to take place while our agreement with the County of Riverside is in place. We cannot provide assurance that we will be able to contract with managed care plans at rates comparable to our current contract with the County or that all of our consumers would move to managed care or that the managed care plans would continue to utilize our services at the same rate that they are provided today.

Our arrangements with all of our California county payors are not exclusive in nature. Rather, each county is permitted to contract for services from independent providers with a registry of independent providers managed by the county authority. The independent provider programs represent a competitive threat to us but we believe independent providers do not provide the level of management or supervision that the counties, or the individuals receiving services would have if the contract were with us.

Nevada Medicaid

We provide services pursuant to an agreement with the State of Nevada Division of Health Care Financing and Policy under Nevada Medicaid s Personal Care Options program. Under this agreement, we identify consumers through community outreach efforts, who are then qualified by the State of Nevada to receive services. We provide personal care and other in-home support services under this program. All services are reimbursed on an hourly fee for service basis.

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-

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week deposit from the consumer. Other private duty payors include workers compensation programs/insurance, preferred provider organizations and other managed care companies and employers.

Commercial Insurance

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

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.

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. Under these 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 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 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.

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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.

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. Because regulatory requirements in Delaware and Indiana require the provision of 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.

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 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.

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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, as well as the employees in our National Support Center, as of December 31, 2013:

		Full-time	Part-time	Total
Continuing Operations	Home and Community Based Services	4,221	12,222	16,443
National Support Center		120	22	142
		4,341	12,244	16,585

Our home and community based service aides provide substantially all of our services and comprise approximately 95% of our total workforce. In most cases, 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 based services aides to maintain a license similar to that of a nurse or therapist. Approximately 70% 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.

Our Technology

We have licensed the Horizon Homecare software solution from McKesson Information Solutions, LLC, or 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.

We have developed internally a customized payroll management system. This system has been utilized to calculate and produce our payroll. This software is integrated with Horizon Homecare and other clinical data-management systems, and includes a feature for general ledger population, tax reporting, managing wage assignments and garnishments, on-site check printing, and direct-deposit paychecks. Secure management reports are made available centrally and through our internal reporting module. We have contracted to replace this internal payroll system with an external vendor of a comprehensive HRIS/Payroll system.

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

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voice recognition (IVR) system or cell phone based system. We have supplemented these commercial systems with company developed smart phone 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.

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 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.

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, will not adversely impact our business, results of operations or financial position.

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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.

Applicable Federal and State Laws

Anti-Kickback Laws: The federal government enforces the federal Anti-Kickback Law 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 Law 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 Law. 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.

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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.

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 (DHHS), 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 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: The DHHS 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, the DHHS 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 then $4.8 billion in improper payments. RACs are paid a contingent fee based on the improper payments identified. 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, 2013, we derived approximately 94% 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 are facing budgetary shortfalls due to the current economic downturn 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 programs.

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Certain of these measures have been implemented by, or are proposed in, states in which we operate. For example, California has considered a number of proposals, including potential changes in eligibility standards or hours utilization and Illinois has delayed payments to providers. In 2013, we derived approximately 66% of our total net service revenues from continuing operations from services provided in Illinois, 6% of our total net service revenues from continuing operations from services provided in California and 7% of our total net service revenues from continuing operations from services provided in Washington. 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 plans 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, 34 states have initiated, or plan to initiate, efforts to pursue these programs, including 15 of the 21 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 plans 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.

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 the medical providers and are not directed toward home and community based

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service providers. 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 2013, we derived approximately 58.8% 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. It is difficult to ascertain what impact, if any, these initiatives will have on our business. If they impact 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 or otherwise have decreased, and may in the future further decrease, 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 21 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. 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 delays in reimbursement would 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, 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

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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 2013, we derived approximately 58.8% of our net service revenues from continuing operations under agreements with the Illinois Department on Aging, 6.6% of our net service revenues from continuing operations under an agreement with Washington, 3.4% of our net service revenues from continuing operations under an agreement with Nevada Medicaid and 3.8% of our net service revenues from continuing operations under an agreement with the Riverside County (California) Department of Public Social Services. 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, while our agreement with the Riverside County Department of Public Social Services is reevaluated and subject to renewal annually. In addition, our relationship with Riverside County may change before the end of the term of our agreement, including any renewal terms, as the State of California and Riverside County are planning to enter into managed care demonstration plans whereby the services we provide to consumers in the county would become the responsibility of the contracted managed care plans. Even though our agreements are stated to be for a specific term, they are generally terminable by the counterparty upon 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.

