Civitas Solutions, Inc.
Form 10-K
December 10, 2015
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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, 2015

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 and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to

submit and post such files). Yes x No ¨

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

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

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

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

The aggregate market value of voting and non-voting common equity held by non-affiliates of the registrant as of March 31, 2015, the last business day of the registrant's most recently completed second fiscal quarter, was approximately $245,000,000.

As of November 30, 2015, there were 37,095,034 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 2016 Annual Meeting of Stockholders, to be filed no later than 120 days after September 30, 2015 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 demand for our services, the political climate and budgetary environment, our expansion efforts and the impact of our recent acquisitions, our plans for investments to further grow and develop our business, our margins and our liquidity. Terminology such as "may," "will," "should," "expect," "plan," "anticipate," "believe," "estimate," "predict," "potential" 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;
- substantial claims, litigation and governmental proceedings;
- reductions in reimbursement rates, policies or payment practices by our payors;
- an increase in labor costs or labor-related liability;
- matters involving employees that expose us to potential liability;
- our substantial amount of debt, our ability to meet our debt service obligations and our ability to incur additional debt;
- our history of losses;
- our ability to maintain effective internal controls;
- our ability to comply with complicated billing and collection rules and regulations;
- failure to comply with reimbursement procedures and collect accounts receivable;
- changes in economic conditions;
- 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 control labor costs, including healthcare costs imposed by the Patient Protection and Affordable Care Act;
- our ability to attract and retain experienced personnel;
- our ability to establish and maintain relationships with government agencies and advocacy groups;
- negative publicity or changes in public perception of our services;
- our ability to maintain our status as a licensed service provider in certain jurisdictions;
- our ability to maintain, expand and renew existing services contracts and to obtain additional contracts or acquire new licenses;

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- our ability to successfully integrate acquired businesses;
- our inability to successfully expand into adjacent markets;
- government regulations, changes in government regulations and our ability to comply with such regulations;
- increased competition;
- decrease in popularity of home- and community-based human services among our targeted client populations and/or state and local governments;
- our susceptibility to any reduction in budget appropriations for our services in Minnesota or any other adverse developments in that state;
- our ability to operate our business due to constraints imposed by covenants in our senior credit agreement;
- our ability to retain the continued services of certain members of our management team;
- our ability to manage and integrate key administrative functions;
- failure of our information systems or failure to upgrade our information systems when required;
- information technology failure, inadequacy, interruption or security failure;
- write-offs of goodwill or other intangible assets; and
- natural disasters or public health catastrophes.

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. (formerly known as NMH Holdings, 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 care for 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 such as those we provide. Our clinicians and caregivers 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 client 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 35-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, or at-risk youth ("ARY") and elders in need of day health services to support their independence, or adult day health ("ADH"). As of September 30, 2015, we operated in 35 states, serving approximately 12,400 clients in residential settings and more than 17,000 clients 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 for acquired brain injury and 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 client lives in the private home of a licensed caregiver, (iii) in-home settings, within which we support clients' 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 client's home. As of September 30, 2015, our services were provided by approximately 22,300 full-time equivalent employees, as well as more than 4,800 independently-contracted host home caregivers.

Although we have announced the closure of the ARY businesses in certain states, the numbers above include the clients, employees and host home caregivers because the divestitures had not yet been completed as of September 30, 2015.

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. See "Our Sponsor" below. Approximately 53% 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 Segment

We have two reportable segments, Human Services and Post-Acute Specialty Rehabilitation Services (“SRS”). We do not derive any revenues from countries outside the United States.

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Human Services

Our Human Services segment provides home- and community-based human services to individuals with intellectual and/or developmental disabilities, youth with emotional, behavioral and/or medically complex challenges, or at-risk youth, and elders. Our Human Services segment represented approximately 80.7% of our net revenue in fiscal 2015.

Delivery of services to individuals with I/DD is the largest portion of our Human Services segment. Our I/DD programs include residential support, day habilitation, vocational services, case management, crisis intervention and hourly support care. We provide services to these clients 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 1,300 group homes and 150 ICFs-I/DD. As of September 30, 2015, we provided I/DD services to approximately 16,900 clients in 22 states. In fiscal 2015, our I/DD services generated net revenue of $891.9 million, representing 65.2% of our net revenue. We receive substantially all our revenue for I/DD services from a diverse group of state and local governmental payors.

