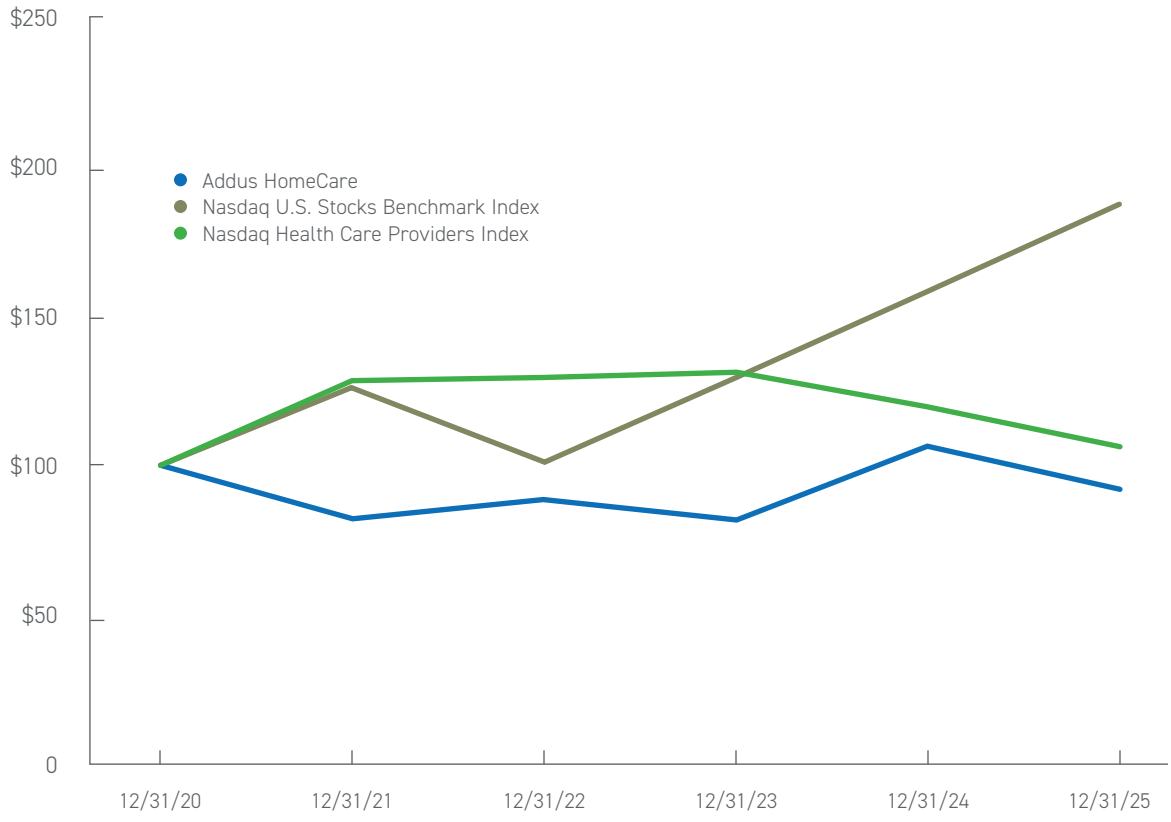
ADDUS HOMECARE

2025 ANNUAL REPORT

Comparison of 5-Year Cumulative Total Returns

The following graph compares the performance of our common stock with performance of a market index, the Nasdaq U.S. Stocks Benchmark index, and a peer group index, the Nasdaq Health Care Providers index. The following graph covers the period from December 31, 2020 through December 31, 2025. The graph assumes that $100 was invested at the closing price on December 31, 2020 in our common stock, the market index and the peer group index, and that all dividends were reinvested.



	12/31/20	12/31/21	12/31/22	12/31/23	12/31/24	12/31/25
Addus HomeCare Corporation	100.00	79.86	84.96	79.28	107.01	91.67
Nasdaq US Stocks Benchmark Index	100.00	125.89	101.05	127.76	159.03	186.96
Nasdaq Healthcare Providers Index	100.00	127.58	128.62	128.77	121.41	105.84

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

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2025

OR

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

For the transition period from to

Commission file number 001-34504

ADDUS HOMECARE CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**20-5340172**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
6303 Cowboys Way, Suite 600 Frisco, TX	**75034**
(Address of principal executive offices)	(Zip Code)

469-535-8200
(Registrant's telephone number, including area code)

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $0.001 par value	ADUS	The Nasdaq Stock Market LLC

Securities registered pursuant to Section 12(g) of the Act: None

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

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

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

Indicate by check mark whether the registrant has submitted electronically 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 ☒ No ☐

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

Large Accelerated Filer	☒	Accelerated Filer	☐
Non-Accelerated Filer	☐	Smaller Reporting Company	☐
		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 has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b). ☐

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

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the registrant, based on the last sale price on The Nasdaq Stock Market LLC on June 30, 2025 (the last business day of the registrant's most recently completed second fiscal quarter) was approximately $2,065,724,000.

As of February 17, 2026, there were 18,518,271 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Certain portions of the registrant's Definitive Proxy Statement for its 2025 Annual Meeting of Stockholders (which is expected to be filed with the Commission within 120 days after the end of the registrant's 2024 fiscal year) are incorporated by reference into Part III of this Annual Report on Form 10-K.

Auditor Firm PCAOB Id: 238 Auditor Name: PricewaterhouseCoopers LLP Auditor Location: Dallas, Texas

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SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

When included in this Annual Report on Form 10-K, or in other documents that we file with the Securities and Exchange Commission ("SEC") or in statements made by or on behalf of the Company, words like "believes," "belief," "expects," "plans," "anticipates," "intends," "projects," "estimates," "may," "might," "would," "should," and similar expressions are intended to be forward-looking statements as defined by the Private Securities Litigation Reform Act of 1995. These statements are based on the beliefs and assumptions of our management based on information currently available to management. Such forward-looking statements are subject to risks, uncertainties and other important factors that could cause actual results and the timing of certain events to differ materially from future results expressed or implied by such forward-looking statements. These risks and uncertainties include, but are not limited to:

- the impact of macroeconomic conditions, including inflation and interest rates, legislative and political developments, including federal government shutdowns, any lapse in appropriations and any hold on or cancellation of congressionally authorized spending or interruptions in the distribution of government funds, trade policies and tensions, including changes in, or the imposition of, tariffs and/or trade barriers and the economic impacts, volatility and uncertainty resulting therefrom, and the potential adverse effects of current conditions;
- business disruptions due to inclement weather, natural disasters, acts of terrorism, military conflicts, pandemics, civil insurrection or social unrest;
- changes in operational and reimbursement processes and payment structures at the state or federal levels;
- changes in Medicaid, Medicare, other government program and managed care organizations' policies and payment rates, and the timeliness of reimbursements received under government programs;
- the implementation of new, and possible changes to existing federal and state laws or regulations, or our failure to comply with such laws or regulations or comply on a timely basis;
- the impact of decisions of the U.S. Supreme Court regarding the actions of federal agencies;
- changes in the executive branch of the federal government;
- changes in the structure and administration of, and funding for, federal and state agencies and programs;
- competition in the healthcare industry;
- the geographical concentration of our operations;
- changes in the case mix of consumers and payment methodologies;
- operational changes resulting from the assumption by managed care organizations of responsibility for managing and paying for our services to consumers;
- the nature and success of future financial and/or delivery system reforms;
- changes in estimates and judgments associated with critical accounting policies;
- our ability to maintain or establish new referral sources;
- our ability to renew significant agreements or groups of agreements;
- our ability to attract and retain qualified personnel;

- federal, state and city minimum wage pressure, including any failure of any governmental entity to enact a minimum wage offset and/or the timing of any such enactment;
- changes in payments and covered services due to the overall economic conditions and deficit or spending reduction measures by federal and state governments, and our expectations regarding these changes;
- cost containment initiatives undertaken by federal and state governmental and other third-party payors;
- our ability to access financing through the capital and credit markets;
- our ability to meet debt service requirements and comply with covenants in debt agreements;
- our ability to integrate and manage our information systems;
- any security breaches, cyber-attacks, loss of data, or cybersecurity threats or incidents, and any actual or perceived failures to comply with legal requirements related to the privacy of confidential consumer data and other sensitive information;
- the size and growth of the markets for our services, including our expectations regarding the markets for our services;
- eligibility standards and limits on services imposed through legislation or by governmental agencies or other third-party payors;
- the potential for litigation, audits and investigations;
- discretionary determinations by government officials;
- our ability to successfully implement our business model to grow our business;
- our ability to continue identifying, pursuing, consummating and integrating acquisition opportunities and expanding into new geographic markets;
- the impact of acquisitions and dispositions on our business, including the potential inability to realize the benefits of potential acquisitions;
- the effectiveness, quality and cost of our services;
- our ability to successfully execute our growth strategy;
- changes in tax rates; and
- various other matters, many of which are beyond our control.

Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified, you should not rely on any forward-looking statement as a prediction of future events. We expressly disclaim any obligation or undertaking, and we do not intend to release publicly any updates or changes in our expectations concerning the forward-looking statements or any changes in events, conditions or circumstances upon which any forward-looking statement may be based, except as required by law. For a discussion of some of the factors discussed above as well as additional factors, see Part I, Item 1A—"Risk Factors" and Part II, Item 7—"Management's Discussion and Analysis of Financial Condition and Results of Operations—Critical Accounting Policies and Estimates."

Summary Risk Factors

You should carefully read and consider the risk factors set forth under the Item 1A, "Risk Factors," as well as all other information contained in this Annual Report on Form 10-K. Additional risks and uncertainties are not presently known to us or that we currently deem immaterial may also affect us. If any of these risks occur, our business, financial position, results of operations, cash flows or prospects could be materially and adversely affected. Our business is subject to the following principal risks and uncertainties:

- Our growth strategy depends on our ability to manage growing and effectively integrating operations and we may not be successful in managing this growth.
- Completed or future acquisitions, or growth initiatives, may be unsuccessful and could expose us to unforeseen liabilities.
- We may be unable to pursue acquisitions or expand into new geographic regions without obtaining additional capital or consent from our lenders.
- Our financial results have been, and may continue to be, adversely impacted by negative macroeconomic conditions.
- Timing differences in reimbursement may cause liquidity problems.
- We have been and may become the subject of surveys, audits and investigations by governmental agencies and private payors, which could have adverse findings that may negatively impact our business.
- Our revenues are concentrated in a small number of states, which makes us particularly sensitive to regulatory and economic changes in those states.
- Future efforts to reduce the costs of the Illinois Department on Aging programs could adversely affect our service revenues and profitability.
- Failure to renew a significant payor agreement or group of related payor agreements may materially impact our revenue.
- Negative publicity or changes in public perception of our services may decrease consumer volumes and adversely affect our ability to receive referrals, obtain new agreements and renew existing agreements, any of which could adversely affect our business.
- Our business may be harmed by labor relations matters.
- If we were required to write down all or part of our goodwill and/or our intangible assets, our net earnings and net worth could be materially adversely affected.
- If we fail to maintain an effective system of internal control over financial reporting, such failure could adversely impact our business and stock price.
- Any increase in the volume of self-pay patients or deterioration in the collectability of patient responsibility accounts could adversely affect our financial condition or results of operations.
- Our hospice operations are subject to annual Medicare caps. If we exceed the caps, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.
- Reductions in reimbursement and other changes to Medicare, Medicaid, and other federal, state and local medical and social programs could adversely affect our consumer caseload, units of service, revenues, gross profit and profitability.
- Federal and state regulation may impair our ability to consummate acquisitions or open new agencies.

