Civitas Solutions, Inc.
Form 10-K
December 13, 2018
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

Form 10-K

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x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended September 30, 2018
or
¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to .
COMMISSION FILE NUMBER: 001-36623

CIVITAS SOLUTIONS, INC.
(Exact name of registrant as specified in its charter)

Delaware	65-1309110
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
313 Congress Street, 6th Floor Boston, Massachusetts 02210	(617) 790-4800
(Address of principal executive offices, including zip code)	(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, $0.01 par value per share	New York Stock Exchange

Securities Registered Pursuant to Section 12(g) of the Act:
None.

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ¨ No x
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No x
Indicate by check mark whether the registrant (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 every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes x No ¨
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x

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

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

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

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

The aggregate market value of voting and non-voting common equity held by non-affiliates of the registrant as of March 31, 2018, the last business day of the registrant’s most recently completed second fiscal quarter, was approximately $270,000,000.

As of November 30, 2018, there were 36,116,252 shares of the registrant’s common stock, $0.01 par value, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE:

Portions of the registrant’s proxy statement for use in connection with its 2019 Annual Meeting of Stockholders, to be filed no later than 120 days after September 30, 2018 are incorporated by reference to Part III of this report.

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FORWARD-LOOKING STATEMENTS

Some of the matters discussed in this report may constitute "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act").

These statements relate to future events or our future financial performance, and include statements about our expectations for future periods with respect to our markets, demand for our services, the political climate and budgetary and rate environment, our expansion efforts and the impact of our recent acquisitions, our plans for investments to further grow and develop our business, our margins, our liquidity, our labor costs, and costs of ongoing litigation. Terminology such as "may," "will," "should," "could," "expect," "plan," "anticipate," "believe," "estimate," "predic or "continue," or similar expressions are intended to identify these forward looking statements. These statements are only predictions. Actual events or results may differ materially.

The information in this report is not a complete description of our business or the risks associated with our business. There can be no assurance that other factors will not affect the accuracy of these forward-looking statements or that our actual results will not differ materially from the results anticipated in such forward-looking statements. While it is not possible to identify all such factors, factors that could cause actual results to differ materially from those estimated by us include, but are not limited to, those factors or conditions described under "Part I. Item 1A. Risk Factors" in this Annual Report on Form 10-K as well as the following:

- reductions or changes in Medicaid or other funding or changes in budgetary priorities by federal, state and local governments;
- an increase in labor costs or labor-related liability;
- substantial claims, litigation and governmental proceedings;
- reductions in reimbursement rates, policies or payment practices by our payors;
- information technology failure, inadequacy, interruption or security failure;
- our ability to attract and retain experienced personnel;
- negative publicity or changes in public perception of our services;
- an increase in our self-insured retentions and changes in the insurance market for professional and general liability, workers' compensation and automobile liability and our claims history and our ability to obtain coverage at reasonable rates;
- an increase in workers' compensation related liability;
- our ability to comply with complicated billing and collection rules and regulations;
- failure to comply with reimbursement procedures and collect accounts receivable;
- the Patient Protection and Affordable Care Act materially reduced the flexibility we had in managing our healthcare cost and may make it harder for us to compete as an employer;
- our history of losses;
- changes in economic conditions;
- our ability to maintain effective internal controls;
- our substantial amount of debt, our ability to meet our debt service obligations and our ability to incur additional debt;
- our ability to establish and maintain relationships with government agencies and advocacy groups;
- our ability to maintain our status as a licensed service provider in certain jurisdictions;
- our susceptibility to any reduction in budget appropriations for our services in Minnesota or any other adverse developments in that state;

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- our ability to maintain, expand and renew existing services contracts and to obtain additional contracts or acquire new licenses;
- our ability to realize and anticipate benefits of future acquisitions and our ability to successfully integrate acquired businesses;
- government regulations, changes in government regulations and our ability to comply with such regulations;
- write-offs of goodwill or other intangible assets;
- increased competition in our industry;
- decrease in popularity of home- and community-based human services among our targeted populations of individuals and/or state and local governments;
- our ability to operate our business due to constraints imposed by covenants in our senior credit agreement;
- our inability to successfully expand into adjacent markets;
- our ability to manage and integrate key administrative functions;
- natural disasters or public health catastrophes;
- our classification as a "controlled company";
- our stock price may be volatile and/or decline;
- our equity sponsor has the ability to control significant corporate activities;
- future sales of common stock may depress our stock price; and
- as a holding company we rely on dividends, disbursements and other transfers of funds from our subsidiaries to meet our financial obligations.

Although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee future results, levels of activity, performance or achievements. Moreover, we do not assume responsibility for the accuracy and completeness of the forward-looking statements. All written and oral forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by the “Risk Factors” and other cautionary statements included herein. We are under no duty to update any of the forward-looking statements after the date of this report to conform such statements to actual results or to changes in our expectations.

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PART I

Item 1. Business

Company Overview

In this section “Civitas”, “we”, “us”, the “Company” and “our” refer to Civitas Solutions, Inc. and its consolidated subsidiaries Throughout this Annual Report on Form 10-K we use the term “must serve” to describe the people we serve. We consider “must-serve individuals” to be those that public policy has recognized a responsibility to support because they are highly vulnerable by virtue of a condition acquired at birth or after birth, or their status as a minor, or as elders, and have special needs and/or disabilities such that they need to be supported or cared for in the daily activities of living.

We are the leading national provider of home- and community-based health and human services to must-serve individuals with intellectual, developmental, physical or behavioral disabilities and other special needs. These populations are large, growing and increasingly being served in home- and community-based settings. Our clinicians and direct support professionals develop customized service plans, delivered in non-institutional settings, designed to address a broad range of often life-long conditions and to enable those we serve to thrive in less restrictive settings. We believe we offer a powerful value proposition to government and non-public payors, referral sources and individuals and families by providing innovative, high-quality and cost-effective services that enable greater independence, skill building and community involvement.

Since our founding in 1980, we have been a pioneer in the movement to provide home- and community-based services for people who would otherwise be institutionalized. During our more than 38-year history, we have evolved from a single residential program serving at-risk youth to a diversified national network providing an array of high-quality services and care in large, growing and highly-fragmented markets. While we have the capabilities to serve individuals with a wide variety of special needs and disabilities, we currently provide our services to individuals with intellectual and/or developmental disabilities (“I/DD”), individuals with catastrophic injuries and illnesses, particularly acquired brain injury (“ABI”), youth with emotional, behavioral and/or medically complex challenges, and elders in need of day health services to support their independence. As of September 30, 2018, we operated in 36 states, serving approximately 12,700 individuals in residential settings and approximately 19,000 individuals in non-residential settings. We have a diverse group of hundreds of public payors that fund our services with a combination of federal, state and local funding, as well as an increasing number of non-public payors for our services to individuals with acquired brain injuries or other catastrophic injuries and illnesses.

Our core strength is providing a continuum of residential, day and vocational programs, and periodic services to support diverse populations with disabilities and special needs. We currently offer our services through a variety of models, including (i) neighborhood group homes, most of which are residences for six or fewer individuals, (ii) host homes, or the “Mentor” model, in which a person lives in the private home of a licensed providers, (iii) in-home settings, within which we support an individual's independent living or provide therapeutic services, (iv) specialized community facilities to support individuals with more complex medical, physical and behavioral challenges, and (v) non-residential care, consisting primarily of day and vocational programs and periodic services that are provided outside the individual's home. As of September 30, 2018, our services were provided by approximately 23,600 full-time equivalent employees, as well as more than 3,500 independently-contracted host home providers.

The Company

Civitas Solutions, Inc. is the parent and public reporting entity of a consolidated group of subsidiaries that market their services under The MENTOR Network tradename. Prior to October 1, 2015, Civitas Solutions, Inc. was a subsidiary of NMH Investment, LLC (“NMH Investment”), which was formed in connection with the acquisition of our business by affiliates of Vestar Capital Partners (“Vestar”) in 2006. Approximately 54% of the Common Stock of Civitas Solutions, Inc. is owned by Vestar. Our common stock is listed on the New York Stock Exchange under the ticker symbol CIVI .

Description of Services by Operating Division

We have four operating divisions, Community Support Services ("CSS"), Specialty Rehabilitation Services (“SRS”), Children & Family Services ("CFS") and Adult Day Health ("ADH"). Each operating division represents a reportable

segment except ADH, which is included within Corporate and Other, because it does not meet the thresholds for separate reporting. As of October 1, 2018, Community Support Services and Children & Family Services are new names for the operating divisions formerly referred to as Intellectual and Developmental Disabilities ("I/DD") and At-Risk Youth ("ARY") respectively. There were no changes to the composition of the operating divisions as a result of these name changes.

We do not derive any revenues from countries outside the United States.

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Community Support Services (CSS)

Our CSS operating division is focused on supporting individuals with intellectual and developmental disabilities ("I/DD") through programs that include residential support, day habilitation, vocational services, case management, crisis intervention and hourly support care. We provide services to these individuals through small group homes, Intermediate Care Facilities for Individuals with Intellectual and/or Developmental Disabilities ("ICFs-I/DD"), host homes, in-home settings and non-residential settings. We operate approximately 1,500 group homes and 150 ICFs-I/DD. As of September 30, 2018, we provided CSS services to approximately 18,500 individuals in 21 states. In fiscal 2018, our CSS services generated net revenue of $1,025.6 million, representing 64.0% of our net revenue. We receive substantially all our revenue for CSS services from a diverse group of state and local governmental payors.

Specialty Rehabilitation Services (SRS)

Our SRS operating division delivers health care and community-based health and human services to individuals who have suffered acquired brain injury, spinal injuries and other catastrophic injuries and illnesses.

Our SRS operating division is focused on rehabilitation and transitional living services and more medically-intensive post-acute care services. Our SRS services range from sub-acute healthcare for individuals with intensive medical needs to day treatment programs, and include: neurorehabilitation; neurobehavioral rehabilitation; specialized nursing; physical, occupational and speech therapies; supported living; outpatient treatment; and pre-vocational services. Our goal is to provide a continuum of care to allow individuals to achieve the highest level of function possible while enhancing their quality of life. We provide these services primarily through specialized community facilities, small group homes, in-home and non-residential settings. As of September 30, 2018, our SRS operations provided services in 25 states and served approximately 2,200 individuals nationally. In fiscal 2018, our SRS services generated net revenue of $356.3 million, representing approximately 22.2% of our net revenue. In fiscal 2018, we received 51% of our SRS revenue from non-public payors, such as commercial insurers, workers' compensation funds, managed care and other private payors and 49% from state, local and federal governmental payors.

Children & Family Services (CFS)

Our CFS operating division is focused on supporting youth with emotional, behavioral and/or medically complex challenges through programs that include therapeutic foster care, family preservation, adoption services, early intervention, school-based services and juvenile offender programs. Our individualized approach allows us to work with an ever-changing population that is diverse demographically as well as in type and severity of condition. We provide these services through host homes, group homes, educational settings, in their family homes and in other non-residential settings. As of September 30, 2018, we provided CFS services to approximately 6,000 children, adolescents and their families in 9 states. In fiscal 2018, our CFS services generated net revenue of $147.7 million, representing 9.2% of our net revenue. We receive substantially all our revenue for CFS services from a diverse group of state and local governmental payors.

Adult Day Health (ADH)

Our newest operating division, ADH, delivers elder services including case management, nursing oversight, medication management, nutrition, daily living assistance, transportation, and therapeutic services. Our adult day health facilities provide outpatient, center-based services to approximately 5,000 adults in a group environment in 4 states. In fiscal 2018, our ADH services generated net revenue of $72.6 million, representing 4.5% of our net revenue. We receive substantially all our revenue for ADH services from state and local governmental payors.

Industry Overview

We provide home- and community-based services to large populations of individuals with intellectual, developmental, physical or behavioral disabilities and other special needs. These populations are must serve due to the nature of their disabilities, which in many cases are life-long and irreversible, or their status as children, adolescents, or elders. Within the broader health and human services market, we currently serve four primary populations:

- Intellectual and Developmental Disabilities (I/DD). Based on reports prepared by Dr. David Braddock, public spending on I/DD services was estimated to be $65.2 billion in 2015, of which approximately 85% was spent to provide services in community settings of six or fewer beds, our target market, and for other non-institutional services, including supported living, supported employment and family assistance. In 2015, there were approximately

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5.1 million individuals with an intellectual or developmental disability across the nation. Over the past two decades, the delivery of services to the I/DD population in supervised residential settings has grown significantly and, at the same time, there has been a shift from institutional settings to home- and community-based settings. Dr. Braddock is Associate Vice President of the University of Colorado (CU) System and Executive Director of the Coleman Institute for Cognitive Disabilities.

- Acquired Brain Injury (ABI). The market for acute care and rehabilitation for individuals with ABI is approximately $10.0 billion annually, according to the Centers for Disease Control and Prevention. According to the Brain Injury Association of America ("BIAA"), more than 3.2 million children and adults sustain a brain injury each year, many of which result in complex, life-long medical and/or behavioral issues that require specialized care. Approximately 5.3 million individuals in the United States are living with permanent disability as a result of an ABI. Many of these individuals are currently served in costly and often medically inappropriate care settings such as long-term acute care facilities and nursing homes. We expect that there will be a continuing shift in care delivery to more appropriate community-based settings such as those that we offer.
- Children & Family Services (CFS). According to reports published by the organization Child Trends, an estimated $29.1 billion was spent in state fiscal year 2014 on child welfare, including spending for residential and non-residential family support services such as those that we offer. Approximately 4.1 million referrals for abuse or neglect, which involved an estimated 7.4 million children, were investigated or assessed in the United States in federal fiscal year 2016. An estimated 688,000 children and adolescents were served by the foster care system in 2016. According to the Federal Department of Health and Human Services AFCARS data, there were nearly 437,000 children and adolescents in foster care as of September 30, 2016. Of those individuals, approximately 196,000 are living in non-relative foster family homes, which includes the therapeutic foster care market, the primary market for our residential CFS services.
- Adult Day Health (ADH). The ADH portion of the elder services market is an estimated $8.5 billion based on an IBISWorld 2018 report. IBISWorld forecasts growth to be at an annualized rate for ADH of 5.5% with revenue for this industry projected to reach $11.1 billion in 2021. We believe that there will be a growing demand for ADH services for several reasons, including that the population of adults 65 years of age and older is a growing demographic. According to the United States Census Bureau, the population of individuals age 65 and older will reach 82.8 million by 2050, almost double the estimated population of 49.2 million in 2016. Moreover, states are increasingly looking for alternatives to more expensive models of home-based, residential and institutional care. The ADH market, like other markets in which we operate, is highly fragmented with opportunities for consolidation.

Our Business Strategy

We believe the market opportunity for home- and community-based health and human services that increase independence and participation in community life for the individuals we serve while reducing costs will continue to grow. We intend to continue leveraging our strengths to capitalize on this trend, both in existing markets and in new markets where we believe significant opportunities exist. The primary aspects of our strategy include the following:

Pursue Opportunistic Acquisitions.

As a leading provider in our markets with national scale and a proven track record of quality care, we are well positioned as an acquiror of choice for small operators in a highly-fragmented industry. This dynamic leads to a number of attractive acquisition opportunities that can drive returns. We continue to maintain a robust acquisition pipeline and deploy capital in a disciplined and opportunistic manner to pursue acquisitions.

We intend to continue to pursue acquisitions that are consistent with our mission and complement our existing operations. We have invested in a team dedicated to mergers and acquisitions, as well as the infrastructure and formalized processes to enable us to pursue acquisition opportunities and to integrate them into our business.

We monitor the market nationally for businesses that we can acquire at attractive prices and efficiently integrate with our existing operations. From the beginning of fiscal 2014 through September 30, 2018, we have successfully acquired 55 companies, at an aggregate purchase price of approximately $329.5 million, including $9.7 million to settle contingent consideration obligations.

Leverage our Core Competencies to Drive the Organic Growth of High-Quality Services.

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We expect to capture the embedded growth opportunities resulting from organic growth initiatives and leverage our core competencies to further expand our presence in markets we currently serve and to further expand our geographic footprint in our existing service lines. During our 38-year history, we have developed and refined a core set of competencies through our experience developing customized service plans for complex cases and supporting our operations with expertise in areas such as quality improvement, risk management, compliance and quality improvement.

Continue to Invest in our New Start Programs.