Our Human Services segment also includes the delivery of ARY services. Our ARY programs 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 client population that is diverse demographically as well as in type and severity of condition. We provide services to these clients through host homes, group homes, educational settings, in their family homes and in other non-residential settings. As of September 30, 2015, we provided ARY services to more than 9,400 children, adolescents and their families in 13 states. In fiscal 2015, our ARY services generated net revenue of $191.5 million, representing 14.0% of our net revenue. As previously disclosed, we have decided to discontinue ARY services in the states of Florida, Louisiana, Indiana, North Carolina and Texas. The net revenue generated and clients served during fiscal 2015 of $48.2 million and approximately 3,900 individuals, respectively, are included in our ARY results for fiscal 2015. We receive substantially all our revenue for ARY services from a diverse group of state and local governmental payors.

Our newest service line, 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 1,400 adults in a group environment. In fiscal 2015, our ADH services generated net revenue of $19.7 million, representing 1.4% of our net revenue. We receive substantially all our revenue for ADH services from a diverse group of state and local governmental payors.

Post-Acute Specialty Rehabilitation Services

Our SRS segment 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 segment represented approximately 19.3% of our net revenue in fiscal 2015.

Within our SRS segment, our NeuroRestorative business unit is focused on rehabilitation and transitional living services and our CareMeridian business unit is focused on the 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 that allows our clients to achieve the highest level of function possible while enhancing their quality of life. We provide services to these clients primarily through specialized community facilities, small group homes, in-home and non-residential settings. As of September 30, 2015, our SRS operations provided services in 26 states and served approximately 1,700 clients nationally. In fiscal 2015, we received 55% of our SRS revenue from non-public payors, such as commercial insurers, workers' compensation funds, managed care and other private payors and 45% from state, local and federal governmental payors.

For additional information on the Company's segments, please see note 20 to the consolidated financial statements.

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:

I/DD. Based on reports prepared by Dr. David Braddock, public spending on I/DD services was estimated to be $61.5 billion in 2013, of which approximately 81% was spent to provide services in community settings of six or fewer beds,

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our target market, and for other non-institutional services, including supported living, supported employment and family assistance. In 2013, there were approximately 5.0 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.

- ABI. The market for post-acute care and rehabilitation for individuals with ABI, the largest of these populations, is approximately $10.0 billion annually, according to the Centers for Disease Control and Prevention (the "CDC"). According to the Brain Injury Association of America ("BIAA"), more than 3.5 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.
- ARY. According to reports published by the organization Child Trends, an estimated $28.2 billion was spent in fiscal year 2012 on child welfare, including spending for residential and non-residential family support services such as those that we offer. Approximately 3.4 million referrals for abuse or neglect, which involved an estimated 6.3 million children, were investigated or assessed in the United States in federal fiscal year 2012. An estimated 653,000 children and adolescents were served by the foster care system in 2014. According to the Federal Department of Health and Human Services AFCARS data, there were more than 415,000 children and adolescents in foster care as of September 30, 2014. Of those individuals, approximately 200,000 are living in non-relative foster family homes, which includes the therapeutic foster care market, the primary market for our residential ARY services.
- ADH. The ADH portion of the elder services market is an estimated $6.2 billion based on IBISWorld estimates for spending in 2010. IBISWorld forecasts growth to be at an annualized rate for ADH of 7% with revenue for this industry projected to reach $8.7 billion in 2018. 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 ("Census Bureau"), the population of individuals age 65 and older will reach 83.7 million by 2050, almost double the estimated population of 43.1 million in 2012. 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 client independence and participation in community life 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:

Leverage our Core Competencies to Drive Organic Growth.

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 35-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 risk management, compliance and quality assurance.

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 tuck-in 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

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beginning of fiscal 2009 through September 30, 2015, we have successfully acquired 50 companies, at an aggregate purchase price of approximately $211.2 million.