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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. Our competition consists of home and community based service providers, home health providers, private caregivers, larger publicly traded companies, privately held companies, privately held single-site agencies, hospital-based agencies, non-for-profit organizations, community-based organizations, managed care organizations and self-directed care programs. 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 66% of our net service revenues from continuing operations from services provided in Illinois in 2013, 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 and California are experiencing large budget deficits, which may result in lower Medicaid payments. In addition, private payors, including commercial insurance companies, could also reduce reimbursement. Any reduction in Medicaid reimbursements or imposition of copayments that dissuade the use of our services, or any reduction in reimbursement from private payors, would materially adversely affect our profitability.

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;

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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). Any of these 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 $1.8 million to the government. See Note 7 to the Consolidated Financial Statements, Details of Certain Balance Sheet Accounts, included elsewhere herein for more information.

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, 2015 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 federal and state regulations and laws, including Anti-kickback laws, the Stark Law, the False Claims Act, Fraud Alerts, HIPPA and the HITECH Act as described in the Section Government Regulation discussed elsewhere in this document. Failure to comply to these regulations or violations to 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

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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.

Under the Health Reform Act, beginning in 2015, if we continue to provide a medical plan, we will be required to provide a minimum level of coverage for 70 percent of our full-time employees or be subject to an annual penalty. Many of our employees are not provided any medical coverage. 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.

In September 2013, the United States 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 will take effect on January 1, 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 are currently evaluating 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

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receive in respect of Medicaid and Medicare can be retroactively adjusted after a new examination during the 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 start-ups 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 start-up, or de novo, locations, and we may in the future start up new locations in existing and new markets. Start-ups involve significant risks, including those relating to licensure, accreditation, hiring new personnel, establishing relationships with referral sources and delayed or difficulty in installing our operating and information systems. We may not be successful in establishing start-up 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, 2013 and December 31, 2012, we had cash balances of $15.6 million and $1.7 million, respectively. As of December 31, 2013, we had no outstanding debt on our credit facility. After giving effect to the amount drawn on our credit facility, approximately $12.4 million of outstanding letters of credit and borrowing limits based on an advanced multiple of adjusted EBITDA, we had $42.6 million available for borrowing under the credit facility as of December 31, 2013. 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 $500,000, in each case without the consent of the lenders. The consideration we paid in connection with 11 of the 14 acquisitions we completed exceeded $500,000. 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, 2013, approximately 70% of our hourly 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, aify">In line with the Company's development and growth strategy, the Shareholders' Meeting, having satisfied the conditions of quorum and majority required for extraordinary general meetings,

having considered the report of the Board of Directors and the Auditors' Special Report,
pursuant to the provisions of articles L. 225-129, L. 225-129-2, L. 225-138 and L. 228-91 et seq. of the French Commercial code,
1. delegates its authority to the Board of Directors to decide, under any such proportion and at any such periods it may deem appropriate, one or several capital increases by issuance of, in France or abroad, ordinary shares of the Company or any securities giving access by any means, whether immediately and/or in the future, to the share capital of the Company (including, in particular, bonds redeemable or convertible into shares and all share warrants, attached or not to shares or other securities). Such securities may be issued in euros, in foreign currencies or in any monetary units whatsoever established by reference to several currencies, at the option of the Board of Directors and which subscription may be made either in cash or by set off,
2. decides that the issuance of preferred shares is expressly excluded from this delegation,
3. decides that the maximum nominal amount of the capital increases which can be consummated, immediately or in the future, pursuant to the authority delegated by the shareholders meeting to the Board of Directors by this resolution, is set at 1.300,000 euros (or its counter-value in foreign currencies at the date of subscription); this amount shall be applied against the aggregate maximum provided for in the sixth resolution above. In any case, such share capital increases may represent, subject to the aforementioned limit, more than 20% of the Company's share capital at the date of issuance,
4. decides to cancel the shareholders' preferential subscription rights for the shares and securities which would be issued hereto and to reserve subscription of such shares and securities which are the subject of this resolution in favor of the following new or existing investors, with a maximum of 100 subscribers, with a minimum individual subscription amount of 10,000 euros or its counter-value in foreign currencies as at the date of subscription (issuance premium included): practitioners who have