- The implementation of alternative payment models and any increases in enrollment in Medicare Advantage or Medicaid managed care plans may limit our market share and could adversely affect our revenues.
- Our industry is highly competitive, fragmented and market-specific.
- If we fail to comply with the extensive laws and regulations governing our business, we could be subject to penalties or be required to make changes to our operations, which could negatively impact our business and profitability.
- We are subject to federal, state and local laws and regulations that govern our employment practices, including minimum wage, living wage, and paid time-off requirements. Failure to comply with these laws and regulations, or changes to these laws and regulations that increase our employment-related expenses, could adversely impact our operations.
- Our business may be adversely impacted by changes and uncertainty in the healthcare industry, including healthcare public policy developments and other changes to laws and regulations.
- The industry trend toward value-based payment models may negatively impact our revenues.
- Our operations subject us to risk of litigation.
- Our insurance liability coverage may not be sufficient for our business needs.
- Our business depends on the proper functioning, availability, and security of our information systems. Our operations may be disrupted if we are unable to effectively integrate, manage and maintain the security of our information systems.
- A cyber-attack or security breach could cause a loss of confidential consumer data, give rise to remediation and other expenses, expose us to liability under privacy laws, consumer protection laws, common law and other legal theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, result in interruptions or delays to services, adversely impact our financial results, and otherwise be disruptive to our business.
- We may not be able to attract and retain qualified personnel or we may incur increased costs in doing so.
- The departure of any member of our executive team may materially adversely affect our operations, and any replacement for a departed member of our executive team may be unable to execute our strategies at the same level.
- Restrictive covenants in the agreements governing our indebtedness may adversely affect us.
- Factors beyond our control, including inclement weather, natural disasters, acts of terrorism, pandemics, riots, civil insurrection or social unrest, looting, protests, strikes and street demonstrations, may impact our ability to provide services.
- The emergence and effects related to a potential future pandemic, epidemic, or outbreak of infectious disease could adversely impact our business and future results of operations and financial condition, and we may be more vulnerable to the effects of a public health crisis than other businesses due to the nature of our business and consumers.

Unless otherwise provided, “Addus,” “we,” “us,” “our,” and the “Company” refer to Addus HomeCare Corporation and our consolidated subsidiaries and “Holdings” refers to Addus HomeCare Corporation. When we refer to 2025, 2024 and 2023, we mean the twelve-month period then ended December 31, unless otherwise provided.

A copy of this Annual Report on Form 10-K for the year ended December 31, 2025 as filed with the SEC, including all exhibits, is available on our internet website at http://www.addus.com on the “Investors” page link. Information contained on, or accessible through, our website is not a part of, and is not incorporated by reference into, this Annual Report on Form 10-K.

PART I

ITEM 1. BUSINESS

Overview

Addus has been providing home care services since 1979. We operate three segments: personal care, hospice, and home health. Our services are principally provided in-home under agreements with federal, state and local government agencies, managed care organizations, commercial insurers and private individuals. Our consumers are predominantly "dual eligible," meaning they are eligible to receive both Medicare and Medicaid benefits.

As of December 31, 2025, we provided services in 23 states through approximately 262 offices. For the year ended December 31, 2025, we served approximately 107,000 discrete consumers.

We continue to drive organic growth while also growing through acquisitions, focusing on growth in the states in which we have a presence while adding clinical care services to our offerings. As of December 31, 2025, we provide all three levels of care, personal care, home health and hospice services, in Ohio, Tennessee, Illinois and New Mexico and strategically continue to pursue other markets.

A summary of our financial results is provided in the table below.

	For the Years Ended December 31,	
	2025	2024
	(Amounts in Thousands)	
Personal care	$ 1,089,215	$ 856,581
Hospice	262,542	228,191
Home health	70,773	69,827
Total net service revenue by segment	$ 1,422,530	$ 1,154,599
Net income	$ 95,910	$ 73,598
Total assets	$ 1,437,308	$ 1,412,634

Our services and operating model address a number of crucial needs across the healthcare continuum. Care provided in the home generally costs less than facility-based care and is typically preferred by consumers and their families. By providing services in the home to the elderly and others who require long-term care and support with the activities of daily living, we lower the cost of chronic and acute care treatment by delaying or eliminating the need for care in more expensive settings. In addition, our caregivers observe and report changes in the condition of our consumers for the purpose of facilitating early intervention in the disease process, which often reduces the cost of medical services by preventing unnecessary emergency room visits and/or hospital admissions and re-admissions. We coordinate the services provided by our team with those of other healthcare providers and payors, as appropriate. Changes in a consumer's conditions are evaluated by appropriately trained managers, which may result in a report to the consumer's case manager at a managed care organization or other payor. By providing care in the preferred setting of the home and by providing opportunities to improve the consumer's conditions and allow early intervention as indicated, our model also is designed to improve consumer outcomes and satisfaction.

We believe our model provides significant value to managed care organizations. States predominantly deliver services to Medicaid enrollees through comprehensive managed care models, most of which are administered by managed care organizations. As a result, managed care organizations have assumed significant responsibility for the healthcare needs and the related healthcare costs of our consumers. Managed care organizations have an economic incentive to better manage the healthcare expenditures of their members, lower costs and improve outcomes. We believe that our model is well positioned to assist in meeting those goals while also improving consumer satisfaction, and, as a result, we expect increased referrals from managed care organizations.

Our Market and Opportunity

We provide home care services that primarily include personal care services to assist with activities of daily living, as well as hospice and home health services. These services allow the elderly and other infirm adults who require long-term care and assistance with activities of daily living to maintain their independence at home with their families. Personal care services are a significant component of home and community-based services ("HCBS"), which have grown in significance and demand in recent years. In particular, the demand for personal care services is growing from managed care delivery models, including Medicaid Long-Term Services and Supports programs and Medicare Advantage plans. Managed care plans aim to manage cost, utilization and quality through collaboration of health insurance plans and healthcare providers. We also offer personal care services to private pay consumers. We expect demand for HCBS to continue to grow due to the aging of the U.S. population and improved opportunities for individuals to receive home-based care as an alternative to institutional care.

Because our model serves an aging population in a home setting at a lower cost, we believe that we have favorable opportunities for growth. The personal care, hospice and home health service industries have developed in a fragmented manner, with many small participants and a few larger participants that have a significant market share across multiple regions or states. The historic lack of licensure or certification requirements in some states makes it difficult to estimate the number of home-based services agencies, although these requirements and other barriers to entry such as the operational requirements discussed in the next paragraph are increasing. We expect ongoing consolidation within our industry, driven by the desire of healthcare systems and managed care organizations to narrow their networks of service providers, and also by the industry's increasingly complex regulatory, operating and technology requirements. We believe we are well-positioned to capitalize on these trends, given our reputation in the market, strong payor relationships and integration of technology into our business model.

The personal care services industry is subject to increasing regulation. Many states require providers to register with regulatory authorities or obtain licenses. At the federal level, efforts have focused on improved coordination of regulation across the various types of Medicaid programs through which personal care services are offered. For example, federal standards require states to mandate that providers use an electronic visit verification ("EVV") system to collect certain data from Medicaid-funded home visits. States that do not comply face incremental reductions in federal Medicaid funding. States have flexibility in the model they use to implement the mandate, which means EVV systems, vendors and contracting processes can vary significantly by state. Providers must dedicate substantial resources toward continuing compliance with all applicable laws and regulations, and significant expenditures may be necessary to offer new services or to expand into new markets. We believe licensing and other operational requirements and regulations, the increasing focus on improving health outcomes, the rising cost and complexity of operations and technology and pressure on reimbursement rates may discourage new providers and may encourage industry consolidation.

As discussed in more detail below, our consumers are predominantly "dual eligibles," meaning they are eligible for both Medicare and Medicaid. We believe that our personal care program and our technology make us well-suited to partner with managed care organizations to address the needs of the dual-eligible population, and we believe that our ability to identify changes in our consumers' health and condition before acute intervention is required will lower the overall cost of care. We believe this approach to care delivery and the integration of our services into the broader healthcare continuum are particularly attractive to managed care organizations and others who are ultimately responsible for the healthcare needs of our consumers and over time will increase our business with these organizations.

Our Growth Strategy

The growth of our revenues is closely correlated with the number of consumers to whom we provide our services. Our continued growth depends on our ability to provide consistent high-quality care, maintain our existing payor relationships, establish relationships with new payors, increase our referral sources and attract and retain caregivers. Our continued growth is also dependent upon the authorization by state agencies of new consumers to receive our services. We believe there are several market opportunities for growth as the population ages. Individuals generally prefer to receive care in their homes, and we believe the COVID-19 pandemic heightened this preference due to health concerns that may be associated with institutional settings for long-term care, along with concerns about the imposition of visitor restrictions that may be imposed during a public health crisis. Finally, we believe the provision of home-based services is more cost-effective than the provision of similar services in institutional settings for long-term care. We plan to continue our revenue growth and enhance our competitive positioning by executing on the following growth strategies:

Consistently Provide High-Quality Care

We schedule and require our caregivers to perform their services as defined within the individual plan of care. We monitor the performance of our caregivers through regular supervisory visits in the homes of consumers. Our caregivers are provided with pre-service training and orientation and an evaluation of their skills. In many cases, caregivers are also required to attend ongoing in-service education. In certain states, our caregivers are required to complete certified training programs and maintain a state certification. The training assists our caregivers with identifying changes in our consumers' health and condition before acute intervention is required, which we believe lowers the overall cost of care.

Drive Organic Growth in Existing Markets

We intend to drive organic growth through several initiatives, including continuing to build and enhance our sales and marketing capabilities, enhancing our business intelligence analytic capabilities, recruiting and retaining employees and investing in technology and operations to drive efficiencies. We also expect our organic growth will benefit from an increase in demand for our services by an aging population and our increased alignment with referral sources and payors. We continue to selectively open new offices in existing markets when an opportunity is identified and appropriate.

Market to Managed Care Organizations

As a large-scale provider of home-based care, we market to and partner with managed care organizations, taking advantage of an industry shift from traditional fee-for-service Medicare and Medicaid toward managed care models that aim to better coordinate care and typically have narrower provider networks. We believe we are attractive to managed care organizations due to our coordinated care model and integration of services into the broader healthcare industry, our status as a larger, more experienced partner than our competition and our ability to provide sophisticated technology, electronic visit records and an outcomes-driven approach to service. In particular, our expansion from primarily personal care services into hospice and home health has increased our value to our managed care partners by diversifying our home-based care offerings.

Grow Through Acquisitions

In addition to our organic growth, we have been growing through acquisitions that have expanded our presence in current markets or facilitated our entry into new markets. We completed four acquisitions in 2025: Gold Horses, LLC, a Texas limited liability company (the "Gold Horses Acquisition") on October 1, 2025; Helping Hands Home Care Service, Inc., a Pennsylvania corporation (the "Helping Hands Acquisition") on August 1, 2025; Great Lakes Home Care Unlimited, LLC (the "Great Lakes Acquisition") on March 1, 2025; and our Jacksonville affiliate (the "Jacksonville Acquisition") on January 1, 2025. Acquisitions completed in 2025 accounted for $11.8 million in net service revenues for the year ended December 31, 2025. We completed two acquisitions in 2024: the personal care business of Curo Health Services, LLC, a Delaware limited liability company that does business as Gentiva, consisting of certain equity interests and assets and liabilities, on December 2, 2024 (collectively, the "Gentiva Acquisition"), and Upstate Home Care Solutions (the "Upstate Acquisition") on March 9, 2024. Acquisitions completed in 2024 accounted for $22.6 million in net service revenues for the year ended December 31, 2024.

Our active pipeline and strong financial position support additional acquisitions. With rising consolidation pressures in the industry, our focus is on identifying growing markets with favorable demographics in states that are fiscally well managed and have a reasonable minimum wage environment and where we have the potential to become one of the leading providers in the state in order to support our managed care organization strategy. We believe our experience identifying and executing on opportunities generated by our acquisition pipeline, as well as our history of integrating acquisitions, will lead to additional growth.