A key driver of growth has been our new start programs that have historically generated attractive returns on our investments. Our demonstrated ability to quickly launch new start programs positions us well to meet new sources of market demand. New starts, which typically turn profitable within 18-24 months, require modest investments, consisting of operating losses and capital expenditures. Investments in the form of operating losses of approximately $16.3 million in new starts between fiscal 2012 and fiscal 2013 generated net revenues and operating income of approximately $83.4 million and $22.0 million, respectively, in fiscal 2018. Investments in the form of operating losses of approximately $11.8 million in new starts between fiscal 2014 and fiscal 2015 generated net revenues and operating income of approximately $57.1 million and $9.4 million, respectively, in fiscal 2018. Investments in the form of operating losses of approximately $13.0 million in new starts between fiscal 2016 and fiscal 2017 generated net revenues and operating income of approximately $33.7 million and $4.6 million, respectively in fiscal 2018. We have made a number of recent investments that we believe will continue to drive near term growth as they reach maturity. Our average annual new start investment in fiscal 2016 through fiscal 2018 was approximately $6.4 million. We intend to continue to aggressively pursue new start opportunities with attractive rates of return.

Expand our SRS Platform.

We intend to leverage our scale and leadership position to continue to expand our SRS platform through continued organic growth in new and existing markets, as well as through opportunistic acquisitions. We are the only provider with a national platform dedicated to providing post-acute care for individuals with brain injuries or other catastrophic injuries and illnesses, and thus we believe we are the leader serving this market. We have grown our SRS operating division revenue by over 70 percent since fiscal 2013, achieving a 11.3% compound annual growth rate in net revenue over that period. Furthermore, our SRS business is funded by a highly attractive payor mix, with approximately 51% of net revenues in fiscal 2018 derived from commercial insurers and other private entities.

Pursue Opportunities in Adjacent Markets and Complementary Service Lines that Diversify our Service Offerings.

We have a proven track record of developing new service areas, as evidenced by the growth of our SRS segment, and we intend to leverage our core competencies and relationships with state agencies to pursue opportunities in adjacent markets, particularly the $7.1 billion market for ADH, which we entered in 2014 with the acquisition of the Mass Adult Day Health Alliance. Since completing this acquisition, we have opened two additional ADH centers in Massachusetts and have acquired seven additional companies located in Massachusetts, Maryland, New Jersey and New Hampshire. We are continuing to evaluate opportunities to expand this service both organically and through potential acquisitions. In the future, we may explore additional opportunities to leverage our periodic, day and residential service models to support individuals in the broader elder care market as well as other adjacent markets, such as those serving youth with autism and individuals with mental health needs.

Customers and Contracts

Our customers that pay us to provide services to the individuals we support are governmental agencies, non-public payors and not-for-profit organizations. Our CSS and CFS services, as well as a significant portion of our SRS services, are delivered pursuant to contracts with various governmental agencies, such as state departments of developmental disabilities, juvenile justice, child welfare and the Federal Veterans Health Administration. Such contracts may be issued at the county or state level, depending upon the structure of the service system of the state in question. In addition, approximately 51% of our SRS revenue is derived from contracts with commercial insurers, workers' compensation carriers and other non-public payors.

In all of our service lines, either the individuals that we support and/or the payors/referral sources (e.g., state agencies) select us as a provider and, although an individual funded by Medicaid has the right to choose an alternative provider at any time, it has been our experience that the individuals we support change providers infrequently. We believe that

many of the individuals we support develop close relationships with their direct support professionals and our organization. Although an individual may develop a close relationship with his or her direct support professional, it is our experience that if such direct support professional leaves our employment, the individuals we support rarely elect to switch providers based on such direct support professional's departure. The length of stay varies widely based on individual needs. For instance, in our SRS segment,

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an individual's care may be focused on rehabilitation, in which case we will provide services for several months, or, if an individual suffered a catastrophic illness or accident, that individual could remain in our care for the duration of their life, which could span years or decades. In our CSS business, the length of stay is generally years, and often we support individuals for decades. In our CFS business, the length of treatment can vary widely but most often is for several months.

Contracts may cover a range of individuals such as all children referred for host home services in a county or a particular set of individuals who will share group living arrangements. Contracts are sometimes issued for specific individuals, where rates are individually determined based on need. Although our contracts generally have a stated term of one year and generally may be terminated without cause on 60 days' notice, the contracts are typically renewed annually if we have complied with licensing, certification, program standards and other regulatory requirements. As a provider of record, we contractually obligate ourselves to adhere to the applicable federal and state regulations regarding the provision of services, the maintenance of records and submission of claims for reimbursement under Medicaid and other government programs. In addition, while we are not obligated to serve each individual that is referred to us, we make every effort to review referrals made and accept individuals who need our services.

During fiscal 2018, revenue from our contracts with state and local governmental payors in the states of Minnesota, California, Massachusetts, Ohio and Indiana, our five largest revenue-generating states, comprised 41% of our net revenue. During fiscal 2017, revenue from our contracts with state and local governmental payors in the states of Minnesota, California, Indiana, Massachusetts, and New Jersey, our five largest revenue-generating states, comprised 40% of our net revenue. During fiscal 2016, revenue from our contracts with state and local governmental payors in the states of Minnesota, California, Indiana, New Jersey, and Massachusetts, our five largest revenue-generating states, comprised 41% of our net revenue. Of the 36 states the Company operates in, Minnesota is our largest state and generates revenue from our contracts with state and local governmental payors which accounted for 16%, 15%, and 15% of our net revenue in fiscal years 2018, 2017 and 2016, respectively. Contracts with state and local governmental payors in California, our second largest state, accounted for 10% of our net revenue in fiscal years 2018 and 2017. No other states accounted for 10% or more of our net revenue during fiscal years 2018, 2017, or 2016.

Training and Supporting our Direct Support Professionals

We provide pre-service and in-service education to all of our direct support professionals and clinical and administrative staff, and we encourage staff to avail themselves of outside training opportunities whenever possible. Employees participate in orientation programs designed to increase their understanding of our mission, philosophy of service, and our Code of Conduct and compliance program. Our employees benefit from our library of training materials and an intranet site that facilitates the identification and exchange of expertise across all of our operations. We work to increase individual job satisfaction and retention of motivated and qualified employees.

We use equally rigorous methods to identify and contract with independent contractor providers (host home providers), whether in an adult host home or foster care environment. In addition to pre-service and in-service orientation to familiarize the host home providers to the specifics of our model and expectations, the contracted host home providers in our CSS and CFS businesses receive a detailed briefing tailored to the individualized needs of the individual or child placed in their home. Prior to any placements being made, we conduct a home study to evaluate the appropriateness of any placement and conduct interviews and criminal background checks on adult members residing in the host home provider household. The services provided by host home providers are evaluated for contractual compliance by our case manager or coordinator according to standards set by licensing and regulatory agencies as well as our own quality standards. While host home providers can provide services independently, they have access to emergency telephone triage and on-site crisis intervention, if necessary. Host home providers also avail themselves of support groups, whether independent or offered at the program office.

Employees and Independent Contractors

As of September 30, 2018, we had approximately 23,600 full-time equivalent employees and more than 3,500 independent contractors. Although our employees are generally not unionized, we have one business in New Jersey with approximately 40 employees who are represented by a labor union and one business in Florida with approximately 62 employees that voted to unionize in June 2018. We consider our employee relations to be good.

Sales/Business Development and Marketing

We market our services nationally as The MENTOR Network, a national network of local service providers. We operate under several brands across the country, predominantly under the REM and MENTOR brands in our CSS and CFS operating divisions and the NeuroRestorative and CareMeridian brands in our SRS operating division.

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The majority of individuals we serve in the CSS and CFS operating divisions come to us through third-party referrals, and frequently our CSS referrals come through recommendations to family members from state or local agencies. Since our operations depend heavily on these referrals, we seek to ensure that we provide high-quality services in all states in which we operate, allowing us to enhance our name recognition and maintain a positive reputation with state and local agencies.

Relationships with referral sources are cultivated and maintained at the local level by key operations managers and supported by an array of corporate resources including marketing communications, government relations and business development services to promote both new and existing product lines.

Our SRS sales activities are independently organized from those of our CSS and CFS businesses. We have dedicated, geographically assigned clinical marketing and sales staff cultivating relationships with public and private payors, referral sources and directly with potential participants and their families. These regional teams are also supported by corporate resources as outlined above.

To further distinguish ourselves in each operating division, we have established a comprehensive presence at both the national and local level through a robust online presence, including social media. Additionally, through our government relations and business development activities, we believe we have successfully positioned ourselves to anticipate and meet the needs of our public partners.

Competition

Community Support Services (CSS)

The CSS market is highly fragmented, with both not-for-profit and for-profit providers ranging in size from small, local agencies to large, national organizations. We and the other leading national provider account for less than 4% of services by revenue in the CSS market. Although state and local governments continue to supply a small percentage of services, the majority of services are provided by the private sector. Not-for-profit organizations are also active in all states and range from small agencies serving a limited area with specific programs to multi-state organizations. Many of the not-for-profit companies are affiliated with advocacy groups such as community mental health and religious organizations.

Specialty Rehabilitation Services (SRS)

We compete with local providers, both large and small, including hospitals, post-acute rehabilitation facilities, residential community-based facilities, day treatment centers and outpatient centers specializing in long-term catastrophic care and short-term rehabilitation. This market also includes several large national providers of general inpatient and outpatient rehabilitation services.

Children & Family Services (CFS)

The CFS market is extremely fragmented, with several thousand providers in the United States. Competitors include both not-for-profit and for profit local providers serving one particular geographic area to a single state, and, to a limited extent, multi-state providers.

Adult Day Health (ADH)

The ADH market in the United States is highly fragmented, with approximately 12,500 providers operating 15,300 centers according to IBISWorld. The majority of providers are relatively small companies, and only 33% of these providers have two or more locations. In 2016, the National Center on Health Statistics reported that for-profit providers served approximately 45% of the nearly 286,000 individuals who received this service.

Regulatory Framework

We must comply with comprehensive government regulation of our business, including federal, state and local statutes, regulations and policies governing the licensing of services, the quality of service, participation in State and Federal payment systems, the revenues received for services, and reimbursement for the cost of services. State and federal regulatory agencies have broad discretionary powers over the administration and enforcement of laws and regulations that govern our operations.

The following regulatory considerations are critical to our operations:

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Funding. Federal and state funding for our services is subject to frequent statutory and regulatory changes, contracting and managed care initiatives, level of care assessments, court orders, rate setting and state budgetary considerations, all of which may materially increase or decrease reimbursement for our services. We actively participate in local and national legislative initiatives that seek to impact funding and regulation of our services. We derive revenues for our CSS and CFS services and a significant portion of our SRS services from Medicaid programs.

Licensure and qualification to deliver service. We are required to comply with extensive licensing and regulatory requirements applicable to the services we deliver. These include requirements for participation in the Medicaid program, state and local contractual obligations, and requirements relating to individual rights, the credentialing of individual employees and contract Mentors (including background and Office of Inspector General checks), the quality of care delivered, the physical plant and facilitation of community participation. Compliance with state licensing requirements is a prerequisite for participation in government-sponsored public health care assistance programs, such as Medicaid. To qualify for reimbursement under Medicaid, facilities and programs are subject to various requirements imposed by federal and state authorities. We maintain a licensing database that tracks activity impacting licenses governing the provision of services.

In addition to Medicaid participation requirements, our facilities and services are subject to annual or semi-annual licensing and other regulatory requirements of state and local authorities. These requirements relate to the condition of the facilities, the quality and adequacy of personnel staff and service ratios and the quality of services provided. State licensing and other regulatory requirements vary by jurisdiction and are subject to change and local interpretation. From time to time we receive notices from regulatory inspectors that, in their opinion, there are deficiencies resulting from a failure to comply with various regulatory requirements. We review such notices and take corrective action as appropriate. In most cases we and the reviewing agency agree upon the steps to be taken to address the deficiency and, from time to time, we or one or more of our subsidiaries may enter into corrective action plans with regulatory agencies requiring us to take certain actions in order to maintain our licenses or certification. Serious or repeat deficiencies, or failure to comply with corrective action plans, may result in the assessment of fines or penalties, referral holds, payment suspensions and/or decertification or de-licensure actions by various federal or state regulatory agencies.

We deliver services and support under a number of different funding and program provisions. Our most significant sources of funding for our CSS services are home and community based waiver programs ("HCBS Waiver"), Medicaid programs for which eligibility is based on a set of criteria (typically disability or age) established by the state and approved by the federal government. There is no uniformity among states and/or regulations governing our delivery of waivered services to individuals. Each state where we deliver services operates under a plan submitted by the state to Centers for Medicare and Medicaid Services (“CMS”) which approves the state plan and thereby authorizes the state to use Medicaid funds in non-institutional settings using federal financial participation (“FFP”). Typically the state writes state specific regulations governing providers and services provided under the state waiver program. Consequently, there is no uniform method of describing or predicting the content or impact of regulations across states where we deliver HCBS Waiver services. On March 17, 2014, a federal regulation governing HCBS Waiver programs became effective. The rule establishes eligibility requirements for payment for Medicaid home and community-based services provided under the “waiver” program. Under the rule, home- and community-based settings must be integrated in and support full access to the greater community, be selected by the individual from different setting options, ensure individual rights of privacy, and optimize autonomy and independence in making life choices. The rule includes additional requirements for provider-owned or controlled home and community-based residential settings, including that the individual has a lease or other legally enforceable agreement, and standards related to the individual’s privacy, control over schedule and visitors, and physical accessibility of the setting. States have the option to request a variation or delay of compliance with the federal standards for as long as five (5) years from the effective date. Each state has its own implementation scheme and schedule, which presents implementation costs and challenges. At this juncture seven states and the District of Columbia have received final approval of their Statewide Transition Plans, and it remains unclear how other states will implement this regulation. Accordingly, the total cost of compliance with the HCBS waiver remains uncertain.

In addition, our ICFs-I/DD are governed by federal regulations, and may also be subject to individual state rules that vary widely in application and content. Federal regulations require that in order to maintain Medicaid certification as an ICF-I/DD, the facility is subject to annual on-site survey (a federal rule and process implemented by state agencies), the results of which provide or deny the certification necessary to bill Medicaid for services in the facility. Failure to successfully pass this inspection and remedy all defects or conditions cited may result in a finding of immediate jeopardy or other serious sanction and, ultimately, may cause a loss of both certification and funding for that particular facility.

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Similarly, child foster care and other children's services are largely governed by individual state regulations which vary both in terms and regulatory content. Failure to comply with any state's regulations requires remedial action on our part and a failure to adequately remedy the problem may result in provider or contract termination.

All states in which we operate have adopted laws or regulations which generally require that a state agency approve us as a provider, and many require a determination that a need exists prior to the admission of covered individuals or services. Provider licenses are not transferable. Consequently, should we intend to acquire, develop, expand or divest services in any state or to enter a new state, we may be required to undergo a rigorous licensing, transfer and approval process prior to conducting business or completing any transaction.

Similarly, some states have a formal Certificate of Need ("CON") process, whereby the state health care authority must first determine that a service proposed is needed under the state health plan, prior to any service being licensed or applied for. The CON process varies by state and may be formal in design, encompassing any transfer, organizational change, capital improvements, divestitures or acquisitions. Formal processes may include public notice, opportunity for affected parties to request a hearing prior to the health care authority approving the project, as well as an opportunity for the state authority to deny the project. Other states have a less formal process for CON application and approval and may be limited to new or institutional projects. Very few states require CON approval for waivered services. Failure to comply with a state CON process may result in a prohibition on Medicaid billing and may subject the provider to fines, penalties, other civil sanctions or criminal penalties for the operators or owners of an unapproved health service.

Other regulatory matters. The Health Insurance Portability and Accountability Act of 1996, or "HIPAA," as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), set national standards for the protection of health information created, maintained or transmitted by health providers. Under the law and regulations known collectively as the privacy and security rules, covered entities must implement standards to protect and guard against the misuse of individually identifiable health information, report breaches and undertake notification and remedial steps consistent with regulation.

Federal regulations issued pursuant to HIPAA and the HITECH ACT contain, among other measures, provisions that require organizations to implement significant and expensive computer systems, employee training programs and business procedures. Rules have been established to protect the integrity, security and distribution of electronic health and related financial information. Many states have also implemented extensive data privacy and security laws and regulations. Failure to timely implement or comply with HIPAA or other data privacy and security regulations may, under certain circumstances, trigger the imposition of civil or criminal penalties.

The federal False Claims Act imposes civil liability on individuals and entities that submit or cause to be submitted false or fraudulent claims for payment to the government. Violations of the False Claims Act may include treble damages and penalties of up to $11,000 per false or fraudulent claim. Similarly, retention of any overpayments may be regarded by the government as a false claim.