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. Our investment of approximately $8.1 million in new starts between fiscal 2007 and fiscal 2010 generated net revenues and operating income of approximately $72.0 million and $17.9 million, respectively, in fiscal 2015. We have made a number of recent investments that we believe will continue to drive near term growth as they reach maturity. In 2011, we increased our level of new start investment, expanding it from an average of $3.1 million in fiscal 2009 and fiscal 2010 to an average of more than $7.0 million in fiscal 2012 through 2015. Our investment of $16.3 million in new starts between fiscal 2012 and 2013 generated net revenues and operating income of approximately $74.6 million and $11.0 million, respectively, in fiscal 2015. 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 more than doubled the size and contribution of our SRS segment since fiscal 2010, achieving a 14.0% compound annual growth rate in net revenue over that period. Furthermore, our SRS business is funded by a highly attractive payor mix, with 55% of net revenues in fiscal 2015 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 $6.2 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 are evaluating opportunities to expand this service both organically and through potential acquisitions in Massachusetts and several other states. 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 issues.

Customers and Contracts

Our customers that pay us to provide services to our clients, are governmental agencies, non-public payors and not-for-profit organizations. Our I/DD and ARY 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, a majority 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, the clients and/or the payors/referral sources (e.g., state agencies) select us as a provider and, although clients funded by Medicaid have the right to choose an alternative provider at any time, it has been our experience that our clients change providers infrequently. We believe that many of our clients develop close relationships with their direct care workers and our organization. Although a client may develop a close relationship with his or her direct care worker, it is our experience that if such direct care worker leaves our employment, clients rarely elect to switch providers based on such direct care worker's departure. The length of stay of our clients varies widely based on their individual needs. For instance, in our SRS segment, a client's care may be focused on rehabilitation, in which case we will provide services for several months, or, if a client suffered a catastrophic illness or accident, that client could remain in our care for the duration of that individual's life, which could span years or decades. In our I/DD business, the length of stay is generally years, with many of our clients having used our services

for decades. For our ARY clients, the length of treatment can vary widely but most often is for several months.

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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 both fiscal 2015 and 2014, revenue from our contracts with state and local governmental payors in the states of Minnesota, California, West Virginia, Florida and New Jersey, our five largest revenue-generating states, comprised 39% and 40% of our net revenue, respectively. Revenue from our contracts with state and local governmental payors in the State of Minnesota, our largest state, accounted for 15% and 14% of our net revenue in each of fiscal 2015 and 2014, respectively.

Training and Supporting our Direct Service Professionals

We provide pre-service and in-service education to all of our direct service 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 ARY business 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, 2015, we had approximately 22,300 full-time equivalent employees and more than 4,800 independent contractors. Although our employees are generally not unionized, we have one business in New Jersey with 35 employees who are represented by a labor union. 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 Human Services segment and the NeuroRestorative and CareMeridian brands in our SRS segment.

The majority of our human services clients come to us through third-party referrals, and frequently our I/DD 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 supports 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 Human Services businesses. We have dedicated, geographically assigned clinical marketing and sales staff cultivating relationships with public and private

payors,

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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 both segments, 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

I/DD

The I/DD 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 5% of services by revenue in the I/DD 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.

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.

ARY

The at-risk youth 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.

ADH

The ADH market in the United States is highly fragmented, with approximately 3,700 providers operating 4,800 centers according to IBISWorld and the National Center on Health Statistics. The majority of providers are relatively small companies, and only 33% of these providers have two or more locations according to a 2010 MetLife study. In 2014, the National Center on Health Statistics reported that in 2012, for-profit providers served nearly one-half, or 47%, of the nearly 275,000 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, 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:

New federal regulation regarding “waivered” services. Individuals with disabilities or chronic illnesses who need certain levels of care may qualify for home- and community-based “waivered” services (“HCBS Waiver”). The waiver program allows the states to furnish an array of home- and community-based services and avoid institutional care. On March 17, 2014, a newly promulgated 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 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. At this

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juncture it is unclear how individual states will seek to implement this newly adopted regulation. The rule may present some implementation costs and challenges. Some of the broad requirements may conflict with individual recipient needs and/or precautions that we must undertake to assure individual
services and safety. It is unclear how each state will seek to address this potential conflict. 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 (5) years from the effective date.

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 I/DD and ARY services and a significant portion of our SRS services from Medicaid programs.

Licensure and qualification to deliver service.