Our Services

We operate three business segments: personal care, hospice and home health. Without our services, many of our consumers would be at increased risk of hospitalization or placement in a long-term care institution.

Personal Care

Our personal care segment provides non-medical assistance with activities of daily living, primarily to persons who are at increased risk of hospitalization or institutionalization, such as the elderly, chronically ill or disabled. The services we provide include assistance with bathing, grooming, oral care, feeding and dressing, medication reminders, meal planning and preparation, housekeeping and transportation services. Many consumers need such services on a long-term basis to address chronic or acute conditions. Our personal care segment also includes staffing services, with clients including assisted living facilities, nursing homes and hospice facilities. Each payor client establishes its own eligibility standards, determines the type, amount, duration and scope of services, and establishes the applicable reimbursement rate in accordance with applicable laws, regulations or contracts.

Hospice

Our hospice segment provides physical, emotional and spiritual care for people who are terminally ill as well as related services for their families. The hospice services we provide include palliative nursing care, social work, spiritual counseling, homemaker services and bereavement counseling. Generally, patients receiving hospice services have a life expectancy of six months or less.

Home Health

Our home health segment provides services that are primarily medical in nature to individuals who may require assistance during an illness or after hospitalization and include skilled nursing and physical, occupational and speech therapy. We generally provide home health services on a short-term, intermittent or episodic basis to individuals, typically to assist patients recovering from an illness or injury.

We measure the performance of each segment using a number of different metrics. See "*Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations*" for information regarding the Company's segment metrics.

Our Payors

Our payor clients are principally federal, state and local governmental agencies and managed care organizations. The federal, state and local programs under which the agencies operate are subject to legislative, administrative and budgetary restrictions, changes and other risks that can influence reimbursement rates. Managed care organizations that effectively operate as an extension of government payors are subject to similar economic pressures. Our commercial insurance payor clients are typically for-profit companies and are continuously seeking opportunities to control costs.

Most of our services are provided pursuant to agreements with state and local governmental social and aging service agencies. These agreements generally have an initial term of one to two years and may be terminated with 60 days' notice. They are typically renewed for one to five-year terms, provided that we have complied with licensing, certification and program standards, and other regulatory requirements. Reimbursement rates and methods vary by state and service type, but are typically based on an hourly or unit-of-service basis. Managed care organizations are a significant portion of our personal care segment payor mix as a result of states shifting from administering fee-for-service programs to utilizing managed care models. See "*Management's Discussion and Analysis of Financial Condition and Results of Operations—Overview*" for our revenue mix by payor type.

Competition

We believe our industry is highly competitive, fragmented and market specific. Each local market has its own competitive profile, and no single competitor has significant market share across all of our markets. Other providers, entities and individuals in the communities we serve provide services similar to those we offer. Our competition consists of personal care service providers, home health providers, hospice providers, private caregivers, publicly held companies, privately held companies, privately held single-site agencies, hospital-based agencies, not-for-profit organizations, community-based organizations, managed care organizations and self-directed care programs. Some of our competitors and/or competitive care models may have greater financial, technical, political and marketing resources, as well as name recognition with consumers and payors. We have experienced, and expect to continue to experience, competition from new entrants into our markets. Increased competition may result in pricing pressures, loss of or failure to gain market share or loss of consumers or payors, any of which could harm our business.

Our strategies are designed to help our service lines remain competitive. Factors that impact our competitive position include the quality of care and services we provide, our ability to attract and retain caregivers and other personnel, our relationships with potential referral sources and our ability to retain and renew our contracts with payors and enter into new contracts on favorable terms. Increased consolidation among payors has increased payor bargaining power. Laws and regulations may also impact our contract terms or ability to contract with third-party payors, such as state laws that permit payors to guide patients to particular providers and eliminate restrictions on placing providers into preferred tiers. Trends toward clinical and pricing transparency may also impact our competitive position, ability to obtain and maintain favorable contract terms and consumer volumes. The current federal administration has signaled its commitment to advancing price transparency initiatives, including through an executive order issued in February 2025 addressing implementation and enforcement of price transparency rules. A number of states have adopted their own healthcare price transparency requirements. The Centers for Medicare & Medicaid Services ("CMS") websites make available to the public data submitted by home health agencies, hospices and other Medicare-certified providers in connection with Medicare reimbursement claims, including performance data on quality measures and patient satisfaction. In addition, federal and state regulations, including state certificate of need ("CON") laws, which limit the expansion of healthcare facilities or services, may affect the competitive landscape. Changes in licensure or other laws and regulations and recognition of new provider types or payment models could also impact our competitive position.

Sales and Marketing

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

We also focus on establishing new and maintaining existing referral relationships with various managed care organizations that contract with the states to service the Medicaid programs. We believe these relationships are necessary to generate continued referrals of new clients in markets we serve.

We receive substantially all of our personal care consumers through third-party referrals, including state departments and local government agencies on aging, social services, rehabilitation, mental health and children's services, managed care organizations and the Veterans Health Administration. Generally, family members of potential consumers are made aware of available in-home services or alternative living arrangements through state or local case management systems, which may be operated by governmental or private agencies.

In addition, we provide ongoing education and outreach in our target communities in order to inform the community about state and locally-subsidized care options and to communicate our role in providing quality personal care services. We also utilize consumer-directed sales, marketing and advertising programs designed to attract consumers.

With respect to our hospice and home health patients, we receive substantially all of our referrals through other healthcare providers, such as hospitals, physicians, nursing homes and assisted living facilities. We have a team of community liaisons in our hospice and home health operations that educate and develop relationships with other healthcare providers and the community at large.

Payment for Services

Substantially all of the reimbursement we receive for services we provide comes from federal, state and local government programs, such as Medicare, Medicaid and other state programs, managed care organizations and the Veterans Health Administration. In addition, we are reimbursed by commercial insurance and private pay consumers. Depending on the type of service, coverage for services may be predicated on a case manager, physician or nurse determination that the care is necessary or on the development of a plan for care in the home.

Medicare

Medicare is a federal program that provides medical insurance benefits to persons aged 65 or older, some disabled persons, persons with end-stage renal disease and persons with amyotrophic lateral sclerosis. Each of our hospice and home care agencies must comply with the extensive conditions of participation in the Medicare program in order to continue receiving Medicare reimbursement.

In addition to the reimbursement adjustments and policies discussed below, the Budget Control Act of 2011 requires automatic spending reductions to reduce the federal deficit, resulting in a uniform percentage reduction across all Medicare programs of 2%. These cuts continue through the first eleven months of federal fiscal year 2032.

Hospice

Medicare beneficiaries who have a terminal illness and a life expectancy of six months or less may elect to receive hospice benefits (i.e., palliative services for management of a terminal illness) in lieu of standard Medicare coverage for treatment. Hospice services are paid under the Medicare Hospice Prospective Payment System ("HPPS"), under which CMS sets a daily rate for each day a patient is enrolled in the hospice benefit. The daily rate depends on the level of care provided to a patient (routine home care, continuous home care, inpatient respite care, or general inpatient care). CMS requires hospice providers to submit quality reporting data each year and updates hospice payment rates annually using a market basket index. Hospices that do not satisfy quality reporting requirements are subject to a 4 percentage point reduction to the market basket percentage update. Additionally, hospice providers are subject to two specific payment limit caps under the Medicare program each federal fiscal year: the inpatient cap and the aggregate cap.

Home Health

CMS reimburses home health agencies under a prospective payment system, paying a national, standardized 30-day period payment rate if a period of care meets a threshold of home health visits. The daily home health payment rate is adjusted for case-mix and area wage levels. CMS uses the Patient-Driven Groupings Model ("PDGM") as the case-mix classification model to place periods of care into payment categories, classifying patients based on clinical characteristics. An outlier adjustment may be paid for periods of care in which costs exceed a specific threshold amount. CMS updates home health payment rates annually using a market basket index. Home health agencies that do not submit required quality data are subject to a 2 percentage point reduction to the market basket update. Under the Home Health Value-Based Purchasing ("HHVBP") Model, home health agencies receive increases or reductions to their Medicare fee-for-service payments of up to 5%, based on performance against specific quality measures relative to the performance of other home health providers. Data collected in each performance year impacts Medicare payments two years later.

Medicare requires home health agencies to submit a one-time Notice of Admission ("NOA") for each patient that establishes that the beneficiary is under a Medicare home health period of care. Failure to submit the NOA within five calendar days from the start of care date will result in a reduction to the 30-day period payment amount for each day from the start of care date until the date the NOA is submitted.

Medicaid

Medicaid is a state-administered program that provides certain social and medical services to qualifying low-income individuals and is jointly funded by the federal government and individual states. The federal government pays a percentage match for state Medicaid expenditures that varies by state and other factors, with no pre-set limit on federal spending. Reimbursement rates and methods vary by state and service type, but are typically based on an hourly or unit-of-service rate. Rates are subject to adjustment based on statutory and regulatory changes, administrative rulings, government funding limitations and interpretations of policy by individual state agencies. Within guidelines established by federal statutes and regulations, and subject to federal oversight, each state establishes its own eligibility standards, determines the type, amount, duration and scope of services, sets the rate of payment for services and administers its own program. Most states currently provide coverage for hospice services and HCBS for seniors and people with disabilities, although federal regulations do not require states to cover these services. In contrast, federal Medicaid rules generally require states to cover certain home health services (part-time or intermittent nursing services, home health aide services, and medical supplies, equipment and appliances), although other home health services, such as occupational therapy, physical therapy, and speech therapy are optional. States must cover more extensive home health services for some children and young adults with complicated medical conditions. Services offered through a Medicaid state plan must be offered to all eligible individuals, but services provided under waivers may be restricted to specific groups. In addition, states may limit the number of people receiving waiver services.

Payment models vary by state. Home health services are often reimbursed by state Medicaid programs on a fee-for-service basis. For hospice services, the state pays an amount for each day that a beneficiary is under the care of a hospice provider based on the type and intensity of services furnished. Many states have transitioned the administration of their Medicaid hospice and home health programs to managed care organizations in order to effectively manage costs by making spending more predictable for states. Personal care services and other HCBS are largely reimbursed on a fee-for-service basis. In states that deliver HCBS through managed care, reimbursement can be set as a percentage of the Medicaid fee-for-service rates or otherwise tied to state fee-for-service schedules. Some states use supplemental payment arrangements to make additional payments to providers that are separate from base payments and not specifically tied to an individual's care. For example, some supplemental payments are intended to address the difference between Medicaid fee-for-service payments and Medicare reimbursement rates, or payments under other state-specific programs. These supplemental reimbursement arrangements are generally authorized by CMS for a specified period of time and require CMS' approval to be extended.

The budget reconciliation legislation enacted on July 4, 2025, commonly known as the "One Big Beautiful Bill Act" ("OBBBA"), is expected to decrease federal Medicaid spending, including as a result of changes to Medicaid eligibility policies and changes to Medicaid financing mechanisms, such as limitations on provider tax arrangements. The federal government and many states are using or considering various strategies to reduce Medicaid expenditures, and most states have adopted broad taxes on healthcare providers to fund the non-federal share of Medicaid programs. For states to be able to draw down federal Medicaid matching funds based on the revenues from provider taxes, the taxes must satisfy federal requirements including that the taxes be broad-based, uniform, and not hold taxpayers "harmless," subject to limited exceptions. The OBBBA includes restrictions on provider tax arrangements intended to reduce the federal matching funds received by state Medicaid programs. The OBBBA effectively prohibits states from establishing new provider taxes or increasing rates of existing provider taxes, with greater restrictions in states that have expanded Medicaid, including states with waiver-based expansions. In addition, the OBBBA limits the structure and applicability of provider taxes, such that some taxes on managed care organizations and providers permitted prior to the enactment of the OBBBA are no longer permissible, subject to transition periods. The law also impacts state directed payment ("SDP") arrangements, as further discussed below.