In addition to actions being brought by government officials under the False Claims Act, this statute and analogous state laws also allow a private individual with direct knowledge of fraud to bring a "whistleblower" claim on behalf of the government for violations. The whistleblower receives a statutory amount of up to 30% of the recovered amount from the government's litigation proceeds if the litigation is successful or if the case is successfully settled. Recently, the number of whistleblower suits brought against healthcare providers has increased dramatically, and has included suits based (among other things) upon alleged violations of the Federal Anti-Kickback Law.

The Anti-Kickback Law prohibits kickbacks, rebates and any other forms of remuneration in return for referrals. Any remuneration, direct or indirect, offered, paid, solicited or received, in return for referrals of patients or business for which payment may be made in whole or in part under Medicaid, could be considered a violation of law. The language of the Anti-Kickback law also prohibits payments made to anyone to induce them to recommend purchasing, leasing, or ordering any goods, facility, service or item for which payment may be made in whole or in part by Medicaid. Criminal penalties under the Anti-Kickback Law include fines up to $25,000, imprisonment for up to 5 years, or both. In addition, acts constituting a violation of the Anti-Kickback Law may also lead to civil penalties, such as fines, assessments and exclusion from participation in the Medicaid program.

Additionally we must comply with local zoning and licensing ordinances and requirements. The Federal Fair Housing Amendments Act of 1988 protects the interests of the individuals we serve, prohibits local discriminatory ordinance practices and provides additional opportunities and accommodations for people with disabilities to live in their community of choice.

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Federal regulations promulgated by the Occupational Safety and Health Administration (“OSHA”) require us to have safety plans for blood borne pathogens and other work place risks. At any point in time OSHA investigators may receive a complaint which requires on-site inspection and/or audit, the outcome of which may adversely affect our operations.

The Patient Protection and Affordable Care Act of 2010 provided a mandate for more vigorous and widespread enforcement and directed state Medicaid agencies to establish Recovery Audit Contractor (“RAC”) programs. RACs are private entities which will perform audits on a contingency fee basis, giving them an incentive to identify discrepancies in payments, from which they may be permitted to extrapolate disproportionately large penalties and fines. States were required to be in compliance by January 1, 2012 unless granted an extension. We have experienced only modest RAC auditing activity to date; however this remains a fairly new federal initiative and the ultimate impact remains unclear. Only the passage of time and our experience with enforcement and compliance will permit our assessment of the exact impact the new statute and regulations have on our business.

Similarly the HIPAA and HITECH Regulations increased both the scope of liability and obligations of business associates with whom such covered entities contract for services, as well as increase disclosure obligations of providers in the event of a breach. The Federal enforcement agency has expressed an intent to increase investigations and potential penalties for noncompliance in part due to these new standards.

Managed care initiatives have recently been undertaken in certain states, notably in Iowa and Wisconsin, and those initiatives have impacted our business by modifying the types of services eligible for payment, the qualifications required for payment and the rates that are paid for those services. Managed care organizations ("MCOs") undertake frequent rate changes some of which are difficult to predict and the impact of those changes may reduce our revenue and ability to bill for services. In addition, as MCOs merge with others or leave the marketplace we may experience higher unpaid receivables as we enter into new contracts with the MCO's successor. Similarly, some states are pursuing waivers for dual-eligible populations (that is, persons eligible for both Medicare and Medicaid), and our ability to participate in such waivered services in some markets may depend on our ability to become a Medicare provider.

We participate in Medicare in a very select number of areas of the country, as well as in managed care projects that allocate funds for recipients who are dually eligible for Medicare and Medicaid. Medicare has a unique and different set of regulations, funding mechanisms and audit and compliance risks compared to Medicaid. In recent years, states have begun working toward maximizing Medicare funding for services for dual eligible populations due to the fiscal incentive to lower state contributions and shift the cost of service to Medicare. In some state markets “equalization” of rates is required, thereby mandating that the rates we charge to private payors may not exceed rates established and paid by Medicaid and/or Medicare. Public policy initiatives and cost-containment initiatives in the Medicare program may continue and may affect our operating margins where we participate in Medicare.

Conviction of abusive or fraudulent behavior with respect to one facility or program may subject other facilities and programs under common control or ownership to disqualification from participation in the Medicaid program. Executive Order 12549 prohibits any corporation or facility from participating in federal contracts if it or its principals (included but not limited to officers, directors, owners and key employees) have been debarred, suspended or declared ineligible or have been voluntarily excluded from participating in federal contracts. In addition, some state regulations provide that all facilities licensed with a state under common ownership or control are subject to delicensure if any one or more of such facilities are delicensed.

We must also comply with the standards set forth by the Office of Inspector General (“OIG”) governing internal compliance and external reporting requirements. We regularly review and monitor OIG advisory opinions, although they are often limited in their application to community-based Medicaid providers. Significant legislative, media and public attention has recently focused on health care. Because the law in this area is complex and continuously evolving, ongoing or future governmental investigations or litigation may result in interpretations that are inconsistent with our current practices. It is possible that outside entities could initiate investigations or future litigation impacting our services and that such matters could result in penalties and adverse publicity. It is also possible that our executive and other management personnel could be included in these investigations and litigation or be named defendants.

We are also subject to a large number of employment related laws and regulations, including laws regarding discrimination, wrongful discharge, retaliation, and federal and state wage and hours laws.

The Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010, and the rules and regulations thereunder (together, the "Affordable Care Act"), imposed requirements and restrictions, including, but not limited to, guaranteed coverage requirements, prohibitions on some annual and all lifetime limits on amounts paid on behalf of or to our employees, increased restrictions on rescinding coverage, establishment of minimum medical loss ratio

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requirements, the establishment of state insurance exchanges and essential benefit packages, and greater limitations on product pricing.

A material violation of a law or regulation could subject us to fines and penalties and in some circumstances could disqualify some or all of the facilities and programs under our control from future participation in Medicaid or other government programs. Failure to comply with laws and regulations could have a material adverse effect on our business.

A Compliance Officer (vice president level position) oversees our compliance program and reports to our Chief Legal Officer, a management compliance committee, the board's quality and risk management committee and the board's audit committee, as applicable. The program activities are reported regularly to the management compliance committee which includes the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer and Chief Quality Officer, as well as HR, legal and other quality improvement leaders. In addition, the program activities are periodically reported at the board level.

Seasonality

In general, our financial performance is not significantly impacted by fluctuations from seasonality.

Item 1A. Risk Factors.

Our business faces a number of risks. The risks described below are items of most concern to us, however these are not all of the risks we face. Additional risks and uncertainties not presently known to us or that we currently consider immaterial may also impact our business operations.

Reductions or changes in Medicaid funding or changes in budgetary priorities by the federal, state and local governments that pay for our services could have a material adverse effect on our revenue and profitability.

We currently derive approximately 89% of our revenue from contracts with state and local governments. These governmental payors fund a significant portion of their payments to us through Medicaid, a joint federal and state health insurance program through which state expenditures are matched by federal funds typically ranging from 50% to approximately 75% of total costs, a number based largely on a state's per capita income. Our revenue, therefore, is largely determined by the level of federal, state and local governmental spending for the services we provide.

Efforts at the federal level to reduce the federal budget deficit, restructure the Medicaid program, and/or repeal or replace the Patient Protection and Affordable Care Act pose risk for significant reductions in federal Medicaid matching funds to state governments. Such efforts could include proposals to provide states with more flexibility to determine Medicaid benefits, eligibility or provider payments through the use of block grants, per capita caps or streamlined waiver approvals, as well as those that would reduce the amount of federal Medicaid matching funding available to states by curtailing the use of provider taxes or by adjusting the Federal Medical Assistance Percentage (FMAP). Furthermore, any new Medicaid-funded benefits and requirements established by Congress that mandate certain uses for Medicaid funds could have the effect of diverting those funds from the services we provide.

Budgetary pressures, a decline in tax revenue, as well as other economic, industry, and political factors, could cause state governments to limit spending, which could significantly reduce our revenue, referrals, margins and profitability, and adversely affect our growth strategy. Governmental agencies generally condition their contracts with us upon a sufficient budgetary appropriation. If a government agency does not receive an appropriation sufficient to cover its contractual obligations with us, it may terminate a contract or defer or reduce our reimbursement. There is also risk that previously appropriated funds could be reduced through subsequent legislation or that the Federal Government will fail to approve amendments to a waiver plan proposed by a state. In the past, several states in which we operate, including the states of Minnesota, California, Massachusetts, Indiana, Arizona, and West Virginia, where we generate significant revenue have implemented rate reductions, rate freezes and service reductions in response to state budgetary deficits. Delays in payment caused by a state's financial pressures could have a material adverse effect on our cash flows, liquidity and financial condition. Similarly, programmatic changes such as conversions to managed care with related contract demands regarding billing and services, unbundling of services, governmental efforts to increase consumer autonomy and reduce provider oversight, coverage and other changes under state Medicaid plans, may cause unanticipated costs and risks to our service delivery. The loss or reduction of or changes to reimbursement under our contracts could have a material adverse effect on our business, financial condition and operating results.

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Our variable cost structure is directly related to our labor costs, which may be adversely affected by labor shortages, a deterioration in labor relations, increased unionization activities or mandated wage increases.

Our variable cost structure and operating profitability are directly related to our labor costs. Labor costs may be adversely affected by a variety of factors, including employee turnover, a limited supply of qualified personnel in any geographic area, local competitive forces, ineffective utilization of our labor force, increases in minimum wages or the need to increase wages to remain competitive, health care costs and other personnel costs, and adverse changes in our service models. We typically cannot recover our increased labor costs from payors and must absorb them ourselves. We have incurred higher labor costs in certain markets from time to time because of difficulty in hiring qualified direct support professionals. These higher labor costs have resulted from increased wages and overtime and the costs associated with recruitment and retention, training programs and use of temporary staffing personnel.

Although our employees are generally not unionized, we acquired one business in New Jersey in 2010 that currently has approximately 40 employees who are represented by a labor union. From time to time, we experience attempts to unionize certain of our non-union employees. In June 2018, we lost a union petition to organize approximately 62 employees in Florida. The National Labor Relations Board ("NLRB") currently has a rule that significantly reduces the maximum number of days to hold a union election and this reduction in the open election period limits the Company's ability to adequately inform employees regarding the risks associated with unionization. Future unionization activities could result in an increase of our labor and other costs. If any employees covered by a collective bargaining agreement were to engage in a strike, work stoppage or other slowdown, we could experience a disruption of our operations and/or higher ongoing labor costs, which could adversely affect our business, financial condition and results of operations.

We expect increases in payroll expenses as a result of recent policy initiatives to increase the minimum wage. The financial impact of such increases is not expected to be material in most of our states with an increasing minimum wage, and in others we anticipate receiving corresponding rate increases intended to pay for much of or all of the increased expense incurred as a result of the higher minimum wages. However, we cannot assure you that there will not be a material impact from increasing minimum wages in the future.

Our business subjects us to substantial claims, litigation and governmental proceedings.

We are in the health and human services business and, therefore, we have been and continue to be subject to substantial claims alleging that we, our employees or our Mentors failed to provide proper care for an individual we support. We are also subject to claims by the individuals we support, our employees, our Mentors or community members against us for negligence and intentional misconduct, or violation of applicable laws. Included in our recent claims are claims alleging personal injury, assault, abuse, wrongful death, violations of wage and hour laws and other charges. For more information, see "Item 3, Legal Proceedings".

We are subject to United States federal, state and local employment laws that expose us to potential liability if we are determined to have violated such employment laws. Failure to comply with federal and state labor laws pertaining to minimum wage, overtime pay, meal and rest breaks, unemployment tax rates, workers' compensation rates, citizenship or residency requirements, and other employment-related matters may have a material adverse effect on our business or operations. In addition, employee claims based on, among other things, discrimination, harassment or wrongful termination may divert financial and management resources and adversely affect operations. We are further subject to the Fair Labor Standards Act (which governs such matters as minimum wages, overtime and other working conditions) as well as state and local wage and hour laws.

There are currently two pending complaints in California state court that allege certain wage and hour violations of California laws and seek to be designated as class-actions. Two additional wage and hour class actions brought in California have been settled and approved by the court.The Company's policy is to accrue for all probable and estimable claims using information available at the time the financial statements are issued. Actual claims could settle in the future at materially different amounts due to the nature of litigation.

A litigation award excluded by, or in excess of, our third-party insurance limits and self-insurance reserves could have a material adverse impact on our operations and cash flow and could adversely impact our ability to continue to purchase appropriate liability insurance. Even if we are successful in our defense, lawsuits or regulatory proceedings

could also irreparably damage our reputation.

Regulatory agencies may initiate administrative proceedings alleging that our programs, employees or agents violate statutes and regulations and seek to impose monetary penalties on us or ask for recoupment of amounts paid. We could be required to incur significant costs to respond to regulatory investigations or defend against lawsuits and, if we do not prevail,

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we could be required to pay substantial amounts of money in damages, settlement amounts or penalties arising from these legal proceedings.

Reductions in reimbursement rates, a failure to obtain increases in reimbursement rates or subsequent negative audit adjustments could adversely affect our revenue, cash flows and profitability.

Our revenue and operating profitability depend on our ability to maintain our existing reimbursement levels and to obtain periodic increases in reimbursement rates to meet higher costs and demand for more services. Approximately 4.9% of our revenue is derived from contracts based on a retrospective cost reimbursement model, whereby we are required to maintain a certain cost structure in order to realize the specified rate. For such programs, if our costs are less than the required amount, we are required to return a portion of the revenue to the payor. Some of our programs are also subject to prospective rate adjustments based on current spending levels. For such programs, we could experience reduced rates in the future if our current spending is not sufficient. If we are not entitled to, do not receive or cannot negotiate increases in reimbursement rates, or are forced to accept a reduction in our reimbursement rates at approximately the same time as our costs of providing services increase, including labor costs and rent, our margins and profitability could be adversely affected.

Changes in how federal and state government agencies operate reimbursement programs can also affect our operating results and financial condition. Some states have, from time to time, revised their rate-setting methodologies in a manner that has resulted in rate decreases. In some instances, changes in rate-setting methodologies have resulted in third-party payors disallowing, in whole or in part, our requests for reimbursement. Any reduction in or the failure to maintain or increase our reimbursement rates could have a material adverse effect on our business, financial condition and results of operations. Changes in the manner in which state agencies interpret program policies and procedures or review and audit billings and costs could also adversely affect our business, financial condition and operating results.

As a result of cost reporting, we have from time to time experienced audit adjustments which are based on subjective judgments of reasonableness, necessity or allocation of costs in our services provided to individuals that we support. These adjustments are generally required to be negotiated as part of the overall audit resolution and may result in paybacks to payors and adjustments of our rates. We cannot assure you that our rates will be maintained or that we will be able to keep all payments made to us, until an audit of the relevant period is complete.

Our information systems are critical to our business and a failure of those systems, or a failure to upgrade them when required, could materially harm us.

We depend on our ability to store, retrieve, process and manage a significant amount of information, and to provide our operations with efficient and effective accounting, census, incident reporting and other quality assurance systems. Our information systems require maintenance and upgrading to meet our needs, which could significantly increase our administrative expenses.

We rely on information technology networks and systems to process, transmit and store electronic information in order to manage or support a variety of our business processes, including consumer records, financial transactions and maintenance of records. These processes may include sensitive financial information, personally identifiable information of individuals we serve and employees, and personal health information protected by HIPPA. Our business and operations may be harmed if we do not securely maintain our business processes and information systems or maintain the integrity of our confidential information. Although we have developed systems and processes that are designed to protect information against security breaches, it is impossible to prevent all security breaches. Failure to protect such information or mitigate any such breaches may adversely affect our operating results. Security breaches, including physical or electronic break-ins, computer viruses, attacks by hackers and similar breaches, can create system disruptions, shutdowns and unauthorized disclosure of confidential information. Any failure to maintain proper function, security and availability of our information systems could interrupt our operations, damage our reputation, subject us to liability claims or regulatory penalties, increase administrative expenses or lead to other adverse consequences.

Any system failure that causes an interruption in service or availability of our critical systems could adversely affect operations or delay the collection of revenues. Even though we have implemented network security measures, our servers are vulnerable to computer viruses, hacking and similar disruptions from unauthorized tampering. The occurrence of any of these events could result in interruptions, delays, the loss or corruption of data, or cessations in

the availability of systems, all of which could have a material adverse effect on our financial position and results of operations and harm our business reputation. Furthermore, a loss of health care information could result in potential penalties in certain of our businesses if we fail to comply with privacy and security standards in violation of HIPAA, as amended by the HITECH Act.