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used the Company's technologies over the course of the last 24 months preceding the issuance of the shares, subject to compliance with the applicable laws and professional ethics,

5. specifies that, pursuant to article L. 225-132 of the French Commercial code, this delegation shall automatically result in the cancellation by the shareholders of their preferential subscription rights to the shares to which the issued securities entitle them,

6. decides that the issuance price (or the amount of the counterparty which is due to the Company for each share to be issued, in the case of issuance of securities giving access to the Company's share capital), will be set in accordance with usual market practices, in accordance with the over-the-counter negotiations the Board of Directors will carry out with said practitioners. In any case, the price so determined by the Board of Directors may represent a discount compared to the trading price of the Company's share on the NASDAQ,

7. decides that the Board of Directors shall have all powers to implement this delegation, in compliance with applicable laws, including but not limited to the following purposes:

- determine, the amount of the share capital increase, the issuance price (being specified that the latter will be set in accordance with the modalities defined above) as well as any issuance premium, that may be requested,
- set the dates, the terms and conditions of any issuance as well as the form and characteristics of shares or securities giving access to the share capital to be issued,
- set the date of dividend rights, including retroactive, for the shares and securities giving access to the share capital to be issued, and determine the method of paying-up,
- set the list of beneficiaries for the aforementioned category and the number of shares to be allocated to each of them,
- allocate the costs of capital increases to the amount of premiums related thereto and deduct from such amount the sums necessary to raise the level of the legal reserve to one-tenth of the new capital after each capital increase,
- perform formalities following each capital increase and subsequent modification of the by-laws,
- more generally, enter into any agreement, in particular if necessary to ensure completion of the contemplated issuances, take all measures and perform all formalities required in light of the issuance, listing and financial services for the securities issued pursuant to this resolution and the exercise of rights attached thereto,

8. decides that this delegation is granted for a period of eighteen (18) months from the date of this meeting and replaces the prior authorization having the same purpose granted to the Board of Directors by the extraordinary general meeting on June 24, 2010,

9. acknowledges that, in the event that the Board of Directors uses the delegation of authority granted to it under this resolution, it shall report to the next shareholders' general meeting on the use made by it of such delegation, in accordance with applicable laws and regulations.

Fourteenth resolution (Delegation of authority to be granted to the Board of Directors to increase the share capital, by issuance of shares or other securities giving access to the Company's share capital, with cancellation of shareholders' preferential subscription rights in favor of the following category of persons: directors and officers of the Company in office at the date of issuance of the shares or other securities, and natural persons who have an employment contract with the Company at the date of issuance of the shares or other securities)

The Shareholders' Meeting, having satisfied the conditions of quorum and majority required for extraordinary general meetings,

having considered the report of the Board of Directors and the Auditors' Special Report,
pursuant to the provisions of articles L. 225-129, L. 225-129-2, L. 225-138 and L. 228-91 et seq. of the French Commercial code,

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1. delegates its authority to the Board of Directors to decide, under any such proportion and at any such periods it may deem appropriate, one or several capital increases by issuance of, in France or abroad, ordinary shares of the Company or any securities giving access by any means, whether immediately and/or in the future, to the share capital of the Company, (including, in particular, bonds redeemable or convertible into shares and all share warrants, attached or not to shares or other securities). Such securities may be issued in euros, in foreign currencies or in any monetary units whatsoever established by reference to several currencies, at the option of the Board of Directors, and which subscription might be made either in cash or by set off.
2. decides that the issuance of preferred shares is expressly excluded from this delegation,
3. decides that the maximum nominal amount of the share capital increases which may be consummated, immediately or in the future, pursuant to the authority delegated by the shareholders meeting to the Board of Directors by this resolution, is set at 1.300,000 euros (or its counter-value in foreign currencies); this amount shall be applied against the aggregate maximum provided for in the sixth resolution above. In any case, such share capital increases may represent, subject to the aforementioned limit, more than 20% of the Company's share capital at the date of issuance,
4. decides to cancel the shareholders' preferential subscription rights to the shares and securities which will be issued and to reserve subscription of shares and securities subject to this resolution in favor of the following category of persons: (i) directors and officers of the Company in office at the date of issuance of the shares or other securities, and (ii) natural persons who have an employment contract with the Company at the date of issuance of the shares or other securities.
5. specifies that, pursuant to article L. 225-132 of the French Commercial code, this delegation shall automatically result in the waiver by the shareholders, in favor of holders of securities to be issued by the Board of Directors, of their preferential subscription rights to the shares to which the issued securities entitle them,
6. decides that the issuance price will be set by the Board of Directors, by reference to the price of the latest transaction on the Company's share capital carried out during the 6 months prior to the issuance, with a premium or discount of respectively 10% more or less compared to such price. In any case, the price so determined by the Board of Directors may represent a discount compared to the trading price of the Company's share on the NASDAQ,