Many states are facing increasing or evolving budgetary pressures, including as a result of the OBBBA and other recent federal actions. Because most states must operate with balanced budgets and because the Medicaid program is often a state's largest budget expenditure, many states have adopted, or are considering, various strategies to reduce their Medicaid expenditures. State strategies to control Medicaid expenditures may include legislation designed to reduce coverage, change patient eligibility requirements and/or enroll Medicaid recipients in managed care programs. Some states use, or have applied to use, waivers granted by CMS to impose non-standard eligibility or enrollment restrictions, implement Medicaid expansion under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), or otherwise implement programs that vary from federal standards. For example, most states provide Medicaid HCBS through waivers that offer benefits targeted to people in specific populations, such as adults over age 65 who have physical disabilities, and waiver coverage of different home care services varies by the target population served.

In recent years, aspects of existing or proposed Medicaid programs have been subject to legal challenge, resulting in uncertainty. Federal legislation and administrative policies that shape administration of the Medicaid programs at the state level are also subject to change. CMS administrators may in the future make various changes impacting eligibility or enrollment conditions and other aspects of waiver programs. Reductions in federal Medicaid funds and increases to state administrative burdens could have a significant impact on Medicaid programs, such as limitations on eligibility or coverage, particularly if states are unable to offset federal funding reductions.

Medicare and Medicaid Managed Care

Managed Medicare, also known as Medicare Part C or Medicare Advantage, and managed Medicaid programs remain common strategies as the federal and state governments seek to control healthcare costs. Under the Medicare Advantage program, the federal government contracts with private health plans to provide members with Medicare benefits. In addition to covering Medicare Part A and Part B benefits, the plans may choose to offer supplemental benefits, including in-home support services, and impose higher premiums and cost-sharing obligations.

Managed Medicaid programs enable states to contract with private entities to handle program responsibilities like patient enrollment, care management and claims adjudication. The states usually retain program responsibilities for financing, eligibility criteria and core benefit plan design. Managed care is the predominant delivery system for Medicaid enrollees, with the majority of beneficiaries enrolled in managed care organizations. For example, over three-quarters of Medicaid beneficiaries in Illinois are a part of the HealthChoice Illinois statewide managed care program, which is serviced by various managed care organizations and includes senior citizens, adults with disabilities who are not eligible for Medicare, and dual eligibles receiving certain long-term services and supports. States are increasingly using SDP arrangements to direct certain Medicaid managed care plan expenditures, and states have converted supplemental payment programs to SDP arrangements, diverting previously available funding. SDP arrangements are subject to approval by CMS and allow states to implement delivery system and provider payment initiatives by requiring Medicaid managed care organizations to pay providers according to specific rates or methods. For example, SDP arrangements may require managed care plans to implement value-based purchasing models or performance improvement initiatives or may direct managed care plans to adopt specific payment parameters, such as minimum or maximum fee schedules for specific types of providers. SDP arrangements can be limited to a specific subset of providers, and providers that do not satisfy applicable criteria may be ineligible for payments. The use and nature of SDP arrangements are subject to policy changes. For example, the OBBBA directs HHS to revise regulations governing SDP arrangements by tying caps on total payment rates paid by Medicaid managed care organizations for hospital and other specified services to Medicare payment rates instead of average commercial rates. CMS issued a final rule in May 2024 that revised SDP arrangement requirements, including changes intended to help states use the arrangements to implement value-based payment arrangements and include non-network providers in SDP arrangements. Further, the rule requires states to ensure each provider receiving an SDP attest by January 1, 2028, that they do not participate in any arrangement that holds taxpayers harmless for the cost of a tax. The various elements of the rule take effect between issuance and early 2028.

Dual Eligibles

"Dual eligibles" are individuals who are eligible for both Medicare and Medicaid by virtue of their age or disability and low income. Most dual-eligible individuals have full Medicaid benefits, covered either through Medicaid fee-for-service or Medicaid managed care, but some are partial-benefit dual eligibles who are not eligible for full Medicaid benefits but receive assistance with Medicare premiums and, in some cases, cost-sharing. Most dual eligibles have Medicare benefits separately covered under traditional Medicare or Medicare Advantage, but there are some single coverage arrangements that provide both Medicare and Medicaid benefits under one program. Medicare is generally the primary payor for services covered by the Medicare program, while Medicaid covers services not included in the Medicare benefit. The Medicare-Medicaid Coordination Office ("MMCO") was established within CMS to enhance access to services for dual-eligible individuals by improving coordination between the federal government and states. The MMCO works with state Medicaid agencies, other federal and state agencies and other stakeholders to more effectively integrate benefits between Medicare and Medicaid and to improve care coordination, quality and cost-effectiveness. The MMCO and the CMS Innovation Center collaborate to support care coordination models for dually eligible individuals, including by implementing demonstration projects affecting reimbursement for services provided to dual eligibles. Some members of Congress and the federal administration have raised potential changes such as requiring integrated Medicare and Medicaid coverage for dual eligibles in a single plan or program.

Illinois Department on Aging

A significant amount of our net service revenues from our personal care segment are derived from one specific payor client, the Illinois Department on Aging, which accounted for 18.1% and 21.0% of our net service revenues for 2025 and 2024, respectively. The Illinois Department on Aging coordinates programs and community-based services intended to improve quality of life and preserve the independence of older individuals. The Illinois Department on Aging is funded by Medicaid, Illinois' Commitment to Human Services Fund and general revenue funds of the state of Illinois and historically has received funding available under the federal Older Americans Act ("OAA"), although OAA funding expired in 2025. The Illinois Department on Aging's Community Care Program ("CCP") provides adult day services, emergency home response, automated medication dispenser services, and in-home services, which include personal care services, to individuals who are age 60 and over and meet other eligibility requirements. Some of these services are provided through a Medicaid waiver granted by CMS.

Consumers are identified by "care coordinators" contracted independently with local organizations affiliated with the Illinois Department on Aging. Once a consumer has been evaluated and determined to be eligible for a program, an assigned care coordinator refers the consumer to a list of authorized providers, from which the consumer selects the provider. We provide our services in accordance with a care plan developed by the care coordinator and under administrative directives from the Illinois Department on Aging. We are reimbursed on an hourly fee-for-service basis.

Veterans Health Administration

The Veterans Health Administration operates the nation's largest integrated healthcare system, with more than 1,300 healthcare facilities, and provides healthcare benefits, including personal care, hospice and home health services, to eligible military veterans. The Veterans Health Administration provides funding to regional and local offices and facilities that support the in-home care needs of eligible aged and disabled veterans. Services are funded by local Veterans Medical Centers and the aid and attendance pension, which reimburses veterans for their otherwise unreimbursed health and long-term care expenses. We currently have relationships and agreements with the Veterans Health Administration to provide personal care services in several states, principally in Texas, New Mexico, Illinois and California.

Other

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

Commercial Insurance

Health insurance coverage offered by private-sector insurance companies is the most common form of health coverage in the United States. Most private plans have a managed care approach, involving a limited network of providers and attempting to control costs and utilization with strategies such as financial incentives and utilization management. Most private health insurance plans cover the same types of services as Medicare, meaning long-term care coverage under these plans is typically limited to skilled, short-term, medically necessary care.

Long-term care insurance, which is separate from health insurance, is intended to cover costs of care associated with a chronic condition or disability that requires extended or long-term care. Long-term care insurance policies may cover services provided in a variety of settings, and most policies include benefits for in-home services. Policies are generally subject to dollar limitations on the amount of daily, weekly or monthly coverage provided, and many policies have limits on the duration of coverage.

Private Pay

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

Value-Based Care Arrangements

There is a trend toward value-based purchasing of healthcare services across the industry among both governmental and commercial payors. Generally, value-based care aims to hold providers accountable for delivering efficient, effective care by tying provider reimbursement to patient outcomes or related measures. Value-based care arrangements vary in the method for determining payments and the level of risk assumed, among other factors. For example, Medicare reimbursement may be adjusted based on quality and efficiency measures and/or compliance with quality reporting requirements. In addition, CMS websites make available to the public data submitted by home health agencies, hospices, and other Medicare-certified providers in connection with Medicare reimbursement claims, including performance data on quality measures and patient satisfaction. CMS uses quality information to administer other value-based care models, such as the HHVBP Model, under which home health agencies receive increases or reductions to their Medicare fee-for-service payments based on their performance against specific quality measures, relative to the performance of other home health agencies.

An accountable care organization ("ACO"), an example of a value-based care model, is a group of providers and suppliers that work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. ACOs are intended to produce savings through improved quality and operational efficiency. Medicare-approved ACOs that achieve quality performance standards established by HHS are eligible to share in a portion of the amounts saved by the Medicare program. Under some payment tracks, ACOs may be required to pay shared losses if quality-adjusted Medicare expenditures exceed an established benchmark.

The CMS Innovation Center is responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for health care that create savings under the Medicare and Medicaid programs, while improving quality of care. In recent years, the CMS Innovation Center has implemented several bundled payment models, which are intended to lead to high quality, more coordinated care at a lower cost. Providers participating in bundled payment initiatives receive one payment for services provided to patients for certain medical conditions or episodes of care, accepting accountability for costs and quality of care. The CMS Innovation Center released a new strategic direction in 2025, which continues to support the transition from Medicare fee-for-service models to value-based payment and care delivery models. The new strategy is based on three pillars: promoting disease prevention, empowering individuals through information and processes, and driving choice and competition in health care markets. The CMS Innovation Center indicated it will update existing value-based models and release new models consistent with these pillars. Model reviews and new model designs may require that all alternative payment models involve downside risk and that a growing proportion of Medicare and Medicaid beneficiaries are in global downside risk arrangements, among other requirements. The CMS Innovation Center also indicated that it plans to test improvements in Medicare Advantage and Medicaid. Several state Medicaid programs and private third-party payors are also increasingly employing alternative payment models, which may increasingly shift financial risk to providers or increase payments for quality improvement. We expect value-based purchasing programs, including models that condition reimbursement on patient outcome measures, to become more common with both governmental and non-governmental payors.

Insurance Programs and Costs

We maintain workers' compensation, general and professional liability, cyber, automobile, directors' and officers' liability, fiduciary liability and excess liability insurance. We offer various health insurance plans to eligible full-time and part-time employees. We believe our insurance coverage and self-insurance reserves are adequate for our current operations. However, we cannot be certain that any potential losses or asserted claims will not exceed such insurance coverage and self-insurance reserves.

Human Capital Management

The following is a breakdown of our part- and full-time employees, including the employees in our corporate support center, as of December 31, 2025:

	Full-time	Part-time	Total
Caregivers and agency staff	5,290	44,658	49,948
Corporate support centers	692	19	711
	5,982	44,677	50,659

At Addus, our people are crucial to our mission. Our Addus CARES commitment to human capital excellence inspires a culture that attracts, retains, and engages our employees to serve our important mission, and it is fundamental to our corporate philosophy.

Workforce Composition:

Our workforce is a dynamic and diverse assembly of talent. At the core of our operations is a dedicated team of 5,290 full-time caregivers, clinical staff, and administrative employees. Complementing their efforts are 44,658 part-time caregivers and administrative employees. We offer flexibility in the form of adaptable work options, which may not be as readily available in other industries. In our most recent annual employee engagement survey, our workforce scored work-life balance at an 80% satisfaction rating.

We have over 700 administrative and professional employees at our two corporate support centers.

Approximately 17,468 or 34.5% of our total employees are represented by labor unions. We maintain strong working relationships with these labor unions. We have numerous collective bargaining agreements with local affiliates of the Service Employees International Union ("SEIU"), which are renegotiated from time to time.