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The performance of our information technology and systems is critical to our business operations. Our information systems are essential to a number of critical areas of our operations, including:

- accounting and financial reporting;
- billing and collecting accounts;
- coding and compliance;
- clinical systems, including census and incident reporting;
- records and document storage; and
- monitoring quality of care and collecting data on quality and compliance measures.

In addition, as we continue to upgrade our systems, we run the risk of ongoing disruptions while we transition from legacy, and often paper-based, systems. Disruptions in our systems could result in delays and difficulties in billing, which could negatively affect our results from operations and cash flows. We may choose systems that ultimately fail to meet our needs, or that cost more to implement and maintain than we had anticipated. Such systems may become obsolete sooner than expected, our payors may require us to invest in other systems, and state and/or federal regulations may impose electronic records standards that we cannot easily address from our existing platform. If we fail to upgrade successfully and cost-effectively, or if we are forced to invest in new or incompatible technology, our financial condition, cash flows and results of operations may suffer.

In late December 2017, we discovered that an unencrypted disk sent to us by a third party software provider was lost in the mail. We conducted an investigation to determine the nature and scope of this incident, the types of information involved and the individuals affected. Based on the results of the investigation, personal identifiable information of approximately 80 individuals was potentially compromised and personal health information of approximately 7,300 individuals across 35 states was potentially compromised. We offered free credit monitoring to the 80 individuals where personal identifiable information was potentially compromised. In accordance with State and Federal Law, we notified the state Attorney General office for the states of California, Indiana, Massachusetts, Maryland, New York and New Jersey and the Office of Health and Human Services. In response to our notification to the Office of Health and Human Services ("HHS"), HHS requested additional information which we have provided. We have notified our cybersecurity insurance provider of the event. As of the date of this filing, we are not aware of any actual or attempted misuse of information as a result of this incident.

We have high turnover among our direct service professionals, particularly in the first year of employment, substantial competition in attracting and retaining experienced personnel, and we may be unable to maintain or grow our business if we cannot attract and retain qualified employees.

Our success depends to a significant degree on our ability to attract and retain qualified and experienced human service and other professionals, who possess the skills and experience necessary to deliver quality services to the individuals we support and manage our operations. We face significant competition for certain categories of our employees, particularly direct service professionals and managers. Contractual requirements and service needs determine the number, as well as the education and experience levels, of health and human service professionals we hire. We have high turnover among our direct service professionals, particularly in their first year of employment. Also, due to the nature of the services we provide, our working conditions require additional sensitivities and skills relative to traditional medical care environments. Our ability to attract and retain employees with the requisite credentials, experience and skills depends on several factors, including, but not limited to, our ability to offer competitive wages, benefits, working conditions and professional growth opportunities. The inability to attract and retain experienced personnel could have a material adverse effect on our business.

Negative publicity or changes in public perception of our services may adversely affect our ability to obtain new contracts and renew existing ones or obtain third-party referrals.

Our success in obtaining new contracts and renewals of our existing contracts depends upon maintaining our reputation as a quality service provider among governmental authorities, advocacy groups, families of individuals we serve, our individuals we serve and the public. Negative publicity, changes in public perception, quality lapses, legal proceedings and government investigations with respect to our operations could damage our reputation and hinder our ability to retain contracts and obtain new contracts, and could reduce referrals, increase government scrutiny and compliance or litigation costs, or generally discourage individuals from choosing us as a provider. Any of these events

could have a material adverse effect on our business, financial condition and operating results.

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Our reputation and prior experience with agency staff, direct support professionals and others in positions to make referrals to us are important for building and maintaining our operations. Any event that harms our reputation or creates negative experiences with such third parties could impact our ability to receive referrals and maintain or grow our base of individuals we serve.

On April 24, 2015, the United States Senate Finance Committee (the "SFC") sent a letter to the governor of every state requesting information regarding the state's administration of its foster care system and, in particular, the role of privatized foster care involving both not-for-profit and for-profit agencies. On June 17, 2015, the SFC sent a letter to us requesting extensive information regarding our foster care services. Following the June 17, 2015 letter, we received additional requests for further information regarding our foster care services from the SFC. We cooperated with the SFC's requests for information. In October 2017, the SFC issued a report. While our organization was a focus of the report, there was no recommendation to take any action against us. The report could engender further negative publicity and other negative actions that may harm us.

Our financial results could be adversely affected if claims against us are successful, to the extent we must make payments under our self-insured retentions, if claims are not covered by our applicable insurance or if the costs of our insurance coverage increase.

We have been and continue to be subject to substantial claims against our professional and general liability and automobile liability insurance. In addition, we have been and continue to be subject to substantial wage and hour claims. Professional and general liability claims, if successful, could result in substantial damage awards which might require us to make significant payments under our self-insured retentions and increase future insurance costs. Commencing October 1, 2015, we have been self-insured for $3.0 million per claim and $28.0 million in the aggregate. We may be subject to increased self-insurance retention limits in the future which could have a negative impact on our results. An award may exceed the limits of any applicable insurance coverage, and awards for punitive damages may be excluded from our insurance policies either contractually or by operation of state law. In addition, our insurance does not cover all potential liabilities including, for example, those arising from employment practice claims, wage and hour violations, and governmental fines and penalties. As a result, we may become responsible for substantial damage awards that are uninsured.

Insurance against professional and general liability and automobile liability can be expensive and our insurance premiums may increase in the future. Insurance rates vary from state to state, by type and by other factors. It is also possible that our liability and other insurance coverage will not continue to be available at acceptable costs or on favorable terms. Rising costs of insurance premiums, and successful claims against us or the unavailability of insurance, could have a material adverse effect on our financial position and results of operations.

If payments for claims exceed actuarially determined estimates, if claims are not covered by insurance, or if our insurers fail to meet their obligations, our results of operations and financial position could be adversely affected.

The nature of services that we provide could subject us to significant workers' compensation related liability, some of which may not be fully reserved for.

We use a combination of insurance and self-insurance plans to provide for potential liability for workers' compensation claims. Because we have so many employees, and because of the inherent physical risk associated with the interaction of employees with the individuals we support, many of whom have intensive care needs, the potential for incidents giving rise to workers' compensation liability is high.

We estimate liabilities associated with workers' compensation risk and establish reserves each quarter based on internal valuations, third-party actuarial advice, historical loss development factors and other assumptions believed to be reasonable under the circumstances. In prior years, our results of operations have been adversely impacted by higher than anticipated claims, and they may be adversely impacted in the future if actual occurrences and claims exceed our assumptions and historical trends.

The Patient Protection and Affordable Care Act materially reduced the flexibility we had in maintaining our healthcare costs and may make it harder for us to compete as an employer.

The Patient Protection and Affordable Care Act imposed mandates on employers and individuals. Since January 2014, we offer employees health coverage that meets the requirements of the Patient Protection and Affordable Care Act. Uncertainty and speculation regarding the possible repeal of all or a portion of the Patient Protection and Affordable Care Act has continued since the Presidential election in 2016. Depending upon claims experience or enrollment changes in our new plans, or changes to the existing law, our cost for employee health insurance could materially increase. Moreover, if the coverage we are offering

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isn’t competitive with the health insurance benefits our employees could receive at other employers, we may become less attractive as an employer and it may become more difficult for us to compete for qualified employees.

Economic conditions could have a material adverse effect on our cash flows, liquidity and financial condition.

Our government payors rely on tax revenue to pay for our services. In the wake of the last economic recession that began in 2008, most states faced unprecedented declines in tax revenues and, as a result, record budget gaps. Furthermore, even after nine years of economic improvement, state tax revenue is on average only slightly above prerecession levels, after adjusting for inflation, and only 34 states' revenues have surpassed prerecession levels in inflation adjusted terms. If the economy were to contract into a recession, our government payors or other counterparties that owe us money could be delayed in obtaining, or may not be able to obtain, necessary funding and/or financing to meet their cash flow needs. If the credit rating of the federal government is downgraded, it is possible there will be related downgrades of state credit ratings as well. If this or unrelated state downgrades occur, it could be more expensive for states to finance their cash flow needs and put additional pressure on state budgets. Delays in payment could have a material adverse effect on our cash flows, liquidity and financial condition. In the event that our payors or other counterparties are financially unstable or delay payments to us, our financial condition could be impaired.

State and local government payors with which we have contracts have complicated billing and collection rules and regulations, and if we fail to meet such requirements, our business could be materially impacted.

We derive approximately 89% of our revenue from contracts with state and local government agencies, and a substantial portion of this revenue is state-funded with federal Medicaid matching dollars. In billing for our services to third-party payors, we must follow complex documentation, coding and billing rules and there can be delays before we receive payment. These rules are based on federal and state laws, rules and regulations, various government pronouncements, and on industry practice. If we fail to comply with federal and state documentation, coding and billing rules, we could be subject to criminal and/or civil penalties, loss of licenses and exclusion from the Medicaid programs, which could materially adversely affect us. Specifically, failure to follow these rules could result in potential criminal or civil liability under the False Claims Act and various federal and state criminal healthcare fraud statutes, under which extensive financial penalties and exclusion from participation in federal healthcare programs can be imposed.

Federal false claims laws prohibit any person from knowingly presenting or causing to be presented a false claim for payment to the federal government, or knowingly making or causing to be made a false statement to get a false claim paid. Penalties for a False Claims Act violation include three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim, the potential for exclusion from participation in federal healthcare programs and criminal liability. The majority of states also have statutes or regulations similar to the federal false claims laws, which apply to items and services reimbursed under Medicaid and other state programs, or, in several states, apply regardless of the payor. See “—We are subject to extensive governmental regulations, which require significant compliance expenditures, and a failure to comply with these regulations could adversely affect our business.”

We annually submit a large volume of claims for Medicaid and other payments, and there can be no assurance that there have not been errors. The rules are frequently vague and confusing, our systems are often manual, and we cannot assure that governmental investigators, private insurers, private whistleblowers or Medicaid auditors will not challenge our practices. Such a challenge could result in a material adverse effect on our business.

We are routinely subject to governmental reviews, audits and investigations to verify our compliance with applicable laws and regulations. As a result of these reviews, audits and investigations, these governmental payors may be entitled to, at their discretion:

- require us to refund amounts we have previously been paid;
- terminate or modify our existing contracts;
- suspend or prevent us from receiving new contracts or extending existing contracts;

- impose referral holds on us;
- impose fines, penalties or other sanctions on us; and
- reduce the amount we are paid under our existing contracts.

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As a result of past reviews and audits of our operations, we have been and are subject to some of these actions from time to time. While we do not currently believe that our existing governmental reviews and audit proceedings will have a material adverse effect on our financial condition or significantly harm our reputation, we cannot assure you that such actions or similar actions in the future will not do so. In addition, such proceedings could have a material adverse impact on our results of operations in a future reporting period. Moreover, if we are required to restructure our billing and collection methods, these changes could be disruptive to our operations and costly to implement. Complicated billing and collection procedures can result in delays in collecting payment for our services, which may adversely affect our liquidity, cash flows and operating results.

The reimbursement process is time consuming and complex, and there can be delays before we receive payment. Government reimbursement, facility credentialing, Medicaid recipient eligibility, service authorization procedures, and the use of MCOs, are often complicated and burdensome, and delays can result from, among other things, securing documentation and coordinating necessary eligibility paperwork between agencies. Similar issues arise in seeking payment from some of our private payors. These reimbursement and procedural issues occasionally cause us to have to resubmit claims several times and manage other administrative requests before payment is remitted. Missed filing deadlines can cause rejections of claims. If there is a billing error, the process to resolve the error may be time-consuming and costly. To the extent that complexity associated with billing for our services causes delays in our cash collections, we assume the financial risk of increased carrying costs associated with the aging of our accounts receivable as well as increased potential for write-offs. We can provide no assurance that we will be able to collect payment for claims at our current levels in future periods. The risks associated with third-party payors and the inability to monitor and manage accounts receivable successfully could have a material adverse effect on our liquidity, cash flows and operating results.

Failure to comply with requirements to design, implement and maintain effective internal controls could have a material adverse effect on our business.

We are required, pursuant to Section 404 of the Sarbanes-Oxley Act, to furnish a report by management on the effectiveness of our internal control over financial reporting. In addition, our independent registered public accounting firm must report on its evaluation of our internal controls over financial reporting. If we are unable to remedy deficiencies, or if we identify additional deficiencies in the future, we may be unable to conclude that our internal control over financial reporting is effective or obtain an unqualified opinion from our independent registered public accounting firm.

We have a history of losses, and we might not be profitable in the future.

Due in large part to our high levels of indebtedness, prior to fiscal 2015 we have had a history of losses. Although we generated net income of $14.9 million, $6.3 million, and $9.2 million for the years ended September 30, 2018, 2017, and 2016, respectively, and have decreased our interest obligations by repaying all of our senior notes and refinancing our senior secured credit facilities, we could report losses in the future. Other factors may cause us to report losses in the future, including reductions in funding for our services, reductions in reimbursement rates, increases in our costs, increased competition and other factors described elsewhere under this “Item 1A, Risk Factors”.

Our level of indebtedness could adversely affect our liquidity and ability to raise additional capital to fund our operations, and it could limit our ability to invest in our growth initiatives or react to changes in the economy or our industry.

We have a significant amount of indebtedness and substantial leverage. As of September 30, 2018, we had total indebtedness, excluding capital lease obligations, of $700.1 million and an ability to borrow up to an additional $157.1 million under our revolving credit facility. On January 31, 2019, the aggregate revolving commitments under the revolving credit facility will decrease from $160.0 million to $70.0 million. Borrowings under the senior secured credit facilities bear interest at rates that fluctuate with changes in certain short-term prevailing interest rates. If interest rates increase, our debt service obligations on any portion of our variable rate indebtedness that we have not

hedged would increase even though the amount borrowed remained the same. We expect to continue to make new investments in our growth that may reduce liquidity, and we may need to increase our indebtedness in the future. Our substantial degree of leverage could have important consequences, including the following:

- it may curtail our acquisitions program and may limit our ability to invest in our infrastructure and in growth opportunities;

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- it may diminish our ability to obtain additional debt or equity financing for working capital, capital expenditures, debt service requirements and general corporate or other purposes;
- the debt service requirements of our indebtedness could make it more difficult for us to satisfy our indebtedness and contractual and commercial commitments;
- a significant portion of our cash flows from operations will be dedicated to the payment of principal and interest on our indebtedness and will not be available for other purposes, including our operations, future business opportunities and acquisitions and capital expenditures;
- interest rates on any portion of our variable interest rate borrowings under the senior secured credit facilities that we have not hedged may increase;
- it may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that have less debt and a lower degree of leverage; and
- we may be vulnerable if the country falls into another recession, or if there is a downturn in our business, or we may be unable to carry out activities that are important to our growth.

Subject to restrictions in the senior credit agreement, we may be able to incur more debt in the future, which may intensify the risks described in this risk factor. All of the borrowings under our senior secured credit facilities are secured by substantially all of the assets of the National Mentor Holdings, Inc. ("NMHI") and its subsidiaries.

In addition to our significant amount of indebtedness, we have significant rental obligations under our operating leases for our group homes, other service facilities and administrative offices. For the fiscal year ended September 30, 2018 our aggregate rental expense for these leases was $92.9 million. We expect this number will increase during fiscal 2019 as a result of new leases entered into pursuant to acquisitions and new program starts. Our ongoing rental obligations could exacerbate the risks described above.

Our ability to generate sufficient cash flow to fund our debt service, rental payments and other obligations depends on many factors beyond our control. In addition, possible acquisitions or investments in organic growth and other strategic initiatives could require additional debt financing. If our future cash flows do not meet our expectations and we are unable to service our debt, or if we are unable to obtain additional debt financing, we may be forced to take actions such as revising or delaying our strategic plans, reducing or delaying acquisitions, selling assets, restructuring or refinancing our debt, or seeking additional equity capital. We may be unable to effect any of these transactions on satisfactory terms, or at all. Our inability to generate sufficient cash flow to satisfy our debt service obligations, or to obtain additional financing on satisfactory terms, or at all, could have a material adverse effect on our business, financial condition and operating results.

If we fail to establish and maintain relationships with government agencies, we may not be able to successfully procure or retain government-sponsored contracts, which could negatively impact our revenue.

To facilitate our ability to procure or retain government-sponsored contracts, we rely in part on establishing and maintaining relationships with officials of various government agencies, primarily at the state and local level but also including federal agencies. These relationships enable us to maintain and renew existing contracts and obtain new contracts and referrals. The effectiveness of our relationships may be reduced or eliminated with changes in the personnel holding various government offices or staff positions. We also may lose key personnel who have these relationships, and such personnel may not be subject to non-compete or non-solicitation covenants. Any failure to establish, maintain or manage relationships with government and agency personnel may hinder our ability to procure or retain government-sponsored contracts, and could negatively impact our revenue.