7. decides that the Board of Directors shall have all powers to implement this delegation, in accordance with applicable laws, including but not limited to the following purposes:
- determine, the amount of the share capital increase, the issuance price (being specified that the latter will be set in accordance with the modalities defined above) as well as any issuance premium, that may be requested,
- set the dates, the terms and conditions of any issuance as well as the form and characteristics of shares or securities giving access to the share capital to be issued,
- set the date of dividend rights, including retroactive, for the shares and securities giving access to the share capital to be issued, and determine the method of paying-up,
- set the list of the beneficiaries for each aforementioned categories and the number of shares to be allocated to each of them,
- allocate the costs of capital increases to the amount of premiums related thereto and deduct from such amount the sums necessary to raise the level of the legal reserve to one-tenth of the new capital after each capital increase,
- perform formalities following each capital increase and subsequent modification of the by-laws,
- more generally, enter into any agreement, in particular if necessary to ensure completion of the contemplated issuances, take all measures and perform all formalities required in light of the issuance, listing and financial services for the securities issued pursuant to this resolution and the exercise of rights attached thereto,

8. decides the present delegation is granted for a period of eighteen (18) months from the date of this meeting and replaces the prior authorization having the same purpose granted to the Board of Directors by the extraordinary general meeting on June 24, 2010,

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9. acknowledges that, in the event that the Board of Directors uses the delegation of authority granted to it under this resolution, it shall report to the next shareholders' general meeting on the use made by it of such delegation, in accordance with applicable laws and regulations,

Fifteenth resolution (Delegation of authority to allow the Board of Directors to increase the share capital by issuance of shares or other securities giving access to the Company's share capital, with cancellation of shareholders' preferential subscription rights in favor of participants in the Company's employee savings scheme)

The Shareholders' Meeting, having satisfied the conditions of quorum and majority required for extraordinary general meetings,
having considered the report of the Board of Directors and the Auditors' Special Report,
pursuant to the provisions of articles L. 225-129-6 of the French Commercial code and articles L. 3332-18 et seq. of the French Labor code,

1. delegates its authority to the Board of Directors to decide, pursuant to its own deliberations, one or several capital increases by issuance of ordinary shares of the Company, directly or through an employee mutual fund, reserved for participants in the Company's employee savings scheme as permitted under articles L. 3332-1 et seq. of the French Labor code which would be open to the Company's employees and affiliated entities, as defined by article L. 225-180 of the French Commercial code, and who further meet, as the case may be, the conditions that may be set by the Board of Directors (hereinafter the "Group Employees")
2. decides therefore to cancel the shareholders' preferential subscription rights under article L. 225-132 of the French Commercial code for the ordinary shares which would be issued hereto and to reserve subscription of such ordinary shares to the Group Employees,

3. decides that this authorization is granted for a period of eighteen (18) months from the date of this meeting and replaces the prior authorization having the same purpose granted to the Board of Directors by the extraordinary general meeting on June 24, 2010,
4. decides that the maximum nominal amount of the shares which may be issued pursuant to this resolution is set at 42,549 (forty two thousand five hundred forty nine) euros (or its counter-value in foreign currencies at the date of subscription),
5. decides that this amount shall be applied against the aggregate maximum of 1.300.000 euros for share capital increase which may be carried out pursuant to the delegations granted to the delegations granted to the Board of Directors, as provided in the sixth resolution above,

6. decides that the issuance price per share will be set by the Board of Directors in accordance with article L. 3332-20 of the French Labor code.

This document is not an offer to purchase, or a solicitation of an offer to buy OCRABSA, shares or any other securities of the Company. There can be no guarantee that the Board of Directors will undertake, or if it does undertake that it will be successful in, a renegotiation of the terms of the OCRABSA. Furthermore, there can be no assurance that any such renegotiation, if it is undertaken will be completed, or if it is completed that it will result in a favorable outcome for the Company or its shareholders.