People Development and Experience:

We believe in a strong workplace culture focused on people development. We have named this initiative "Addus CARES", which represents our commitment to creating a culture that attracts, retains, and engages people to serve our important mission. We aspire to create a workplace that values and listens to its employees, provides ample opportunities for their skills development, and effectively recognizes their achievements. By leveraging our People Development and Experience Department, we aspire to create a workplace that values and listens to its employees, provides ample opportunities for their skills development, and effectively recognizes their achievements throughout the employee life cycle.

Addus prioritizes a robust listening strategy that offers regular feedback opportunities throughout an employee's tenure. We leverage tools such as our annual engagement survey and a newly introduced innovative tool for conducting more effective one-on-one conversations between supervisors and employees, allowing for more open communication and the opportunity to better address our employees' needs and concerns.

Our dedication to workforce experience is also reflected in the breadth of our training programs and our ongoing commitment to employee development, including our Ignite and Emerge employee development programs. Ignite equips new leaders with the necessary skills, tools, and resources to lead within our organizational culture and values. Emerge cultivates future leaders, strengthening our future with a diverse internal leadership pipeline for potential future promotions. Additionally, Addus deploys ongoing learning opportunities throughout the employee life cycle via the Addus Learning Academy and clinical learning management systems. The Addus Learning Academy allows employees to access online resources needed to build and enhance the important skills related to their respective roles at Addus and to provide beneficial soft-skills training for personal growth. Addus' clinical learning management systems provide a catalog of continuing learning opportunities for patient-facing employees to improve their clinical skills and promote consistent, quality care.

We believe it is important to acknowledge our employees and managers who are carrying our mission and values forward every day, and we are committed to fostering employee engagement through effective recognition programs and communications. The Addus Elite employee recognition program consists of three levels of employee recognition: real-time peer-to-peer, quarterly company-wide, and annual Addus Elite Hall of Fame. All three components are designed to recognize and celebrate the work our employees do daily. Additionally, we have focused our organizational communication tools to disseminate vital company information more efficiently and effectively through the Addus Resource Center, AddusConnect, and Addus Ink. The Addus Resource Center is a company information portal for on-demand company information. AddusConnect is a biweekly e-newsletter that succinctly features important company updates, information, and resources. Addus Ink is a semi-annual publication that highlights local stories and news from around the country that celebrate our mission and values.

Employee Welfare

As part of our commitment to providing high quality care and service to our clients and patients, while also promoting the health and well-being of our employees, Addus takes a multifaceted approach to employee wellness and safety.

Through strategically designed benefit offerings, Addus provides access to healthcare coverage that balances the medical needs of our workforce with affordability for our diverse employment populations. In addition, the company aims to assist in the financial well-being of our workforce through company benefits such as early wage access programs, an employee discount marketplace, and educational resources for employees on financial well-being. Addus offers a non-profit employee disaster relief fund program, Addus ACTS, that provides emergency financial grants for employees in need.

In addition, Addus maintains a structured workplace safety program throughout the employee life cycle that provides job-relevant education, training, and skills focused on both the prevention of workplace injuries and improving awareness of mitigation efforts, should risks materialize on the job. Through these comprehensive safety efforts, the Addus safety program enhances our ability to provide consistent and quality client care and service.

Talent Acquisition

Talent acquisition is a strategic imperative of the company, and our Addus CARES culture is committed to attracting, retaining, and engaging talent. Our commitment to talent acquisition is evident in both our internal mobility efforts and our external recruitment. Internally, the company provides a tuition reimbursement program designed to encourage the continued educational pursuit of academic degrees that prepare employees for their next logical internal career progression, or that improve their ability to perform their current role. Clinical ladder initiatives focus on clinical certification advancement of existing employees. External recruitment has been bolstered by new investments in job search efforts, programmatic job advertising, and new recruitment technologies, most recently with the introduction of an artificial intelligence ("AI") powered conversation and scheduling assistant designed to engage in real-time with potential job candidates. Recruitment strategies, including company-wide hiring events, local partnerships with colleges and nursing schools, sponsored clinical rotations, and student scholarships have better positioned the company to attract top talent.

Technology

We currently utilize multiple applications to support our various lines of business and locations for patient accounting. Each application supports its respective line of business and locations with administrative, office, clinical and operating information system needs, including compliance of our operating systems with federal and state privacy, security and interoperability requirements. Each assists our staff in gathering information to improve the quality of consumer care, optimize financial performance, promote regulatory compliance and enhance staff efficiency. Each application is hosted by the vendor in a secure data center, which provides multiple redundancies for storage, power, bandwidth and security.

In order to comply with federal and state laws and regulations around EVV use, we utilize several different vendors and have built interfaces between the EVV vendor and the patient accounting system utilized in the respective branch location. Our caregivers use a mix of Interactive Voice Response ("IVR") and mobile applications for EVV. In addition, we use these technologies to record basic information about each visit, record start and end times for a scheduled shift, track mileage reimbursement, send text messages to the caregivers and communicate basic payroll information.

We license the Qlik Business Intelligence ("Qlik") platform to provide historical, current, and forward-looking operational performance analysis. We currently have our personal care and hospice segments integrated into Qlik. Qlik provides high-level historical and current analytical views to measure performance against budget and deliver insight into the various factors driving our execution against our financial, operational, and compliance goals. This analysis is available in summary and detailed views to accommodate user needs at all levels, from senior management to operators in the field.

We utilize the ADP Vantage Suite as our base human resources and payroll processing system and use their services and products to manage our leave of absence processes, benefits, 401(k) and flexible spending account administration, garnishment services, payroll tax filings, ACA compliance and filings, and time and attendance. For financial management, we utilize Oracle's Planning Budgeting Cloud Service as our solution for budgeting, forecasting, and financial reporting and Oracle Fusion for the general ledger, accounts payable and fixed assets.

Government Regulation

Overview

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

Medicare and Medicaid Participation

To participate in and qualify for reimbursement under Medicare, our home health agencies and hospices must enroll and comply with extensive conditions of participation. Likewise, to participate in and qualify for reimbursement under Medicaid programs, our personal care services, hospices and home health agencies are subject to various federal and state requirements. If we were to violate the applicable federal and state regulations governing Medicare or Medicaid participation, we could be subject to substantial administrative, civil and criminal penalties, including exclusion from participation in federal and state healthcare programs.

Developments in Healthcare Policy

The healthcare industry is subject to changing political, regulatory, economic and other influences at the federal and state level, along with scientific and technological initiatives and innovations that may affect our business. The outcome of the 2024 federal elections has increased regulatory uncertainty and the potential for significant policy changes. Actions by the executive branch have resulted in holds on or cancellations of congressionally authorized spending as well as interruptions in the distribution of government funds. In addition, the executive branch has significant influence over healthcare policy changes through government agency regulation. Federal agencies oversee, regulate and otherwise affect many aspects of our business, including through Medicare and Medicaid policies, policies affecting the size of the uninsured population and interpretation and enforcement of fraud and abuse laws. In March 2025, HHS announced a significant agency restructuring intended to reduce the HHS workforce and consolidate divisions of the agency, including by integrating some functions of the Administration for Community Living, which administers programs that support older adults, into other HHS agencies. HHS also announced a change in its policy on public participation in rulemaking that may negatively affect the ability of industry participants to receive advance notice of and offer feedback on some policy changes. Regulatory uncertainty has also increased as a result of recent U.S. Supreme Court decisions that increase judicial scrutiny of agency authority, shift greater responsibility for statutory interpretation to courts and expand the timeline in which a plaintiff can sue regulators. These decisions may increase legal challenges to healthcare regulations and agency guidance and decisions, and may result in inconsistent judicial interpretations and delays in and other impacts to the agency rulemaking and legislative processes.

In recent years, the U.S. Congress and certain state legislatures have introduced and passed a large number of proposals and legislation affecting the healthcare system, including laws intended to reduce healthcare costs and government spending and increase or, more recently, decrease access to health insurance. For example, the OBBBA includes several healthcare policy changes that are expected to decrease access to health insurance. Further, healthcare providers may be significantly impacted by reforms to the Medicaid program, including changes resulting from legislation and administrative actions at the federal and state levels. Changes at the federal level may impact funding for, or the structure of, the Medicaid program, including through changes to Medicaid waiver programs, and may shape provider reimbursement rates, eligibility and coverage policies, waiver programs and other aspects of the Medicaid program at the state level. For example, as further discussed in Item 1, "Business – Payment for Services – Medicaid Programs," the OBBBA includes provisions that are expected to result in Medicaid spending reductions and changes in administration of state Medicaid programs. The law requires changes to Medicaid financing mechanisms, including limitations on provider tax arrangements, a mandate that HHS revise regulations governing state-directed payment arrangements to cap total payment rates paid by Medicaid managed care organizations for specified services and additional restrictions on federal funding for eligibility-related erroneous Medicaid payments. Some of these changes are intended to reduce the federal matching funds received by state Medicaid programs. In addition, the OBBBA limits Medicaid eligibility and increases administrative and financial obligations for states and enrollees, particularly with regard to the Medicaid expansion population, which consists of low-income, non-elderly adults.

In addition to implementing changes mandated through legislation, CMS administrators may modify Medicaid payment models and may impose new restrictions or grant states additional flexibility in the administration of state Medicaid programs. For example, in May 2024, CMS finalized a rule intended to improve access to services and quality of care for Medicaid beneficiaries across fee-for-service and managed care delivery systems. The final rule includes significant provisions related to HCBS, including the "80/20" or "payment adequacy" requirement, which will require states to ensure by mid-2030 that at least 80% of all Medicaid payments a provider receives for homemaker, home health aide, and personal care services, less certain excluded costs, under specified programs are spent on total compensation (including benefits) for direct care workers furnishing these services, rather than administrative overhead or profit, subject to limited exceptions. The final rule includes several other measures intended to promote transparency and enhance quality and access to services, including a variety of reporting requirements for states. Some states have adopted or may consider adopting similar caregiver compensation restrictions. In addition, some states use, or have applied to use, waivers granted by CMS to impose different eligibility or enrollment conditions, implement Medicaid expansion, or otherwise implement programs that vary from federal standards, such as HCBS waiver programs. The Medicaid landscape is constantly evolving as federal and state governments consider and test various models of delivery and payment system reform.

The federal and state governments also continue to explore other payment and delivery system reform initiatives, including value-based purchasing models and related initiatives that incentivize reporting of and improvements in quality of care and cost-effectiveness. The CMS Innovation Center tests innovative payment and service delivery systems to reduce Medicare and Medicaid program expenditures while maintaining or enhancing quality. For example, the CMS Innovation Center has established pilot programs that bundle acute care hospital services with physician services and post-acute care services, which may include home health services for certain patients. In addition, the CMS Innovation Center collaborates with the Medicare-Medicaid Coordination Office to support care coordination models for dually eligible individuals. Other congressional and administrative initiatives and proposals have also focused on the dual-eligible population, including proposals to enroll all dual-eligible individuals in a single plan or program that provides both Medicare and Medicaid benefits. Other industry participants, such as private payors and large employer groups and their affiliates, may introduce or encourage additional financial or delivery system reforms. For example, in recent years, private and/or public payer policies have encouraged or required enrollment in managed care programs, favored outpatient care over inpatient care, and resulted in provider consolidation.

There is also uncertainty regarding the potential impact of further health-related public policy developments at the federal and state levels. For example, some members of Congress and the executive branch have raised potential measures that may impact our operations, such as those intended to accelerate the shift from traditional Medicare to Medicare Advantage or eliminating some or all of the consumer protections established by the ACA.