A loss of our status as a licensed service provider in any jurisdiction could result in the termination of existing services and our inability to market our services or acquire other services in that jurisdiction.

We operate in numerous jurisdictions and are required to maintain licenses and certifications in order to conduct our operations in each of them. Each state and local government has its own regulations, which can be complicated. Additionally, each of our operating divisions can be regulated differently within a particular jurisdiction. As a result, maintaining the necessary licenses and certifications to conduct our operations is cumbersome. Our licenses and certifications could be suspended, revoked or terminated for a number of reasons, including the:

- failure by our direct care staff or host-home providers to properly care for individuals;

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- failure to submit proper documentation to the applicable government agency, including documentation supporting reimbursements for costs;
- failure by our programs to abide by the applicable laws and regulations relating to the provision of health and human services; and the
- failure of our facilities to comply with the applicable building, health and safety codes and ordinances.

From time to time, some of our licenses or certifications, or those of our employees, are temporarily placed on probationary status or suspended. If we lost our status as a licensed provider of health and human services in any jurisdiction or any other required certification, we would be unable to market our services in that jurisdiction, and the contracts under which we provide services in that jurisdiction would be subject to termination. This includes the possibility of loss or suspension of licenses for an entire state. For instance, in Minnesota a loss or suspension of our license in a particular county may result in the loss or suspension of any license held by one of our affiliates in the state which could preclude us from providing services throughout the entire state. In addition, in providing services in certain jurisdictions, we subcontract to another provider. In those situations, the other provider may hold the license or certification. However, if the other provider's license or certification were revoked or suspended, we may no longer be permitted to provide services in that jurisdiction. Loss of a license as a direct provider or subcontractor of another provider of health and human services could constitute a violation of provisions of contracts in other jurisdictions, resulting in other contract, license or certification terminations. Any of these events could have a material adverse effect on our financial performance and operations.

We conduct a significant percentage of our operations in Minnesota and, as a result, we are particularly susceptible to any reduction in budget appropriations for our services or any other adverse developments in that state.

For the fiscal years ended September 30, 2018, 2017, and 2016, approximately 16%, 15%, and 15% of our net revenue was derived from contracts with government agencies in the State of Minnesota, respectively. Accordingly, any reduction in Minnesota's budgetary appropriations for our services, whether as a result of fiscal constraints due to recession, changes in policy or otherwise, could result in a reduction in our revenues and possibly the loss of contracts. In 2018, through the waiver amendment process, CMS questioned whether a series of rate increases were duplicating intended impact and declined to provide federal match funding. Accordingly, effective July 1, 2018, a 7% rate decrease for a portion of the individuals that we serve in the state went into effect. While the state legislature attempted to reverse the cut prior to the effective date, and may attempt to do so again when the state legislature reconvenes in 2019, there is no assurance that the rate cut will be reversed, and we can provide no assurance there will be no additional rate reductions in the future in Minnesota. The concentration of our operations in Minnesota also makes us particularly susceptible to many of the other risks described above occurring in this state, including:

- the failure to maintain and renew our licenses;
- the failure to maintain important relationships with officials of government agencies; and
- any negative publicity regarding our operations.

Any of these adverse developments occurring in Minnesota could result in a reduction in revenue or a loss of contracts, which could have a material adverse effect on our results of operations, financial position and cash flows.

We have increased and will continue to make substantial expenditures to expand existing services, win new business and grow revenue, but we may not realize the anticipated benefits of such increased expenditures.

In order to grow our business, we must capitalize on opportunities to expand existing services and win new business, some of which require spending in advance of revenue. For example, states such as Ohio, California and Pennsylvania are in the process of transitioning individuals with intellectual and developmental disabilities from state-run institutions and other large institutional settings into community-based settings such as ours. Responding to opportunities such as these typically requires significant investment of our resources in advance of revenue.

We spend a significant amount on growth initiatives, especially new starts. These investments have had a negative effect on our operating margin, and we may not realize the anticipated benefits of the spending as soon as we expect to or at any point in the future. If we target the wrong areas, or fail to identify the evolving needs of our payors by responding with service offerings that meet their fiscal and programmatic requirements, we may not realize the anticipated benefits of our investments and the results of our operations may suffer.

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We may not realize the anticipated benefits of any future acquisitions, and we may experience difficulties in integrating these acquisitions.

As part of our growth strategy, we intend to make acquisitions. Growing our business through acquisitions involves risks because with any acquisition there is the possibility that:

- the business we acquire may not continue to generate income at the same historical levels on which we based our acquisition decision;
- we may be unable to maintain and renew the contracts of the acquired business;
- unforeseen difficulties may arise in integrating the acquired operations, including employment practices, information systems and accounting controls;
- we may not achieve operating efficiencies, synergies, economies of scale and cost reductions as expected;
- we may be required to pay higher purchase prices for acquisitions than we have paid historically;
- the goodwill and intangible assets we acquire may not be recoverable, resulting in an impairment charge that would negatively affect our financial results;
- management may be distracted from overseeing existing operations by the need to integrate the acquired business;
- we may acquire or assume unexpected liabilities or there may be other unanticipated costs;
- we may encounter unanticipated regulatory risk;
- we may experience problems entering new markets or service lines in which we have limited or no experience;
- we may fail to retain and assimilate key employees of the acquired business;
- we may finance the acquisition by incurring additional debt and further increase our leverage ratios; and
- the culture of the acquired business may not match well with our culture.

As a result of these risks, there can be no assurance that any future acquisition will be successful or that it will not have a material adverse effect on our financial condition and results of operations.

We are subject to extensive governmental regulations, which require significant compliance expenditures, and a failure to comply with these regulations could adversely affect our business.

We are required to comply with comprehensive government regulation of our business, including statutes, regulations and policies governing the licensing of our facilities, the maintenance and management of our work place for our employees, the quality of our service, the revenue we receive for our services and reimbursement for the cost of our services. Compliance with these laws, regulations and policies is expensive, and if we fail to comply with these laws, regulations and policies, we could lose contracts and the related revenue, thereby harming our financial results. State and federal regulatory agencies have broad discretionary powers over the administration and enforcement of laws and regulations that govern our operations. A material violation of a law or regulation could subject us to fines and penalties and in some circumstances could disqualify some or all of the facilities and programs under our control from future participation in Medicaid or other government programs.

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as amended by the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”) and other federal and state data privacy and security laws govern the collection, dissemination, security, use and confidentiality of patient-identifiable health information. HIPAA and the HITECH Act require us to comply with standards for the use and disclosure of health information within our company and with third parties, including, among other things, the adoption of administrative, physical and technical safeguards to protect such information. Additionally, certain states have adopted comparable privacy and security laws and regulations, some of which may be more stringent than HIPAA. While we have taken steps to comply with applicable health information privacy and security requirements to which we are aware that we are subject to, if we do not comply with existing or new federal or state laws and regulations related to patient health information, we could be subject to criminal or civil sanctions and any resulting liability could adversely affect our operations. The costs of complying with privacy and security related legal and regulatory requirements are burdensome and could have a material adverse effect on our operations.

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Expenses incurred under governmental agency contracts for any of our services, as well as management contracts with providers of record for such agencies, are subject to review by agencies administering the contracts and services. Representatives of those agencies visit our group homes to verify compliance with state and local regulations governing our service operations. A negative outcome from any of these examinations could increase government scrutiny, increase compliance costs or hinder our ability to obtain or retain contracts. Any of these events could have a material adverse effect on our business, financial condition and operating results.

The federal Anti-Kickback Law and similar state statutes, prohibit the provision of kickbacks, rebates and any other form of remuneration in return for referrals. Any remuneration, direct or indirect, offered, paid, solicited or received, in return for referrals of patients or business for which payment may be made in whole or in part under Medicaid could be considered a violation of law. The Anti-Kickback Law also prohibits payments made to anyone to induce them to recommend purchasing, leasing or ordering any goods, facility, service or item for which payment may be made in whole or in part by Medicaid. Criminal penalties under the Anti-Kickback Law include fines up to $25,000, imprisonment for up to five years, or both. In addition, acts constituting a violation of the Anti-Kickback Law may also lead to civil penalties, such as fines, assessments, exclusion from participation in the Medicaid programs and liability under the False Claims Act.

We are subject to many different and varied audit mechanisms for post-payment review of claims submitted under the Medicaid program. These include Recovery Audit Contractor (“RAC”) auditors, State Medicaid auditors, surveillance integrity review audits and Payment Error Rate Measurement (“PERM”) audits, among others. Any one of these audit activities may identify claims that the auditors deem problematic and, following such determination, auditors may require recoupment of claims by Medicaid to us.

On March 17, 2014, a federal regulation governing home- and community-based services became effective. The rule establishes eligibility requirements for Medicaid home and community-based services provided under the “waiver” program. The waiver program allows the states to furnish an array of home- and community-based services and avoid institutional care. Under the new rule, home- and community-based settings must be integrated in and support full access to the greater community, be selected by the individual from different setting options, ensure individual rights of privacy, and optimize autonomy and independence in making life choices. The rule includes additional requirements for provider-owned or controlled home and community-based residential settings, including that the individual has a lease or other legally enforceable agreement, and standards related to the individual’s privacy, control over schedule and visitors, and physical accessibility of the setting. The rule requires that each state submit a transition plan to the federal government that describes how each state will implement the new regulation. At this juncture seven states and the District of Columbia have received final approval of their Statewide Transition Plans, and it remains unclear how other states will implement this regulation. The rule presents some implementation challenges, as some of the broad requirements may conflict with the needs and/or precautions that we must take for some of the individuals that we serve. It is unclear how each state will seek to address this potential conflict, and the impact and costs of implementation and compliance with this regulation are currently unknown. States have the option to request a variation or delay of compliance with the federal standards for as long as five years from the effective date. Moreover, each state Medicaid agency may interpret and submit different requests and extension timelines.

Any change in interpretations or enforcement of existing or new laws and regulations could subject our current business practices to allegations of impropriety or illegality, or could require us to make changes in our homes, equipment, personnel, services, pricing or capital expenditure programs, which could increase our operating expenses and have a material adverse effect on our operations or reduce the demand for or profitability of our services.

Should we be found out of compliance with these statutes, regulations and policies, depending on the nature of the findings, our business, our financial position and our results of operations could be materially adversely impacted.

Our financial results may suffer if we have to write off goodwill or other intangible assets.

A large portion of our total assets consists of goodwill and other intangible assets. Goodwill and other intangible assets, net of accumulated amortization, accounted for 55.8% and 55.9% of the total assets on our consolidated balance sheets as of September 30, 2018 and 2017, respectively.

We evaluate on a regular basis whether events and circumstances have occurred that indicate that all or a portion of the carrying amount of goodwill or other intangible assets may no longer be recoverable, and is therefore impaired. Under current accounting rules, any determination that impairment has occurred would require us to write-off the impaired portion of our goodwill or the unamortized portion of our intangible assets, resulting in a charge to our earnings. We may not realize the value of our goodwill or other intangible assets and we expect to engage in additional transactions that will result in our recognition of additional goodwill or other intangible assets. During the years ended September 30, 2017 and 2016, we recorded goodwill

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and indefinite-lived intangible asset impairment charges of $31.0 million and $10.3 million, respectively associated with our ADH businesses. (Refer to Note 7, "Goodwill and Intangible Assets") There were no impairment charges related to goodwill or indefinite lived intangible assets recorded during year ended September 30, 2018.

The high level of competition in our industry could adversely affect our contract and revenue base.

We compete in a highly fragmented industry with a wide variety of competitors, ranging from small, local agencies to a few large, national organizations. Competitive factors may favor other providers and reduce our ability to obtain contracts, which would hinder our growth. Not-for-profit organizations are active in all states and range from small agencies, serving a limited area with specific programs to multi-state organizations. Smaller local organizations may have a better understanding of the local conditions and may be better able to gain political and public acceptance. Not-for-profit providers may be affiliated with advocacy groups, health organizations or religious organizations that have substantial influence with legislators and government agencies. Increased competition may result in pricing pressures, loss of or failure to gain market share or loss of individuals we serve or payors, any of which could harm our business.

Home and community-based human services may become less popular among our targeted populations and/or state and local governments, which would adversely affect our results of operations.

Our growth depends on the continuation of trends in our industry toward providing services to individuals in smaller, community-based settings and increasing the percentage of individuals served by non-governmental providers. For example, while demand for foster care services has been increasing for the last several years, during the course of much of the prior decade, state governments increasingly adopted policies that emphasized greater family preservation and family reunification for at-risk youth, which reduced the demand for foster care services, caused us to adapt our service offerings and contributed to our decision to divest CFS operations in six states. Shifts in public policy and, therefore, our future success, are subject to a variety of political, economic, social and legal pressures, all of which are beyond our control. A reversal in the downsizing and privatization trends could reduce the demand for our services, which could adversely affect our revenue and profitability.

Covenants in our senior credit agreement impose several restrictions on our business.

The senior credit agreement contains various covenants that limit our ability to, among other things:

- incur additional debt or issue certain preferred shares;
- pay dividends on or make distributions in respect of capital stock or make other restricted payments;
- make certain investments;
- sell certain assets;
- create liens on certain assets to secure debt;
- enter into agreements that restrict dividends from subsidiaries;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets; and
- enter into certain transactions with our affiliates.

The senior credit agreement governing the senior secured credit facilities also requires us to maintain a specified financial ratio in the event that we draw greater than 30% of the revolving commitment under our senior revolver. Our ability to meet this financial ratio could be affected by events beyond our control. The breach of any of these covenants or financial ratio could result in a default under the senior secured credit facilities and our lenders could elect to declare all amounts borrowed thereunder, together with accrued interest, to be due and payable and could proceed against the collateral securing that indebtedness.

If we are not successful in expanding into adjacent markets, our growth strategy could suffer.

Our growth strategy depends on pursuing opportunities in adjacent markets, and we may not be successful in adapting our service models to markets or service lines in which we have little or no prior experience. We recently expanded into the ADH services market. In the ADH services market, competition for elders to serve can sometimes be intense and employees may leave and compete. In the future, we may explore other adjacent markets, such as services to youth with autism and individuals with mental health issues, which would expose us to additional operational, regulatory and legal risks. Serving other populations may require compliance with additional federal and state laws and regulations which may differ from the laws and regulations that apply to the populations we currently serve. Compliance with new laws and regulations may result in

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unanticipated expenses or liabilities. Programs we open in adjacent markets may also take longer to reach expected revenue and profit levels on a consistent basis and may have higher occupancy or operating costs than programs in our existing markets, which may affect our overall profitability. Adjacent markets may have different payors, referral sources, staffing requirements, individual preferences and competitive conditions. We may find it more difficult to hire, motivate and keep qualified direct care workers and other employees in these adjacent markets. We may need to augment our staffing to meet regulatory requirements, and the overall cost of labor may be higher. As a result, we may not be successful in diversifying the populations we serve, and we may fail to capture market share in adjacent markets. If any steps taken to expand our existing business into adjacent markets are unsuccessful, we may not be able to achieve our growth strategy and our business, financial condition or results of operations could be adversely affected.

Our success depends on our ability to manage and integrate key administrative functions.

Our operations and administrative functions are largely decentralized and subject to disparate accounting and billing requirements established and often modified by our local payors and referral sources. Although in recent years we have undertaken an effort to consolidate accounting, billing, cash collections and other financial and administrative functions which may have mitigated this risk to some degree, there remains a substantial portion of the business that has not yet been centralized and some risk in the centralization process itself. If we encounter difficulties in integrating our operations further or implementing our cost saving measures or fail to effectively manage these functions to ensure compliance with disparate and evolving requirements imposed by our payors and referral sources, it could have a material adverse effect on our results of operations, financial position and cash flows.

We may be more susceptible to the effects of a natural disaster or public health catastrophe, compared with other businesses due to the vulnerable nature of our population.

Our primary population served includes individuals with developmental disabilities, brain injuries, or emotionally, behaviorally and/or medically complex challenges, many of whom would be more vulnerable than the general public in a natural disaster or public health catastrophe. In a natural disaster, we could be forced to relocate some of our individuals we serve on short notice under dangerous conditions and our new program starts and acquisitions could experience delays. Accordingly, natural disasters and certain public health catastrophes could have a material adverse effect on our financial condition and results of operations.

We are classified as a “controlled company” and, as a result, we qualify for, and rely upon, certain exemptions from certain corporate governance requirements. You will not have the same protections afforded to stockholders of companies that are subject to such requirements.