Permits, Licensure and Certificate of Need

Our hospice, home health and personal care services are authorized and/or licensed in accordance with various state and local requirements, which also address a variety of operational issues including standards for the provision of medical or care services, clinical records, personnel, infection control and care plans. Additionally, healthcare professionals at our agencies are required to be individually licensed or certified under state law. Although our personal care service caregivers are generally not subject to licensure requirements, certain states require them to complete varying degrees of pre- and post-employment training programs, continuing education, background checks and maintain state certification. We believe we are currently licensed appropriately as required by the laws of the states in which we operate in all material respects, but additional licensing requirements may be imposed upon us in existing markets or markets that we enter in the future.

Some states also require a provider to obtain a CON or permit of approval before establishing, constructing, acquiring or expanding certain health services, operations or facilities or making certain capital expenditures. These CON requirements, which are intended to avoid unnecessary duplication of services, generally require a state health planning agency to determine that a need exists for the project before granting approval. Failure to obtain necessary state approvals or provide required notices may result in the inability to expand services or facilities, complete an acquisition or expenditure or change ownership or other penalties.

Fraud and Abuse Laws

The laws and regulations governing our operations, including the terms of participation in Medicare, Medicaid and other government programs, impose certain requirements and limitations on our operations, business arrangements and our interactions with providers and consumers. These laws include, but are not limited to, the federal Anti-Kickback Statute, the federal Stark Law, the federal False Claims Act ("FCA"), the federal Civil Monetary Penalties Law, other federal and state fraud and abuse, insurance fraud, and fee-splitting laws, which may extend to services reimbursable by any payor, including private insurers.

The fraud and abuse laws and regulations to which we are subject include but are not limited to:

- The federal Anti-Kickback Statute, which prohibits providers and others from directly or indirectly soliciting, receiving, offering or paying any remuneration with the intent of generating referrals or orders for services or items covered by a federal healthcare program. Courts have interpreted this statute broadly and held that there is a violation of the Anti-Kickback Statute if just one purpose of the remuneration is to generate referrals.

- The federal physician self-referral law, commonly known as the Stark Law, which prohibits physicians from referring Medicare and Medicaid patients to healthcare entities in which they or any of their immediate family members have ownership interests or other financial arrangements, if these entities provide certain "designated health services" (including home health services) reimbursable by Medicare or Medicaid, unless an exception applies. The Stark Law also prohibits entities that provide designated health services reimbursable by Medicare and Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires the entities to refund amounts received for items or services provided pursuant to the prohibited referral on a timely basis.

- The federal FCA and similar state laws that govern the submission of claims for reimbursement and prohibit the making of false claims or statements. The government may use the FCA to prosecute Medicare and other government program fraud in areas such as coding errors and billing for services not provided. Among the many other potential bases for liability is the knowing and improper failure to report and refund amounts owed to the government within 60 days of identifying an overpayment. Submission of claims for services or items generated in violation of the Anti-Kickback Statute constitutes a false or fraudulent claim under the FCA. The federal government has taken the position, and some courts have held, that providers who allegedly have violated other statutes, such as the Stark Law, have thereby submitted false claims under the FCA. The FCA may be enforced directly by the federal government or by a whistleblower on the government's behalf.

- The federal Civil Monetary Penalties Law, which prohibits, among other conduct, offering remuneration to influence a Medicare or Medicaid beneficiary's selection of a healthcare provider, contracting with an individual or entity known to be excluded from a federal healthcare program, billing for services not rendered or for medically unnecessary services, misrepresenting actual services rendered in order to obtain higher reimbursement, and the failure to return overpayments in a timely manner.

- State anti-kickback and self-referral provisions, false claims laws, insurance fraud laws, and fee-splitting laws. The scope and interpretation of these state laws vary, and in some cases apply to items or services reimbursed by any payor, including patients and commercial insurers. For instance, the Illinois Insurance Claims Fraud Prevention Act penalizes the knowing offer or payment of remuneration to induce a person to procure clients or patients under a contract of insurance, including commercial insurance plans. Some state laws include whistleblower provisions, allowing for enforcement by private parties on the government's behalf.

Penalties for violation of various fraud and abuse laws or other failure to substantially comply with the numerous conditions of participation in the Medicare or Medicaid programs may result in criminal penalties, civil sanctions, including substantial civil monetary penalties, and exclusion from participation in federal healthcare programs, including Medicare and Medicaid.

Payment Integrity

We are subject to routine and periodic surveys and audits by various governmental agencies and other payors. From time to time, we receive and respond to survey reports containing statements of deficiencies. Periodic and random audits conducted or directed by these agencies could result in a delay in receipt or an adjustment to the amount of reimbursements due or received under federal or state programs and could result in referrals to other agencies to investigate and/or prosecute potential fraud or abuse.

CMS and state Medicaid agencies contract with third parties to promote the integrity of the Medicaid and Medicare programs through reviews of quality concerns and detections and corrections of improper payments. For example, CMS and state Medicaid agencies contract with recovery audit contractors ("RACs") on a contingency fee basis to conduct post-payment reviews to detect and correct improper payments in the Medicare and Medicaid programs. RACs review claims submitted to these programs for billing compliance, including correct coding and medical necessity. States may coordinate with Medicaid RACs regarding recoupment of overpayments and refer suspected fraud and abuse to appropriate law enforcement agencies. In addition, CMS engages unified program integrity contractors ("UPICs") to perform proactive analysis, audits, investigations and other program integrity functions across the Medicare and Medicaid programs, with the goal of identifying and deterring fraud and abuse to avoid improper payments. Working across five geographic jurisdictions, UPICs collaborate with states and coordinate provider investigations across the Medicare and Medicaid programs.

CMS is implementing a new payment integrity program, the Wasteful and Inappropriate Service Reduction ("WISeR") model, in six states in 2026, including Arizona, Ohio, Texas and Washington. Under the WISeR model, CMS will contract with technology vendors tasked with using enhanced technologies, including AI, to streamline medical necessity review for selected items and services under traditional fee-for-service Medicare. Providers will be required to submit prior authorization requests for the selected items and services or claims will be subject to post-service, pre-payment medical review. Participating technology vendors will receive a percentage of the cost savings resulting from their reviews, adjusted based on performance measures. The model will run for six performance years.

From time to time, various federal and state agencies, such as HHS, issue guidance that identifies practices and provider types that may be subject to heightened scrutiny, as well as practices that may violate fraud and abuse laws. We believe, but cannot assure you, that our operations comply with the principles expressed by these agencies.

HIPAA and Other Privacy and Security, Data Exchange and AI Requirements

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and its implementing regulations require the use of uniform electronic data transmission standards and code sets for certain healthcare claims and reimbursement payment transactions submitted or received electronically. HIPAA extensively regulates the use, disclosure, confidentiality, availability and integrity of individually identifiable health information, known as "protected health information," and provides for a number of individual rights with respect to such information. As a "covered entity" subject to HIPAA, we are required to maintain privacy and security policies, train workforce members, maintain physical, administrative, and technical safeguards, enter into confidentiality agreements with vendors that handle protected health information ("business associates"), and permit individuals to access and amend their protected health information. In addition, we must report any breaches of unsecured protected health information to affected individuals, to HHS and, in situations involving large breaches, to the media. HIPAA violations may result in criminal penalties and significant civil penalties.

Other federal and state laws and regulations that apply to the collection, use, retention, protection, security, disclosure, transfer and storage of personal information, including restrictions on the offshoring of data, and other processing of personal data may impose additional or inconsistent obligations and/or result in additional penalties. For example, various state laws and regulations require us to notify affected individuals in the event of a data breach involving individually identifiable information. Several states have passed or are considering comprehensive privacy legislation. Others have enacted "offshoring" prohibitions that restrict the transfer, storage and access of patient data outside of the United States or North America. Providers subject to those laws may not be able to rely on outside vendors who operate overseas to store or handle patient records. Further, several privacy bills have been proposed at the federal level that may result in additional legal requirements that impact our business. Laws, regulations, regulatory guidance and industry standards related to privacy, data protection, and security continue to evolve, often have far-reaching effects, could impact our operations, and have required, and will continue to require, us to incur substantial expenses to comply, including costs associated with modifying our data processing practices and policies.

Healthcare providers and industry participants are also subject to a growing number of requirements intended to promote the interoperability and exchange of patient health information, including prohibitions on information blocking. For example, certain healthcare providers and other entities are subject to information blocking restrictions pursuant to the 21st Century Cures Act that prohibit practices that are likely to interfere with the access, exchange or use of electronic health information, except as required by law or specified by HHS as a reasonable and necessary activity. Violations may result in penalties or other disincentives. In July 2024, HHS finalized a rule establishing disincentives for information blocking by hospitals, clinicians eligible for the Merit-based Incentive Payment System ("MSSP") and ACOs, ACO participants, and ACO providers or suppliers under the MSSP.

We use AI in connection with recruitment and are considering other uses. The regulatory framework for AI is rapidly evolving as many federal and state legislatures and agencies have adopted, introduced or are currently considering additional laws and regulations that impact the use of AI, particularly in the employment and health care space. For example, California enacted Assembly Bill 3030, known as the Artificial Intelligence in Health Care Services Bill ("AB 3030"), which requires that any health care facility using generative AI to create patient communications pertaining to patient clinical information ensure that the communications include (i) a disclaimer that the communication was generated by generative AI and (ii) clear instructions describing how a patient may contact a human health care provider or other appropriate person at the health care facility. Further, Texas enacted the Texas Electronic Health Record Requirements Act, which allows healthcare practitioners to use AI for diagnostic purposes, including recommendations on diagnosis or treatment, provided the practitioner is licensed, reviews all AI-generated records in accordance with Texas Medical Board standards, and discloses AI use to patients. Additionally, existing laws and regulations may be interpreted in ways that could impact our use of AI. The cost to comply with such laws and regulations could be significant and would increase our operating expenses. There is further uncertainty in the effectiveness of state AI laws given the Executive Order issued on December 11, 2025, entitled "Ensuring a National Policy Framework for Artificial Intelligence", which directs federal regulators to challenge and preempt state laws that the administration views as obstructive to AI innovation. As a result, implementation standards and enforcement practices are likely to remain uncertain for the foreseeable future, and we cannot yet completely determine the impact future laws, regulations, standards, or market perception of their requirements may have on our business and may not always be able to anticipate how to respond to these laws or regulations.

Environmental, Health and Safety Laws

We are subject to federal, state and local regulations governing the storage, transport, use and disposal of hazardous materials and waste products. In the event of an accident involving such hazardous materials, we could be held liable for any damages that result, and any liability could exceed the limits or fall outside the coverage of our insurance. We may not be able to maintain insurance on acceptable terms, or at all.

In addition, we could be affected by climate change to the extent that climate change results in severe weather conditions or other disruptions impacting the communities in which we conduct operations or adversely impacts general economic conditions, including in communities in which we conduct operations. Moreover, legal requirements regulating greenhouse gas emissions or otherwise associated with the transition to a lower carbon economy may increase in the future, which could increase our costs associated with compliance and otherwise disrupt and adversely affect our operations. At the current time, our compliance with environmental legal requirements, including legal requirements relating to climate change, do not have a material effect on our capital expenditures, financial results or operations, and we did not incur material capital expenditures for environmental matters during the year ended December 31, 2025. However, it is possible that future environmental-related developments may impact us, including as a result of climate change and/or new legal requirements associated with the transition to a lower carbon economy, in a manner that we are currently unable to predict.

Access to Public Filings

Through our website, *www.addus.com,* we make available, free of charge, our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and all amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. In addition to our website, the SEC maintains an internet site that contains our reports, proxy and information statements, and other information that we file electronically with the SEC at *www.sec.gov.* The references to our website address in this Form 10-K do not constitute incorporation by reference of the information contained on the website and should not be considered part of this document.

ITEM 1A. RISK FACTORS

Any of the risks described below, and the risks described elsewhere in this Form 10-K, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows, cause the trading price of our common stock to decline and cause the actual outcome of matters to differ materially from our current expectations as reflected in forward-looking statements made in this Form 10-K. The considerations and risks that follow are organized within relevant headings but may be relevant to other headings as well. The risk factors described below and elsewhere in this Form 10-K are not the only risks we face. Our business and consolidated financial condition, results of operations and cash flows may also be materially adversely affected by factors that are not currently known to us, by factors that we currently consider immaterial or by factors that are not specific to us, such as general economic conditions.

You should refer to the explanation of the qualifications and limitations on forward-looking statements under "Special Caution Concerning Forward-Looking Statements." All forward-looking statements made by us are qualified by the risk factors described below.

Risks Related to our Growth Strategy

Our growth strategy depends on our ability to manage growing and effectively integrating operations and we may not be successful in managing this growth.

Our business plan calls for significant growth over the next several years through the expansion of our services in existing markets and the potential establishment of a presence in new markets. This growth has placed and continues to place significant demands on our management team, systems, internal controls and financial and professional resources. Meeting our growth plans requires us to continue to develop our financial control and reporting system and could require us to incur expenses for hiring additional qualified personnel, retaining professionals to assist in developing the appropriate control systems and expanding our information technology infrastructure. Our inability to effectively manage growth could have a material adverse effect on our financial results.

Completed or future acquisitions, or growth initiatives, may be unsuccessful and could expose us to unforeseen liabilities.

Our growth strategy includes potential geographical expansion into new markets and the addition of new services in existing markets through the acquisition of local service providers. These acquisitions involve significant risks and uncertainties, including difficulties assimilating acquired personnel and other corporate cultures into our business, the potential loss of key employees or consumers of acquired providers, regulatory risks, the assumption of liabilities, exposure to unforeseen liabilities of acquired providers and the diversion of the management team's attention. In addition, our due diligence review of acquired businesses may not successfully identify all potential issues. Further, following completion of an acquisition, we may not be able to maintain the growth rate, levels of revenue, earnings or operating efficiency that we and the acquired business have achieved or might achieve separately. The failure to effectively integrate future acquisitions could have a material adverse impact on our operations.

We have grown our business opportunistically through de novo offices and we may in the future selectively open new offices in existing and new states. De novo offices involve risks, including those relating to licensing, accreditation, payor program enrollment, hiring new personnel, establishing relationships with referral sources and delays or difficulty in installing our operating and information systems. We may not be successful in generating sufficient business activity to sustain the operating costs of such de novo operations.

We may be unable to pursue acquisitions or expand into new geographic regions without obtaining additional capital or consent from our lenders.

At December 31, 2025 and 2024, we had cash balances of $81.6 million and $98.9 million, respectively, and $124.3 million and $223.0 million, respectively, of outstanding debt on our credit facility. After giving effect to the amount drawn on our credit facility, approximately $7.9 million of outstanding letters of credit at each of December 31, 2025 and 2024, and borrowing limits based on an advanced multiple of Adjusted EBITDA (as defined in the Credit Agreement), we had $517.7 million and $346.6 million available for borrowing under our credit facility as of December 31, 2025 and 2024, respectively. Since our credit facility provides for borrowings based on a multiple of an Adjusted EBITDA ratio, any declines in our Adjusted EBITDA would result in a decrease in our available borrowings under our credit facility.

We cannot predict the timing, size and success of our acquisition efforts, our efforts to expand into new geographic regions or the associated capital commitments. If we do not have sufficient cash resources or availability under our credit facility, our growth could be limited unless we obtain additional equity or debt financing. In the future, we may elect to issue additional equity securities in conjunction with raising capital, completing an acquisition or expanding into a new geographic region. Such issuances could be dilutive to existing shareholders. In addition, our ability under our credit facility to consummate acquisitions is restricted if we exceed certain Total Net Leverage Ratio (as defined in the Credit Agreement, and subject to adjustments as provided therein) thresholds, without the consent of the lenders; provided, however, in certain circumstances, in connection with a Material Acquisition (as defined in the Credit Agreement), we can elect to increase our Total Net Leverage Ratio compliance covenant for the then current fiscal quarter and the three succeeding fiscal quarters. Further, our credit facility requires, among other things, that we are in pro forma compliance with the financial covenants set forth therein and that no event of default exists before and after giving effect to any proposed acquisition. Our ability to expand in a manner consistent with historic practices may be limited if we are unable to obtain such consent from our lenders.

Business Risks

Our financial results have been, and may continue to be, adversely impacted by negative macroeconomic conditions.

Economic conditions in the United States continue to be challenging in certain respects, including as a result of inflationary pressures, elevated interest rates, challenging labor market conditions and potential adverse effects associated with current geopolitical conditions. Taking into account these factors, we have incurred, and may continue to incur, increased competition for new caregivers and skilled healthcare staff, which will continue to impact our ability to attract and retain new employees. Further, the inflationary conditions have resulted in, and may continue to result in, increased operating costs, particularly as the result of increased wages we have paid and may continue to pay our caregivers and other personnel and our ability to attract and retain personnel. We might not be able to realize rate increases from government programs and private payors, which represent most of our revenue, and any rate increases obtained may not be sufficient to offset increases to operating expenses. Higher interest rates also raise our financing costs. These factors had an unfavorable impact on our financial results during the year ended December 31, 2025, and may have an unfavorable impact on our financial results in future periods which could be material. If economic conditions in the United States significantly deteriorate, any such developments could materially and adversely affect our results of operations, financial position, and/or our cash flows. Negative macroeconomic conditions could also disrupt financial markets and capital markets and the businesses of financial institutions, potentially causing a slowdown in the decision-making of these institutions. This may affect the timing on which we may obtain any additional funding and there can be no assurance that we will be able to raise additional funds on terms acceptable to us, if at all.

Moreover, there is ongoing uncertainty regarding the federal budget and federal spending levels, and we anticipate that the federal deficit, the magnitude of Medicare and Medicaid expenditures and the aging of and health status trends within the U.S. population will continue to place pressure on government healthcare programs. It is difficult to predict whether, when, or what additional deficit reduction initiatives may be proposed by Congress, but it is possible that future deficit reduction legislation will mandate additional Medicare and/or Medicaid spending reductions. There is uncertainty regarding the impact of any failure to increase the "debt ceiling," and any U.S. government default on its debt could have broad macroeconomic effects. Further, any shutdown of the federal government, failure to enact annual appropriations, hold on congressionally authorized spending or interruptions in the distribution of governmental funds could adversely affect our financial results. States may also face significant fiscal challenges and revise their revenue forecasts and adjust their budgets, and sales tax collections and income tax receipts could be depressed, which may place further pressure on government healthcare program spending, among other effects.

Timing differences in reimbursement may cause liquidity problems.

We fund operations primarily through the collection of accounts receivable, but there is a delay between the time that we provide services and the time that we receive reimbursement or payment for these services. These delays may result from such factors as changes by payors to data submission requirements, billing or audit procedures or other payor policies; requests by fiscal intermediaries for additional data or documentation; delays or issues implementing reimbursement-related rules, such as periodic payment updates from government programs; other Medicare or Medicaid issues; information system problems; or a government shutdown, failure to enact annual appropriations or other lapse in appropriations, holds on congressionally authorized spending or interruptions in the distribution of governmental funds. Further, state budgets could be impacted by federal actions, including the OBBBA, and to the extent economic conditions in the United States are challenging in 2026. As a result of fiscal challenges, various states may in the future delay reimbursement, which would adversely affect our liquidity. In addition, from time to time, procedural issues require us to resubmit claims before payment is remitted, which contributes to our aged receivables. Delays in receiving reimbursement or payments from Medicare, Medicaid and other payors may adversely impact our working capital. As a result, working capital management, including prompt and diligent billing and collection, is an important factor in our results of operations and liquidity. Our working capital management procedures may not successfully negate this risk.

We have been and may become the subject of surveys, audits and investigations by governmental agencies and private payors, which could have adverse findings that may negatively impact our business.

We are and have been subject to surveys, audits and investigations by various governmental agencies and their agents. In addition to surveys to determine compliance with the conditions of participation, CMS has engaged a number of contractors (including Medicare Administrative Contractors ("MACs"), RACs and UPICs) to conduct audits and investigations to evaluate billing practices and identify overpayments. In addition, individual states have similar integrity programs, including Medicaid RAC Programs. In certain states in which we operate, payment of home health claims may be impacted by the Review Choice Demonstration for Home Health Services, a program intended to identify and prevent fraud, reduce the number of Medicare appeals, and improve provider compliance with Medicare program requirements.

Private third-party payors may also conduct audits and investigations, and we also perform internal audits and monitoring. These audits and investigations can result and have resulted in recoupments by Medicare, state programs and other payors of amounts previously paid to us if it is determined that we failed to comply with applicable laws, regulations or program requirements. Depending on the nature of the conduct found in such audits and investigations and whether the underlying conduct could be considered systemic, the resolution of these audits and investigations could have a material, adverse effect on our financial position, results of operations and liquidity.

Our revenues are concentrated in a small number of states, which makes us particularly sensitive to regulatory and economic changes in those states.

Our revenues are particularly sensitive to regulatory and economic changes in states in which we generate a significant portion of our revenues including Illinois, New Mexico and Texas. In 2025, we derived approximately 37.0% of our net service revenues from services provided in Illinois, 13.1% from services provided in New Mexico and 15.2% from services provided in Texas. Because a substantial portion of our business is concentrated in a small number of states, any change in the current demographic, economic, competitive or regulatory conditions in these states could have a disproportionately negative impact on our business, financial condition or results of operations. Changes to the Medicaid programs in these states, including the OBBBA's mandated restrictions on Medicaid funding mechanisms, or other significant reductions in state expenditures for the types of services we provide could also have a disproportionately adverse effect on our business, financial condition, results of operations or cash flows. It is difficult to predict whether these or other states material to our operating results will experience changes or other challenges that negatively impact our ability to be adequately reimbursed for our services.

Future efforts to reduce the costs of the Illinois Department on Aging programs could adversely affect our service revenues and profitability.

For the years ended December 31, 2025 and 2024, we derived approximately 18.1% and 21.0%, respectively, of our revenue from the Illinois Department on Aging programs. State government officials have in the past attempted, and in the future may attempt, to reduce government spending by proposing changes aimed at reducing expenditures by this department. The nature and extent of any proposed future cost reduction initiatives is difficult to predict. If future reforms impact the eligibility of consumers for services, the number of hours authorized or otherwise restrict services provided to existing consumers, our service revenues, results of operations, financial position and growth may be adversely affected.

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

Each of our agreements is generally in effect for a specific term, but they are also generally terminable with 60 days' notice. Our ability to renew or retain our agreements depends on our quality of service, reputation and pricing, as well as other factors over which we have little or no control, such as state appropriations and changes in provider eligibility requirements. Additionally, failure to satisfy any of the numerous technical renewal requirements in connection with the proposals we submit for agreements could result in a proposal being rejected even if it contains favorable pricing terms. Failure to obtain, renew or retain agreements with major payors may negatively impact our results of operations and revenue. We can give no assurance these agreements will be renewed on commercially reasonable terms or at all.

Negative publicity or changes in public perception of our services may decrease consumer volumes and adversely affect our ability to receive referrals, obtain new agreements and renew existing agreements, any of which could adversely affect our business.

Our success in receiving referrals, obtaining new agreements and renewing our existing agreements depends upon maintaining our reputation as a quality service provider among governmental authorities, physicians, hospitals, discharge planning departments, case managers, nursing homes, rehabilitation centers, advocacy groups, consumers and their families, other referral sources and the public. The HCBS Quality Measure Set, published by CMS, is intended to promote more common and consistent use of nationally standardized quality measures within and across state HCBS programs. Use of these HCBS measures by states, managed care organizations and other entities involved in HCBS is voluntary. In addition, the CMS websites make publicly available certain data on home health agency and hospice performance on quality measures and patient satisfaction. Medicare reimbursement for these provider types is tied to reporting of quality measures.