We are a “controlled company” within the meaning of the New York Stock Exchange corporate governance standards. Under the rules of the New York Stock Exchange, a company of which more than 50% of the outstanding voting power is held by an individual, group or another company is a “controlled company” and may elect not to comply with certain stock
exchange corporate governance requirements, including the requirements that:

- a majority of the Board of Directors consist of independent directors;
- nominating and corporate governance matters be decided solely by independent directors; and
- employee and officer compensation matters be decided solely by independent directors.

Although as of September 30, 2018, we ceased relying upon the exemptions listed above, we may rely on them in the future if we continue to qualify as a "controlled company." Accordingly, you may not have the same protections afforded to stockholders of companies that are subject to all of the stock exchange corporate governance requirements.

Our stock price may be volatile or may decline regardless of our operating performance, and you may not be able to resell your shares at or above your purchase price.

The market price for our common stock has been and may be volatile. You may not be able to resell your shares at or above the price you paid, due to fluctuations in the market price of our common stock, which may be caused by a number of factors, many of which we cannot control including the following:

- changes in financial estimates by any securities analysts who follow our common stock, our failure to meet these estimates or failure of those analysts to initiate or maintain coverage of our common stock;

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- downgrades by any securities analysts who follow our common stock;
- future sales of our common stock by our officers, directors and significant stockholders;
- market conditions or trends in our industry or the economy as a whole and, in particular, in the healthcare environment;
- investors' perceptions of our prospects;
- announcements by us of significant contracts, acquisitions, joint ventures or capital commitments; and
- changes in key personnel.

In addition, the stock markets have experienced extreme price and volume fluctuations that have affected and continue to affect the market prices of equity securities of many companies, including companies in the healthcare industry. In the past, stockholders have instituted securities class action litigation following periods of market volatility. If we were involved in securities litigation, we could incur substantial costs, and our resources and the attention of management could be diverted from our business.

Our equity sponsor has the ability to control significant corporate activities and our majority stockholder's interests may not coincide with yours.

Vestar owns approximately 54% of our common stock. As a result, Vestar has the ability to control the outcome of matters submitted to a vote of stockholders. In addition, under the director nominating agreement that we entered into in connection with our IPO (the "Nominating Agreement"), affiliates of Vestar will have the right to nominate directors for election to our Board of Directors, and we will agree to support those nominees. Under certain circumstances, those nominees could constitute a majority of our Board of Directors even though affiliates of Vestar at the time owns less than a majority of our common stock, giving Vestar decision-making control over us. Matters over which Vestar may, directly or indirectly, exercise control include:

- the election of our Board of Directors and the appointment and removal of our officers;
- mergers and other business combination transactions, including proposed transactions that would result in our stockholders receiving a premium price for their shares;
- other material acquisitions or dispositions of businesses or assets;
- incurrence of indebtedness and the issuance of equity securities;
- repurchase of stock and payment of dividends; and
- the issuance of shares to management under our equity incentive plans.

Even if Vestar's ownership of our shares falls below a majority, Vestar may continue to be able to influence or effectively control our decisions. Under our amended and restated certificate of incorporation, Vestar and its affiliates will not have any obligation to present to us, and Vestar may separately pursue, corporate opportunities of which they become aware, even if those opportunities are ones that we would have pursued if granted the opportunity.

Future sales of our common stock, or the perception in the public markets that these sales may occur, may depress our stock price.

Sales of substantial amounts of our common stock in the public market, or the perception that these sales could occur, could adversely affect the price of our common stock and could impair our ability to raise capital through the sale of additional shares. As of September 30, 2018, we had 36,116,252 shares of common stock outstanding and 350,000,000 shares of common stock authorized under our amended and restated certificate of incorporation.

On October 1, 2015, NMH Investment distributed all of the shares of our common stock held by it to its existing members in accordance with their respective membership interests (the "Distribution"). These former members of NMH Investment, which include Vestar and certain of our officers and directors, may sell the shares they received in the Distribution that they continue to hold under Rule 144 under the Securities Act, subject to the volume limits and other

requirements of Rule 144 applicable to affiliates, or in future public offerings.

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As of September 30, 2018, holders of an aggregate of approximately 20.3 million shares of our common stock (including Vestar and certain of our directors and executive officers) had the right, subject to certain conditions, to require us to register shares of our common stock pursuant to the terms of a registration rights agreement between us and the holders of those shares. We have also registered the shares of common stock issuable upon the exercise of stock options and RSUs granted under our 2014 omnibus incentive plan on a registration statement on Form S-8.

Members of our management have in the past and may in the future enter into Rule 10b5-1 trading plans pursuant to which they may sell shares of our common stock into the open market.

In the future, we may also issue our securities in connection with acquisitions or investments. The amount of shares of our common stock issued in connection with an acquisition or investment could constitute a material portion of our then-outstanding shares of our common stock. We cannot predict the size of future sales or issuances of our common stock or the effect, if any, that future sales or issuances of our common stock will have on the market price of our common stock.

If securities or industry analysts do not publish research or publish inaccurate or unfavorable research about our business, our stock price and trading volume could decline.

The trading market for our common stock depends in part on the research and reports that securities or industry analysts publish about us or our business. If one or more of the analysts who covers us downgrades our common stock or publishes inaccurate or unfavorable research about our business, our stock price would likely decline. If one or more of these analysts ceases coverage of us or fails to publish reports on us regularly, demand for our common stock could decrease, which could cause our stock price and trading volume to decline.

Because we do not intend to pay cash dividends in the foreseeable future, you may not receive any return on investment unless you are able to sell your common stock for a price greater than your purchase price.

The continued operation and expansion of our business will require substantial funding. Accordingly, we do not anticipate that we will pay any cash dividends on shares of our common stock for the foreseeable future. Any determination to pay dividends in the future will be at the discretion of our Board of Directors and will depend upon results of operations, financial condition, contractual restrictions, including those under our senior secured credit facilities, any potential indebtedness we may incur, restrictions imposed by applicable law and other factors our Board of Directors deems relevant. Accordingly, if you purchase shares, realization of a gain on your investment will depend on the appreciation of the price of our common stock, which may never occur. Investors seeking cash dividends in the foreseeable future should not purchase our common stock.

We are a holding company and rely on dividends, distributions and other payments, advances and transfers of funds from our subsidiaries to meet our obligations.

We are a holding company that does not conduct any business operations of our own. As a result, we are largely dependent upon cash dividends and distributions and other transfers from our subsidiaries to meet our obligations. The deterioration of income from, or other available assets of, our subsidiaries for any reason could limit or impair their ability to pay dividends or other distributions to us.

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Item 1B. Unresolved Staff Comments

We have not received written comments from the Securities and Exchange Commission that remain unresolved.

Item 2. Properties

Our principal executive office is located at 313 Congress Street, Boston, Massachusetts 02210. We operate a number of facilities and administrative offices throughout the United States. As of September 30, 2018, we provided services in 355 owned facilities and 1,862 leased facilities, as well as in homes owned by our Mentors. We also own 4 offices and lease 201 offices. We believe that our properties are adequate for our business as presently conducted and we believe we can meet requirements for additional space by exercising options on leases or by finding alternative space.

Item 3. Legal Proceedings

We are in the health and human services business and, therefore, we have been and continue to be subject to substantial claims alleging that we, our employees or our Mentors failed to provide proper care for an individual that we support. We are also subject to claims by individuals we support, our employees, our Mentors or community members against us for negligence, intentional misconduct or violation of applicable laws. Included in our recent claims are claims alleging personal injury, assault, abuse, wrongful death, violations of wage and hour laws and other charges. Regulatory agencies may initiate administrative proceedings alleging that our programs, employees or agents violate statutes and regulations and seek to impose monetary penalties on us. We could be required to incur significant costs to respond to regulatory investigations or defend against civil lawsuits and, if we do not prevail, we could be required to pay substantial amounts of money in damages, settlement amounts or penalties arising from these legal proceedings.

We also are subject to potential lawsuits under the False Claims Act and other federal and state whistleblower statutes designed to combat fraud and abuse in the health care industry. These lawsuits can involve significant monetary awards that may incentivize private plaintiffs to bring these suits. If we are found to have violated the False Claims Act, we could be excluded from participation in Medicaid and other federal healthcare programs which would have a material adverse effect on our business. The Patient Protection and Affordable Care Act provides a mandate for more vigorous and widespread enforcement activity to combat fraud and abuse in the health care industry.

Finally, we are also subject to employee-related claims under state and federal law, including claims for wage and hour violations under the Fair Labor Standards Act or state wage and hour laws and claims for discrimination, wrongful discharge or retaliation. The Company currently has two pending complaints in California state court that allege certain wage and hour violations of California labor laws and seek to be designated as class-actions. Two additional wage and hour class actions have been settled and approved by the court.

We reserve for costs related to contingencies when a loss is probable and the amount is reasonably estimable. While we believe our provision for legal contingencies is adequate, the outcome of our legal proceedings is difficult to predict, and we may settle legal claims or be subject to judgments for amounts that differ materially from our estimates. In addition, legal contingencies could have a material adverse impact on our results of operations in any given future reporting period.

See “Part I. Item 1A. Risk Factors” and “Part II. Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations” and "Notes to Consolidated Financial Statements. Note 17. Other Commitments and Contingencies" for additional information.

Item 4. Mine Safety Disclosures

Not applicable.

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PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information

Our common stock trades on the NYSE under the symbol "CIVI".

Stockholders

On November 30, 2018, there were 36,116,252 shares of our common stock outstanding, held by 13 stockholders of record, one of which was Cede & Co., which is the nominee of shares held through The Depository Trust Company. The number of beneficial owners is substantially greater than the number of owners of record because a significant portion of our common stock is held through brokerage firms.

Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock from September 17, 2014 through September 30, 2018 with the cumulative total return of the Russell 2000 Healthcare Services Index and the NYSE Composite. This graph assumes an investment of $100.00 in our common stock and in each of the indexes on September 17, 2014 and its relative performance is tracked through September 30, 2018. We paid no dividends on our common stock during the period covered by the graph. Measurement points are September 17, 2014 and the last trading day of each subsequent month end through September 30, 2018.

The comparisons shown in the graph below are based upon historical data. We caution that the stock price performance shown in the graph below is not necessarily indicative of, nor is it intended to forecast, the potential future performance of our common stock.

This graph is not deemed to be "filed" with the SEC or subject to the liabilities of Section 18 of the Exchange Act, and the graph shall not be deemed to be incorporated by reference into any prior or subsequent filing by Civitas under the Securities Act or the Exchange Act.

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Dividends

We did not pay any cash dividends during fiscal 2018 or fiscal 2017. We do not anticipate paying any cash dividends in the foreseeable future. Our ability to pay dividends on our common stock is limited by restrictions on the ability of our subsidiaries and us to pay dividends or make distributions under the terms of NMHI's current and any future agreements governing our indebtedness. Any future determination to pay dividends will be at the discretion of our Board of Directors, subject to compliance with covenants in NMHI's current and any future agreements governing our indebtedness, and will depend upon our results of operations, financial condition, capital requirements and other factors that our Board of Directors deems relevant.

In addition, since we are a holding company, substantially all of the assets shown on our consolidated balance sheet are held by our subsidiaries. Accordingly, our earnings, cash flow and ability to pay dividends are largely dependent upon the earnings and cash flows of our subsidiaries and the distribution or other payment of such earnings to us in the form of dividends.

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Repurchases of Equity Securities

The following table provides information about purchases we made during the three months ended September 30, 2018 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

	Total Number of Shares Purchased [1]	Weighted Average Price Paid per Share [2]	Total Number of Shares Purchased as Part of Publicly Announced Program [3]	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Program (in thousands)
7/1/2018 - 7/31/2018	84,568	$ 16.26	84,568	$ 3,954
8/1/2018 - 8/31/2018	34,325	$ 16.35	34,325	$ —
9/1/2018 - 9/30/2018	3,077	$ 14.57	0	$ —

[1] Our employees surrendered an aggregate of 3,077 shares to us in satisfaction of minimum tax withholding obligations associated with the vesting of restricted stock units during the three months ended September 30, 2018.
[2] The weighted average price paid per share of common stock does not include the cost of commissions.
[3] On February 8, 2018, we announced that our Board of Directors approved a stock repurchase program under which we were authorized to repurchase up to $25.0 million of the Company’s outstanding common stock from time to time in the open market, through negotiated transactions or otherwise (including, without limitation, the use of Rule 10b5-1 plans). We conducted any open market stock repurchase activities in compliance with the safe harbor provisions of Rule 10b-18 of the Exchange Act. During the fourth quarter of fiscal 2018, we repurchased and retired 118,893 shares for $1.9 million under the program, which was implemented through a 10b5-1 plan. The stock repurchase program expired on August 12, 2018, and we do not have authorization to repurchase any additional common stock under the program.

Unregistered Sales of Equity Securities
No unregistered equity securities of the Company were sold during fiscal 2018.

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Item 6. Selected Financial Data

We derived the selected consolidated financial data below from the consolidated financial statements of the Company and the related notes included elsewhere in this Annual Report on Form 10-K and from the consolidated financial statements and the related notes included in previous Annual Reports on Form 10-K that we filed with the SEC. The selected information below should be read in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" and the consolidated financial statements and notes included elsewhere in this report.

	Year Ended September 30,				
	2018	2017	2016	2015	2014
	(Amounts in thousands, except share and per share amounts)				
Statements of Operations Data:					
Net revenue	$1,602,202	$1,474,510	$1,407,587	$1,366,946	$1,255,838
Cost of revenue	1,280,608	1,160,528	1,092,181	1,059,364	983,043
Operating expenses:					
General and administrative expenses	171,803	166,376	174,398	162,839	145,041
Goodwill and intangible impairment	—	31,002	10,251	10,660	—
Depreciation and amortization	95,421	75,713	73,061	71,512	67,488
Total operating expense	267,224	273,091	257,710	245,011	212,529
Income from operations	54,370	40,891	57,696	62,571	60,266
Other income (expense):					
Management fee of related party	—	—	—	28	(9,488)
Other income (expense), net	(1,296)	710	(908)	(1,325)	374
Extinguishment of debt	—	—	—	(17,058)	(14,699)
Interest expense	(38,792)	(33,406)	(34,041)	(37,455)	(69,349)
Income (loss) from continuing operations before income taxes	14,282	8,195	22,747	6,761	(32,896)
Provision (benefit) for income taxes	(604)	1,864	13,290	2,689	(11,463)
Income (loss) from continuing operations	14,886	6,331	9,457	4,072	(21,433)
Loss from discontinued operations, net of tax	—	—	(270)	(1,000)	(1,382)
Net income (loss)	$14,886	$6,331	$9,187	$3,072	$(22,815)
Income (loss) per common share, basic and diluted					
Income (loss) from continuing operations	$0.40	$0.17	$0.25	$0.11	$(0.84)
Loss from discontinued operations	—	—	—	(0.03)	(0.05)
Net income (loss)	$0.40	$0.17	$0.25	$0.08	$(0.89)
Weighted average number of common shares outstanding, basic	36,811,208	37,302,941	37,112,794	36,959,997	25,538,493
Weighted average number of common shares outstanding, diluted	36,945,408	37,466,325	37,262,915	37,088,632	25,538,493
Balance Sheet Data (at end of period):					
Cash and cash equivalents	$8,168	$7,297	$50,683	$41,690	$196,147
Working capital [1]	39,786	30,740	59,341	40,502	31,379
Total assets	1,127,192	1,049,382	1,068,145	1,036,089	999,768
Total debt [2]	711,753	637,488	644,591	651,643	815,509
Stockholders' equity	166,734	162,917	145,590	121,275	115,538

[1] Calculated as current assets minus current liabilities.

[2] Includes obligations under capital leases.

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion of our financial condition and results of operations should be read in conjunction with the historical consolidated financial statements and the related notes included elsewhere in this report. This discussion may contain forward-looking statements about our markets, the demand for our services and our future results. We based these statements on assumptions that we consider reasonable. Actual results may differ materially from those suggested by our forward-looking statements for various reasons, including those discussed in the "Risk Factors" and "Forward-Looking Statements" sections of this report.

Overview

We are the leading national provider of home- and community-based health and human services to must-serve individuals with intellectual, developmental, physical or behavioral disabilities and other special needs. Since our founding in 1980, we have been a pioneer in the movement to provide home- and community-based services for people who would otherwise be institutionalized. During our more than 38-year history, we have evolved from a single residential program serving at-risk youth to a diversified national network providing an array of high-quality services and care in large, growing and highly-fragmented markets. While we have the capabilities to serve individuals with a wide variety of special needs and disabilities, we currently provide our services to individuals with intellectual and/or developmental disabilities ("I/DD"), individuals with catastrophic injuries and illnesses, particularly acquired brain injury ("ABI"), youth with emotional, behavioral and/or medically complex challenges, and elders in need of day health services to support their independence. As of September 30, 2018, we operated in 36 states, serving approximately 12,700 individuals in residential settings and more than 19,000 individuals in non-residential settings. We have a diverse group of hundreds of public payors which fund our services with a combination of federal, state and local funding, as well as an increasing number of non-public payors related to our services for ABI and other catastrophic injuries and illnesses.

We operate our business in four operating divisions, Community Support Services ("CSS"), Specialty Rehabilitation Services ("SRS"), Children & Family Services ("CFS") and Adult Day Health ("ADH"). As of October 1, 2018, Community Support Services and Children & Family Services are new names for the operating divisions formerly named I/DD and ARY, respectively. The segments have been organized by service line.

Our CSS segment is the largest portion of our business. Through the CSS segment, we provide home- and community-based human services to adults and children with intellectual and developmental disabilities. Our CSS programs include residential support, day habilitation, vocational services, case management, crisis intervention and hourly support care.

Through the SRS segment, which is our second largest segment, we deliver services to individuals who have suffered acquired brain injury, spinal injuries and other catastrophic injuries and illnesses. Our SRS segment is primarily focused on providing behavioral therapies to individuals with brain injuries in post-acute community settings and more medically-intensive post-acute care services. Our SRS services range from sub-acute healthcare for individuals with intensive medical needs to day treatment programs, and include, neurorehabilitation, neurobehavioral rehabilitation, specialized nursing, physical, occupational and speech therapies, supported living, outpatient treatment and pre-vocational services.

Through the CFS segment we provide home- and community-based human services to youth with emotional, behavioral and/or medically complex challenges. Our CFS programs include therapeutic foster care, family preservation, adoption services, early intervention, school-based services and juvenile offender programs.

Our newest operating segment, ADH, delivers elder services including case management, nursing oversight, medication management, nutrition, daily living assistance, therapeutic services and transportation. The results of our ADH operating segment are included within Corporate and Other because ADH does not meet the thresholds for separate reporting.

Factors Affecting our Operating Results

Demand for Home and Community-Based Health and Human Services

Our growth in revenue has historically come from increases in the number of individuals served, as well as increases in the rates we receive for our services. This growth has depended largely upon development-driven activities, including the maintenance and expansion of existing contracts and the award of new contracts, our new start program and acquisitions. We also attribute the long-term growth in our base of individuals served to certain trends that are increasing demand in our industry, including demographic, health-care and political developments.

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Demographic trends have had a particular impact on our CSS business. Increases in the life expectancy of individuals with I/DD, we believe, have resulted in steady increases in the demand and length of stay for CSS services. In addition, family members currently caring for their relatives at home are aging and many may soon be unable to continue with these responsibilities. Many states continue to downsize or close large, publicly-run facilities for individuals with I/DD and refer those individuals to private providers of community-based services. Each of these factors affects the size of the I/DD population in need of services. Demand for our SRS services has also grown as emergency response and improved medical techniques have resulted in more people surviving a catastrophic injury. SRS services are increasingly sought out as a clinically-appropriate and less-expensive alternative to institutional care and as a “step-down” for individuals who no longer require care in acute settings.

Political and economic trends can also affect our operations. Reductions or changes in Medicaid funding or changes in budgetary priorities by the federal, state and local governments that pay for our services could have a material adverse effect on our revenue and profitability. Recent efforts at the federal level to reduce the federal budget deficit, repeal and/or replace the Patient Protection and Affordable Care Act and/or restructure the Medicaid program pose risk for significant reductions in federal Medicaid matching funds to state governments. In addition, budgetary pressures facing state governments, especially within Medicaid programs, as well as other economic, industry and political factors could cause state governments to limit spending, which could significantly reduce our revenue, referrals, margins and profitability, and adversely affect our growth strategy. Government agencies generally condition their contracts with us upon a sufficient budgetary appropriation. If the government agency does not receive an appropriation sufficient to cover its obligations with us, it may terminate a contract or defer or reduce our reimbursements. In the past, certain states in which we operate, including Minnesota, California, Massachusetts, Indiana, Arizona, and West Virginia, where we generate significant revenue, have implemented rate reductions, rate freezes and service reductions, in response to state budgetary deficits. While we are currently managing through a small number of rate decreases, we expect the overall rate environment to continue to remain stable in 2019.

Beginning in 2015, West Virginia implemented a redesign of its I/DD Waiver Program. This redesign resulted in a reduction in our West Virginia operations in fiscal 2017 and 2016, totaling decreases of $20.7 million in net revenue and $6.3 million in income from operations. While the direct impact of the redesign was largely behind us entering fiscal 2018, during the year ended September 30, 2018 our West Virginia operations contracted further, mainly as a result of a very challenging labor environment. During the period, West Virginia net revenue and income from operations decreased by $6.8 million and $2.5 million, respectively. Notably, the state’s fiscal condition has continued to improve and the state recently announced that effective January 1, 2019 providers of I/DD Waiver services will receive a 5% rate increase for services billed.

Historically, our business has benefited from the trend toward privatization and the efforts of groups that advocate for the populations we serve. These groups lobby governments to fund residential services that use our small group home or host home models, rather than large, institutional models. Furthermore, we believe that successful lobbying by advocacy groups has preserved CSS and CFS services and, therefore, our revenue base for these services, from significant reductions as compared with certain other human services, although in the past certain states have imposed rate reductions, rate freezes, and service reductions in response to state budgetary pressures. In addition, a number of states have developed community-based waiver programs to support long-term services for survivors of a traumatic brain injury. However, the majority of our specialty rehabilitation services revenue is derived from non-public payors, such as commercial insurers, managed care and other private payors.

Expansion of Services

We have grown our business through expansion of existing markets and programs, entry into new geographical markets, as well as through acquisitions.

Organic Growth

Various economic, fiscal, public policy and legal factors are contributing to an environment with a number of organic growth opportunities, particularly within the CSS and SRS segments, and, as a result, we have a continued emphasis on growing our business organically and making investments to support the effort. Our future growth will depend heavily on our ability to expand our current programs and identify and execute upon new opportunities. Our organic expansion activities consist of both new program starts in existing markets and expansion into new geographical

markets. Our new programs in new and existing geographic markets typically require us to incur and fund operating losses for a period of approximately 18 to 24 months (we refer to these new programs as “new starts”). Net operating loss or income of a new start is defined as its revenue for the period less direct expenses but not including allocated overhead costs. The aggregation of all programs with net operating losses that are less than 18 months old comprise the new start operating loss and the aggregation of all programs with net operating income that are less than 18 months old comprise the new start operating income for such period. During fiscal

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years 2018, 2017, and 2016 new starts generated operating losses of $6.2 million, $5.6 million, and $7.4 million, respectively, and operating income of $2.7 million, $4.9 million and $3.7 million respectively.

Acquisitions

From the beginning of fiscal 2014 through September 30, 2018, we have completed 55 acquisitions, including several acquisitions of small providers, which we have integrated with our existing operations. Acquisitions could have a material impact on our consolidated financial statements.

During the fiscal year ended September 30, 2018, we acquired the assets or equity interests of eleven companies for total consideration of $99.8 million, net of $0.8 million of cash acquired and including $1.8 million of contingent consideration.

During the fiscal year ended September 30, 2017, we acquired the assets or equity interests of eleven companies for total consideration of $82.1 million, net of $0.5 million of cash acquired.

During the fiscal year ended September 30, 2016, we acquired the assets of twelve companies for total consideration of $45.2 million.

Divestitures

We regularly review and consider the divestiture of underperforming or non-strategic businesses to improve our operating results and better utilize our capital. We have made divestitures from time to time and expect that we may make additional divestitures in the future. Divestitures could have a material impact on our consolidated financial statements.

Beginning in the second quarter of fiscal 2018, as part of a larger, multi-year, multi-pronged effort to improve the efficiency of our operations and mitigate margin erosion created by increasing labor and healthcare costs, we recently raised the program performance standard and commenced a comprehensive, top-to-bottom examination of each program's performance across all of our operating divisions. As a result of this initiative, we decided to close and/or consolidate 58 programs during fiscal 2018 primarily within our SRS and CSS operating divisions (the "Program Closures"). During the year ended September 30, 2018, we incurred exit costs associated with these closures of $10.7 million, including $10.0 million in lease termination costs, and $0.7 million in severance. In addition, we recorded $6.1 million of accelerated amortization related to definite-lived intangible assets and a $1.2 million loss on the disposition of fixed assets associated with these locations. These closures are expected to eliminate losses of $1.8 million annually. The comprehensive examination was completed during the fourth quarter of fiscal 2018 and there will no additional closures associated with this review.

During fiscal 2015, we decided to discontinue CFS services in the states of Illinois, Florida, Louisiana, Indiana, North Carolina and Texas ("CFS Divestitures"). In connection with these divestitures we recorded impairment charges for intangible assets of $10.4 million in fiscal 2015, exit costs of $2.0 million and a loss on sale of $1.3 million during the first two quarters of fiscal 2016. It was determined that this disposal group did not meet the criteria to be presented as discontinued operations and, as a result, the operating results are included within continuing operating results in the Consolidated Statement of Income. During fiscal 2016 and 2015, these businesses had net revenue of $7.1 million, and $53.9 million, respectively; and loss from operations of $3.2 million, and $0.5 million, respectively. The CFS Divestitures were not included in our operating results for fiscal 2018 and 2017.

Revenue

Revenue is reported net of allowances for unauthorized sales and estimated sales adjustments, and net of any state provider taxes or gross receipts taxes levied on services we provide. See "—Critical Accounting Policies—Revenue Recognition" for further information. We derive revenue from contracts with state, local and other government payors and non-public payors. During the fiscal years ended September 30, 2018 and 2017, we derived 89% of our net revenue from contracts with state, local and other government payors and 11% of our net revenue from non-public payors. Substantially all of our non-public revenue is generated by our SRS business through contracts with commercial insurers, workers' compensation carriers and other private payors. The payment terms and rates of our contracts vary widely by jurisdiction and service type. We have four types of contractual arrangements with payors which include negotiated contracts, fixed fee contracts, retrospective reimbursement contracts and prospective

payments contracts. See "—Critical Accounting Policies—Revenue Recognition" for further information. Our revenue may be affected by adjustments to our billed rates as well as adjustments to previously billed amounts. Revenue in the future may be affected by changes in rates, rate-setting structures, methodologies or interpretations that may be proposed in states where we operate or by the federal government which provides matching funds. We cannot determine the impact of such changes or the effect of any possible governmental actions. In general, we take prices set by our payors and do not compete based on pricing.

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We bill the majority of our residential services on a per person, per-diem basis. We believe important performance measures of revenues in our residential service business include average daily residential census and average daily billing rates. We bill the majority of our non-residential service on a per service unit basis. These service units, which vary in length, are converted to billable units which are the hourly equivalent for the service provided. We believe important performance measures of revenues in our non-residential service business include billable units and average billable unit rates. We calculate the impact of these measures on gross revenue rather than net revenue because the timing of sales adjustments, both positive and negative, is unpredictable. We define these measures and gross revenue as follows:

- Gross Revenue: Revenues before adjusting for sales adjustments and state provider and gross receipts taxes.
- Average Residential Census: The average daily residential census over the respective period.
- Average Daily Rate: A mathematical calculation derived by dividing the gross residential revenue by the residential census and the resulting quotient by the number of days during the respective period.
- Non-Residential Billable Units: The hourly equivalent of non-residential services provided.
- Average Billable Unit Rate: Gross non-residential revenue divided by the billable units provided during the period.

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A comparative summary of gross revenues by operating division and our key metrics is as follows (dollars in thousands, except for daily and billable unit rates):

	Year Ended September 30,		
	2018	2017	2016
Community Support Services			
Gross Revenues	$1,039,711	$977,843	$946,064
Average Residential Census	8,850	8,278	8,079
Average Daily Rate	$248.81	$246.00	$241.15
Non-Residential Billable Units	12,450,129	12,618,504	12,700,230
Average Non-Residential Billable Unit Rate	$18.95	$18.59	$18.35
Gross Revenue Growth %	6.3 %	3.4 %	4.6 %
Gross Revenue growth due to:			
Volume Growth	4.9 %	1.7 %	2.3 %
Average Rate Growth	1.4 %	1.7 %	2.3 %
Specialty Rehabilitation Services			
Gross Revenues	$363,567	$317,196	$289,978
Average Residential Census	1,424	1,324	1,257
Average Daily Rate	$662.19	$629.14	$605.41
Non-residential Billable Units	254,087	171,098	158,498
Average Non-Residential Billable Unit Rate	$76.30	$77.21	$72.20
Gross Revenue Growth %	14.6 %	9.4 %	8.5 %
Gross Revenue growth due to:			
Volume Growth	9.3 %	5.4 %	7.7 %
Average Rate Growth	5.3 %	4.0 %	0.8 %
Children & Family Services			
Gross Revenues [1]	$148,455	$142,137	$148,400
Average Residential Census	2,213	2,123	2,303
Average Daily Rate	$128.46	$126.72	$124.90
Non-residential Billable Units	525,883	523,429	536,160
Average Non-Residential Billable Unit Rate	$85.01	$83.95	$80.45
Gross Revenue Growth %	4.4 %	(4.2)%	(23.1)%
Gross Revenue growth due to:			
Volume Growth	3.1 %	(6.2)%	(29.4)%
Average Rate Growth	1.3 %	2.0 %	6.3 %
Adult Day Health			
Gross Revenues	$73,437	$57,103	$35,684
Non-residential Billable Units	4,102,607	3,230,599	2,197,263
Average Non-Residential Billable Unit Rate	$17.90	$17.68	$16.24
Gross Revenue Growth %	28.6 %	60.0 %	79.0 %
Gross Revenue growth due to:			
Volume Growth	27.0 %	47.0 %	72.3 %
Average Rate Growth	1.6 %	13.0 %	6.7 %
Consolidated Results			
Gross Revenues	$1,625,170	$1,494,279	$1,420,126
Gross Revenue Growth %	8.8 %	5.2 %	2.6 %
Gross Revenue growth due to:			
Volume Growth [1]	6.6 %	2.8 %	(2.0)%
Average Rate Growth	2.2 %	2.4 %	4.6 %

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(1) Includes $7.3 million of revenue for fiscal 2016 from the six state operations that were divested during the first quarter of fiscal 2016.

Expenses

Expenses directly related to providing services are classified as cost of revenue. These expenses consist of direct labor costs which principally include salaries and benefits for service provider employees and per diem payments to our Mentors; direct program costs such as food, medicine and professional and general liability and employment practices liability expenses; residential occupancy expenses which are primarily composed of rent and utilities related to facilities providing direct care; and other direct costs which include travel and transportation costs and other ancillary direct costs associated with the provision of services to individuals, including workers' compensation expense.

Wages and benefits to our employees and per diem payments to our Mentors constitute the most significant operating cost in each of our operations. Most of our direct support professionals are paid on an hourly basis, with hours of work generally tied to an individual's need. Our Mentors are paid on a per diem basis, but only if the Mentor is currently caring for an individual. Our labor costs are generally influenced by levels of service, and these costs can vary in material respects across regions. In addition, our labor costs can be negatively impacted by higher rates of caregiver turnover, vacant positions and overtime utilization, as well as regulatory actions at the Federal, state, and local levels. For example, states and local governments set localized minimum wage increases, which in turn impact labor costs.

Occupancy costs represent a significant portion of our operating costs. As of September 30, 2018, we owned 355 facilities and 4 offices, and we leased 1,862 facilities and 201 offices. We expect occupancy costs to increase during fiscal 2019 as a result of new leases entered into pursuant to acquisitions and new starts. We incur no facility costs for services provided in the home of a Mentor.

Our business insurance programs include professional and general liability insurance, for which we are self-insured for $3.0 million per claim and $28.0 million in the aggregate, among others. We incurred professional and general liability expenses of $13.5 million, $7.2 million and $12.9 million for the fiscal years ended September 30, 2018, 2017 and 2016, respectively. These expenses are incurred in connection with our claims reserves and insurance premiums. The increase in our professional and general liability expense during fiscal 2018 was due to unfavorable claims experience compared to fiscal 2017. In addition, the professional and general liability expense during fiscal 2017 was positively impacted by changes in assumptions used in our actuarial estimates as a result of our historical claims experience.

We are fully self insured for employment practices liability claims. We currently have two pending complaints in California state court that allege certain wage and hour violations of California labor laws and seek to be designated as class-actions. Two additional California wage and hour class actions have been settled and approved by the court. These actions have increased our expenses for employment-practices liability related claims. For the fiscal years ended September 30, 2018, 2017 and 2016, we incurred employment practices liability expenses of $2.2 million, $5.5 million, and $0.2 million, respectively.

General and administrative expenses primarily include salaries and benefits for administrative employees, or employees that are not directly providing services, administrative occupancy costs as well as professional expenses such as accounting, consulting and legal services, and stock-based compensation expense.

Depreciation and amortization includes depreciation for fixed assets utilized in both facilities providing direct care and administrative offices, and amortization related to intangible assets.

We continue to review our operations in an effort to improve efficiencies, reduce overtime expenses, and implement cost saving measures throughout the Company. This expense reduction project includes a multi-pronged review of total company-wide expenses, inclusive of labor management and organizational structure. In connection with this project to optimize our business operations we have incurred $4.4 million in consulting, severance and contract termination costs in the fiscal year ended September 30, 2018. The cost savings associated with this project was approximately $5.0 million and $6.1 million in fiscal years 2017 and 2018, respectively.

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Results of Operations

The following table sets forth our consolidated results of operations as a percentage of total gross revenues for the periods indicated.

	Year ended September 30,		
	2018	2017	2016
Gross revenue	100.0 %	100.0 %	100.0 %
Sales adjustments	(1.4)%	(1.3)%	(0.9)%
Net revenue	98.6 %	98.7 %	99.1 %
Cost of revenue	78.8 %	77.7 %	76.9 %
Operating expenses:			
General and administrative	10.6 %	11.1 %	12.3 %
Goodwill and intangible asset impairment	0.0 %	2.1 %	0.7 %
Depreciation and amortization	5.9 %	5.1 %	5.1 %
Total operating expense	16.5 %	18.3 %	18.1 %
Income from operations	3.3 %	2.7 %	4.1 %
Other income (expense):			
Other expense, net	(0.1)%	0.0 %	(0.1)%
Interest expense	(2.4)%	(2.2)%	(2.4)%
Income from continuing operations before income taxes	0.8 %	0.5 %	1.6 %
Provision for income taxes	— %	0.1 %	0.9 %
Income from continuing operations	0.8 %	0.4 %	0.7 %
Loss from discontinued operations, net of tax	— %	— %	— %
Net income	0.8 %	0.4 %	0.7 %

Fiscal Year Ended September 30, 2018 compared to Fiscal Year Ended September 30, 2017

Consolidated overview

	Year ended September 30,		Increase
(In thousands)	2018	2017	(Decrease)
Gross revenue	$1,625,170	$1,494,279	$130,891
Sales adjustments	(22,968)	(19,769)	(3,199)
Net revenue	$1,602,202	$1,474,510	$127,692
Income from operations	$54,370	$40,891	$13,479
Operating margin	3.3 %	2.7 %	0.6 %

Consolidated gross revenue for the fiscal year ended September 30, 2018 (“fiscal 2018”) increased by $130.9 million, or 8.8%, compared to gross revenue for the fiscal year ended September 30, 2017 (“fiscal 2017”). Gross revenue increased by $107.2 million from acquisitions that closed during and after fiscal 2017, and $23.7 million from organic growth. Organic growth during fiscal 2018 was negatively impacted by the Program Closures, which resulted in a decrease of $11.4 million in gross revenue.

Consolidated income from operations increased from 2.7% of gross revenue, or $40.9 million, in fiscal 2017 to 3.3% of gross revenue, or $54.4 million, in fiscal 2018. The increase in our operating margin was due to $31.0 million of goodwill and intangible asset impairment charges recorded in the prior year and a decrease in general and administrative expenses as a percentage of net revenue that was the result of cost containment efforts and efficiencies gained from our multi-year project to optimize the Company's cost structure. The increase in our operating margin was partially offset by an increase in occupancy costs due to $10.0 million of lease termination costs associated with the Program Closures and higher levels of open occupancy within our waiver group homes compared to the prior year. In addition, our operating margin was negatively impacted by $6.1 million of accelerated amortization related to intangible assets associated with the Program Closures. Direct labor costs remained relatively consistent as a percentage of revenue compared to fiscal 2017.

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Community Support Services (CSS) Results of Operations

The following table sets forth the results of operations for the CSS segment for the periods indicated (in thousands):

	Year ended September 30,					
	2018		2017			Change in %
	Amount	% of gross revenue	Amount	% of gross revenue	Increase (Decrease)	of gross revenue
Revenue:						
CSS gross revenue	$1,039,711	100.0 %	$977,843	100.0 %	$61,868	
Sales adjustments	(14,099)	(1.4)%	(10,810)	(1.1)%	(3,289)	(0.3)%
CSS net revenue	1,025,612	98.6 %	967,033	98.9 %	58,579	(0.3)%
Cost of revenue:						
Direct labor costs	669,997	64.4 %	627,625	64.2 %	42,372	0.2 %
Direct program costs	43,622	4.2 %	39,626	4.1 %	3,996	0.1 %
Direct occupancy costs	78,710	7.6 %	68,212	7.0 %	10,498	0.6 %
Other direct costs	45,333	4.4 %	42,043	4.3 %	3,290	0.1 %
Total cost of revenue	837,662	80.6 %	777,506	79.6 %	60,156	1.0 %
General and administrative	50,651	4.9 %	50,551	5.2 %	100	(0.3)%
CSS EBITDA	137,299	13.1 %	138,976	14.1 %	(1,677)	(1.0)%
Depreciation and amortization	43,738	4.2 %	37,445	3.8 %	6,293	0.4 %
Income from Operations	$93,561	8.9 %	$101,531	10.3 %	$(7,970)	(1.4)%

CSS gross revenue

CSS gross revenue for the year ended September 30, 2018 increased by $61.9 million, or 6.3%, compared to the year ended September 30, 2017. The increase in CSS gross revenue included $11.6 million from organic growth and $50.3 million from acquisitions that closed during and after the year ended September 30, 2017. The organic growth was the result of a 1.6% increase in average billing rates partially offset by a 0.4% decrease in volume compared to the year ended September 30, 2017.

CSS EBITDA

CSS EBITDA decreased from $139.0 million during the year ended September 30, 2017 to $137.3 million during the year ended September 30, 2018. CSS EBITDA as a percentage of gross revenue decreased from 14.1% during the year ended September 30, 2017 to 13.1% during the year ended September 30, 2018. The decrease in our CSS EBITDA margin was due to an increase in cost of revenue as a percentage of gross revenue compared to the prior year.

CSS cost of revenue for the year ended September 30, 2018 increased, as a percentage of gross revenue, by 1.0%, compared to the year ended September 30, 2017. This was primarily due to an increase in direct labor costs of 0.2%, and an increase in direct occupancy costs of 0.6% . The increase in direct labor costs was primarily due to an increase in overtime pay compared to the year ended September 30, 2017 as we continue to experience higher competition for labor in certain markets. The increase in direct occupancy costs as a percentage of gross revenue was primarily due to higher levels of open occupancy in our waiver group home programs compared to fiscal 2017. Occupancy costs during fiscal 2018 were also negatively impacted by $0.8 million in lease termination costs associated with the Program Closures.

CSS general and administrative expenses decreased as a percentage of gross revenue in fiscal 2018 compared to fiscal 2017 due to cost containment efforts and efficiencies gained from our multi-year project to optimize the Company’s cost structure.

CSS Depreciation and amortization expense

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Depreciation and amortization expense increased $6.3 million or 0.4% as a percentage of gross revenue, compared to the year ended September 30, 2017. The increase as a percentage of gross revenue was primarily due to higher annual amortization expense resulting from intangible assets associated with the Habilitative Services, Inc. ("HSI") acquisition we completed at the end of fiscal 2017.

Specialty Rehabilitation Services (SRS) Results of Operations

The following table sets forth the results of operations for the SRS segment for the periods indicated (in thousands):

	Year ended September 30,					
	2018		2017			Change in %
	Amount	% of gross revenue	Amount	% of gross revenue	Increase (Decrease)	of gross revenue
Revenue:						
SRS gross revenue	$363,567	100.0 %	$317,196	100.0 %	$46,371	
Sales adjustments	(7,286)	(2.0)%	(7,653)	(2.4)%	367	0.4 %
SRS net revenue	356,281	98.0 %	309,543	97.6 %	46,738	0.4 %
Cost of revenue:						
Direct labor costs	187,277	51.5 %	162,990	51.4 %	24,287	0.1 %
Direct program costs	22,820	6.3 %	21,916	6.9 %	904	(0.6)%
Direct occupancy costs	51,088	14.1 %	35,275	11.1 %	15,813	3.0 %
Other direct costs	9,173	2.5 %	8,366	2.6 %	807	(0.1)%
Total cost of revenue	270,358	74.4 %	228,547	72.0 %	41,811	2.4 %
General and administrative	31,411	8.6 %	29,197	9.2 %	2,214	(0.6)%
SRS EBITDA	54,512	15.0 %	51,799	16.4 %	2,713	(1.4)%
Depreciation and amortization	31,045	8.5 %	23,622	7.4 %	7,423	1.1 %
Income from Operations	$23,467	6.5 %	$28,177	9.0 %	$(4,710)	(2.5)%

SRS gross revenue

SRS gross revenue for the year ended September 30, 2018 increased by $46.4 million, or 14.6%, compared to the year ended September 30, 2017. The increase in SRS gross revenue included $3.1 million from organic growth and $43.3 million from acquisitions that closed during and after fiscal 2017. The organic growth was driven by an increase of 0.3% in volume and an increase of 0.7% in the average billing rate.

SRS EBITDA

SRS EBITDA increased from $51.8 million during the year ended September 30, 2017 to $54.5 million during the year ended September 30, 2018. SRS EBITDA as a percentage of gross revenue decreased from 16.4% during the year ended September 30, 2017 to 15.0% during the year ended September 30, 2018. The decrease in our SRS EBITDA margin as a percentage of revenue was primarily due to an increase in cost of revenue.

SRS cost of revenue for the year ended September 30, 2018 increased as a percentage of gross revenue by 2.4% compared to the year ended September 30, 2017. The increase was due to a 3.0% increase in occupancy costs that was primarily due to $8.3 million of lease termination costs related to the Program Closures and an increase in rent expense that was partially driven by the Mentis Neuro Rehabilitation, LLC ("Mentis") acquisition. The increase was partially offset by a 0.6% decrease in direct program costs resulting from lower food and medical cost due to improvements in our procurement processes that have resulted in more favorable pricing with certain vendors.

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SRS general and administrative expenses decreased as a percentage of gross revenue by 0.6% during the year ended September 30, 2018. The decrease in general and administrative expenses was primarily due to cost containment efforts and efficiencies gained from our multi-year project to optimize the Company's cost structure.

SRS Depreciation and amortization expense

Depreciation and amortization expense as a percentage of gross revenue increased by 1.1% as a percentage of revenue, compared to the year ended September 30, 2017. The increase was primarily due to $2.3 million of accelerated amortization related to definite-lived intangible assets associated with the Program Closures and additional amortization expense resulting from intangible assets acquired in the Mentis acquisition that closed during the first quarter of fiscal 2018.

Children & Family Services (CFS) Results of Operations

The following table sets forth the results of operations for the CFS segment for the periods indicated (in thousands):

	Year ended September 30,					
	2018		2017			Change in %
	Amount	% of gross revenue	Amount	% of gross revenue	Increase (Decrease)	of gross revenue
Revenue:						
CFS gross revenue	$148,455	100.0 %	$142,137	100.0 %	$ 6,318	
Sales adjustments	(779)	(0.5)%	(395)	(0.3)%	(384)	(0.2)%
CFS net revenue	147,676	99.5 %	141,742	99.7 %	5,934	(0.2)%
Cost of revenue	113,896	76.7 %	108,410	76.3 %	5,486	0.4 %
General and administrative	12,008	8.1 %	11,742	8.3 %	266	(0.2)%
CFS EBITDA	21,772	14.7 %	21,590	15.1 %	182	(0.4)%
Depreciation and amortization	5,445	3.7 %	5,662	4.0 %	(217)	(0.3)%
Income from Operations	$16,327	11.0 %	$15,928	11.1 %	$ 399	(0.1)%

CFS gross revenue

CFS gross revenue for the year ended September 30, 2018 increased by $6.3 million, or 4.4%, compared to the year ended September 30, 2017. The $6.3 million increase in CFS gross revenue, which was all from organic growth, was due to a 3.1% increase in volume and a 1.3% increase in average billing rate.

CFS EBITDA

CFS EBITDA increased from $21.6 million during the year ended September 30, 2017 to $21.8 million during the year ended September 30, 2018. CFS EBITDA as a percentage of gross revenue decreased from 15.1% during the year ended September 30, 2017 to 14.7% during the year ended September 30, 2018. The decrease in our CFS EBITDA margin as a percentage of revenue was due to an increase in cost of revenue that was primarily attributable to higher direct labor costs, partially offset by a decrease in general and administrative expense resulting from cost containment efforts and efficiencies gained from our multi-year project to optimize the Company's cost structure.

CFS Depreciation and amortization expense

Depreciation and amortization expense for the year ended September 30, 2018 decreased by 0.2 million, or 0.3% of gross revenue, compared to the year ended September 30, 2017. This was primarily due to certain intangible assets becoming fully amortized during the first quarter of the fiscal 2018.

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Corporate and Other Results of Operations

The following table sets forth the results of operations for Corporate and Other for the periods indicated (in thousands):

	Year ended September 30,		
	2018	2017	
	Amount	Amount	Increase (Decrease)
Revenue:			
Corporate and Other gross revenue	$73,438	$57,103	$16,335
Sales adjustments	(805)	(911)	106
Corporate and Other net revenue	72,633	56,192	16,441
Cost of revenue	58,692	46,065	12,627
General and administrative	77,733	74,886	2,847
Goodwill and intangible asset impairment	—	31,002	(31,002)
Depreciation and amortization	15,193	8,984	6,209
Loss from operations	$(78,985)	$(104,745)	$25,760

Corporate and Other revenue

Corporate and Other gross revenue consists of revenue from our Adult Day Health ("ADH") business. ADH gross revenue for the year ended September 30, 2018 increased by $16.3 million, or 28.6%, compared to the year ended September 30, 2017. The increase in gross revenue included $13.6 million from acquisitions closed during and after the year ended September 30, 2017, and $2.7 million from organic growth.

Corporate and Other cost of revenue

Corporate and Other cost of revenue consists of costs associated with our ADH business. Corporate and Other cost of revenue for the year ended September 30, 2018 decreased as a percentage of gross revenue by 0.7% compared to the year ended September 30, 2017. The decrease was primarily due to lower direct labor and occupancy costs as a percentage of revenue resulting from higher operating margins on maturing new start programs and the positive impact of divesting some under-performing programs during fiscal 2017 and fiscal 2018.

Corporate and Other operating expense

General and administrative expenses for the year ended September 30, 2018 increased by $2.8 million as compared to year ended September 30, 2017.

Depreciation and amortization expense for the year ended September 30, 2018 increased by $6.2 million compared to the year ended September 30, 2017. The increase was primarily attributable to accelerated amortization expense on intangible assets associated with two ADH programs that were closed as a result of the Program Closures and additional amortization expense from intangible assets from acquisitions that closed during and after the year ended September 30, 2017.

Consolidated Other income (expense)

Other income (expense), net, which primarily consists of interest income and mark to market adjustments of the cash surrender value of Company owned life insurance policies, was $1.3 million of expense and $0.7 million of income for the years ended September 30, 2018 and September 30, 2017, respectively.

Consolidated Provision (benefit) for income taxes

For the year ended September 30, 2018 our effective income tax rate was (4.2)% compared to an effective tax rate of 22.7% for the year ended September 30, 2017. The lower effective tax rate for the year ended September 30, 2018 compared to the federal statutory income tax rate was primarily due to a $4.9 million tax benefit that was recognized in connection with revaluing of the Company’s deferred tax liabilities as a result of the lower corporate tax rate established by the Tax Act enacted in the first quarter of fiscal 2018. The lower effective tax rate for the year ended September 30, 2017 compared to the federal statutory income tax rate was primarily due to tax credits realized during

fiscal 2017.

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Fiscal Year Ended September 30, 2017 compared to Fiscal Year Ended September 30, 2016

Consolidated overview

	Year ended September 30,		Increase
(In thousands)	2017	2016	(Decrease)
Gross revenue	$1,494,279	$1,420,126	$74,153
Sales adjustments	(19,769)	(12,539)	(7,230)
Net revenue	$1,474,510	$1,407,587	$66,923
Income from operations	$40,891	$57,696	$(16,805)
Operating margin	2.7%	4.1%	