While we believe that the services that we provide are of high quality, if our quality measures, some of which are published online by CMS, are deemed to be unsatisfactory or not of the highest value in relation to those of our competitors, our reputation could be negatively affected. Negative publicity, changes in public perceptions of our services or government investigations of our operations could damage our reputation, hinder our ability to receive referrals, retain agreements or obtain new agreements and discourage consumers from using our services. Increased government scrutiny may also contribute to an increase in compliance costs. Any of these events could reduce consumer volumes and have a negative effect on our business, financial condition and operating results.

Our business may be harmed by labor relations matters.

We are subject to a risk of work stoppages and other labor relations matters because our hourly workforce is highly unionized. As of December 31, 2025, 34.5% of our workforce was represented by labor unions. We have numerous agreements with local SEIU affiliates which are renegotiated from time to time. These negotiations are often initiated when we receive increases in our hourly rates from various state agencies. Upon expiration of these collective bargaining agreements, we may not be able to negotiate labor agreements on satisfactory terms with these labor unions. A strike, work stoppage or other slowdown could result in a disruption of our operations and/or higher ongoing labor costs, which could adversely affect our business. Moreover, potential changes to federal labor laws and regulations, could increase the likelihood of employee unionization activity and the ability of employees to unionize. Labor costs are the most significant component of our total expenditures and, therefore, an increase in the cost of labor could significantly harm our business.

If we were required to write down all or part of our goodwill and/or our intangible assets, our net earnings and net worth could be materially adversely affected.

Goodwill and intangible assets with finite lives represent a significant portion of our assets. Goodwill represents the excess of cost over the fair market value of net assets acquired in business combinations. For example, if our market capitalization drops significantly below the amount of net equity recorded on our balance sheet, it might indicate a decline in our fair value and would require us to further evaluate whether our goodwill has been impaired. If as part of our annual review of goodwill and intangibles, we were required to write down all or a significant part of our goodwill and/or intangible assets, our net earnings and net worth could be materially adversely affected, which could affect our flexibility to obtain additional financing. In addition, if our assumptions used in preparing our valuations for purposes of impairment testing differ materially from actual future results, we may record impairment charges in the future and our financial results may be materially adversely affected. We had $996.7 million and $970.6 million of goodwill and $102.4 million and $109.6 million of intangible assets recorded on our Consolidated Balance Sheets at December 31, 2025 and 2024, respectively.

It is not possible at this time to determine if there will be any future impairment charge, or if there is, whether such charges would be material. We will continue to review our goodwill and other intangible assets for possible impairment. We cannot be certain that a downturn in our business or changes in market conditions will not result in an impairment of goodwill or other intangible assets and the recognition of resulting expenses in future periods, which could adversely affect our results of operations for those periods.

If we fail to maintain an effective system of internal control over financial reporting, such failure could adversely impact our business and stock price.

Section 404 of the Sarbanes-Oxley Act of 2002, or the Sarbanes-Oxley Act, requires our management to report on, and requires our independent registered public accounting firm to attest to, the effectiveness of our internal control over financial reporting. Compliance with SEC regulations adopted pursuant to Section 404 of the Sarbanes Oxley Act requires annual management assessments of the effectiveness of our internal control over financial reporting. Compliance with Section 404(b) of the Sarbanes-Oxley Act has increased our legal and financial compliance costs making some activities more difficult, time-consuming or costly and may also place strain on our personnel, systems and resources.

To the extent that we now or in the future have deficiencies in our internal control over financial reporting that are not remediated, our ability to accurately and timely report our financial position, results of operations, cash flows or key operating metrics could be impaired, which could result in a material misstatement in our financial statements, late filings of our annual and quarterly reports under the Exchange Act, restatements of our consolidated financial statements or other corrective disclosures, or other material adverse effects on our business, reputation, results of operations, financial condition or liquidity and could create a perception that our financial results do not fairly state our financial condition or results of operations, any of which could have an adverse effect on the value of our stock.

Any increase in the volume of self-pay patients or deterioration in the collectability of patient responsibility accounts could adversely affect our financial condition or results of operations.

The primary collection risks for our accounts receivable relate to uninsured consumers and consumer accounts for which the primary third-party payor has paid the amount covered by the applicable agreement but consumer responsibility amounts (generally deductibles and copayments) remain outstanding. Collections are impacted by the economic ability of consumers to pay and the effectiveness of our collection efforts. Our ability to collect consumer responsibility accounts may be limited by statutory, regulatory and investigatory initiatives.

Any increase in the volume of self-pay consumers or deterioration in collectability of uninsured, self-pay and other consumer responsibility accounts could adversely affect our cash flows and results of operations. We may experience growth in total uncompensated care as a result of a number of factors, including conditions impacting the overall economy. In recent years, federal and state legislatures have considered or passed various proposals impacting the size of the uninsured population. For example, federal legislation temporarily enhanced subsidies available for purchasing coverage through the ACA health insurance marketplaces, but these enhanced subsidies expired at the end of 2025. Their expiration is expected to adversely impact health insurance exchange enrollment and increase the uninsured rate. The OBBBA is expected to further adversely affect the uninsured rate, including by effectively ending automatic renewals of ACA marketplace coverage and by limiting Medicare and Medicaid eligibility based on immigration status and other factors. Other legislative and regulatory initiatives related to health insurance, such as permitting the sale of insurance plans that lack currently required consumer protections, could also increase rates of uninsured and underinsured individuals. It is difficult to predict what, whether and when legislation and regulatory changes may be made in the future.

We may also be adversely affected by growth in consumer responsibility accounts as a result of increases in the adoption of health plan structures that shift greater payment responsibility for care to individuals through greater exclusions and copayment and deductible amounts.

Regulatory Risks

Our hospice operations are subject to annual Medicare caps. If we exceed the caps, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Overall payments made by Medicare to each hospice provider number (generally corresponding to each of our hospice agencies) are subject to an inpatient cap and an aggregate cap, which CMS sets each federal fiscal year. The inpatient cap limits the number of days of inpatient care for which Medicare will pay to no more than 20% of total patient care days. The aggregate cap limits the amount of Medicare reimbursement a hospice may receive each year, based on the number of Medicare patients served. If a hospice's Medicare payments exceed its inpatient or aggregate caps, it must repay to Medicare the excess amount. If payments received under any of our hospice provider numbers exceed these caps, we are required to reimburse Medicare such excess amounts, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Reductions in reimbursement and other changes to Medicare, Medicaid, and other federal, state and local medical and social programs could adversely affect our consumer caseload, units of service, revenues, gross profit and profitability.

A significant portion of our caseload and revenues are derived from government healthcare programs, primarily Medicare and Medicaid. For the year ended December 31, 2025, we derived approximately 39.3% of our net service revenues from state and local governmental agencies, primarily through Medicaid state programs and 20.5% from Medicare. The Budget Control Act of 2011 ("BCA") requires automatic spending reductions to reduce the federal deficit, resulting in a uniform reduction across all Medicare programs of 2% per fiscal year that extends through the first eleven months of 2032. It is difficult to predict whether, when, or what other deficit reduction initiatives may be proposed by Congress, but we anticipate that the federal deficit will continue to place pressure on government healthcare programs and that future legislation may include additional Medicare spending reductions. Legislation and administrative actions at the federal level may impact the funding for, or structure of, the Medicaid program, and may shape the administration of the Medicaid program at the state level. For example, the OBBBA includes significant healthcare policy reforms that are expected to result in Medicaid spending reductions and changes in administration of state Medicaid programs. The law makes significant changes to Medicaid financing mechanisms, including restrictions intended to reduce the federal matching funds received by state Medicaid programs, such as limitations on provider tax arrangements and SDP arrangements.

Many states in which we operate face budgetary challenges as a result of economic conditions, rising healthcare costs, the impact of OBBBA, and other factors, and these budgetary pressures are creating additional uncertainty and may result in decreased spending, or decreased spending growth, for Medicaid programs. The magnitude of the spending reductions anticipated as a result of the OBBBA may limit the ability of states to cover services and result in significant reductions in access to care, especially for services such as HCBS that are optional under Medicaid. Budgetary shortfalls and funding changes may affect our contracts and the reimbursement we receive, as governmental agencies generally condition their agreements upon a sufficient budgetary appropriation.

As federal healthcare expenditures continue to increase and as many state governments navigate budgetary pressures, federal and state governments have made, and may continue to make, significant changes to the Medicare and Medicaid programs, including changes to reimbursement for or coverage of items and services rendered to beneficiaries of such programs. Cost containment initiatives at the federal or state level have included, and in the future may include, for example:

- limiting increases in, or decreasing, reimbursement rates;
- redefining eligibility standards or coverage criteria for social and medical programs or otherwise restricting the receipt of services under those programs, including by limiting the number of people receiving waiver services;
- eliminating or reducing the scope of coverage for optional Medicaid benefits;
- increasing consumer responsibility, including through increased co-payment requirements;
- decreasing benefits, such as limiting the number of hours of personal care services that will be covered;
- changing reimbursement methodology and program participation eligibility;
- slowing payments to providers;
- increasing utilization of self-directed care alternatives or "all inclusive" programs;
- shifting beneficiaries to managed care organizations; and
- implementing demonstration projects and alternative payment models.

In addition, from time to time, Congress or CMS revises the reimbursement systems used to reimburse healthcare providers, which may result in reduced Medicare and/or Medicaid payments. Delays or issues implementing reimbursement-related rules, including periodic payment updates for government programs, and interruptions in the distribution of governmental funds, could have an adverse impact on our business.

If changes in Medicare, Medicaid or other state and local medical and social programs result in a reduction in available funds for the services we offer, increased costs of providing services, a reduction in the number of beneficiaries eligible for our services or able to access our services, or a reduction in the number of hours or amount of services that beneficiaries eligible for our services may receive, then our revenues and profitability could be negatively impacted. Our profitability depends principally on the levels of government-mandated payment rates and our ability to manage the cost of providing services. In some cases, commercial insurance companies and other private payors rely on government payment systems to determine payment rates and policies. As a result, changes to government healthcare programs that reduce Medicare, Medicaid or other payments may negatively impact payments from private payors, as well. Any reduction in reimbursements from governmental or private payors or policies that negatively affect utilization of our services, such as the imposition of copayments or prior authorization requirements, could also materially adversely affect our profitability.

Federal and state regulation may impair our ability to consummate acquisitions or open new agencies.

Federal and state laws and regulations may adversely impact our ability to acquire or open new start-up agencies, and the change of ownership processes for Medicare, Medicaid and other payors can be complex. For example, a Medicare regulation known as the "36 Month Rule" restricts the assumption by a new majority owner of a Medicare-certified home health agency or hospice provider's Medicare provider agreement and billing privileges. The 36 Month Rule applies if the acquired home health agency or hospice either enrolled in Medicare or underwent a change in majority ownership fewer than 36 months prior to the acquisition, subject to certain exceptions. In such circumstances, the buyer must enroll as a new provider with Medicare. The 36 Month Rule can increase competition for acquisition targets that are not subject to the rule and may cause significant Medicare billing delays for the purchases of home health agencies and hospices that are subject to the rule. Home health agencies and hospices undergoing changes of ownership are considered a "high-risk" provider type, subjecting provider enrollment applications to increased scrutiny, which may result in delays in processing. Further, in the past, CMS has limited enrollment of new home health agencies. If another moratorium is imposed on enrollment of new providers in a geographic area we desire to service, our ability to expand operations may be impacted.

Our ability to expand operations in a state will also depend, where required, on our ability to obtain a state license to operate and, in some cases, CON approval. States may limit the number of new licenses they issue or restrict changes of ownership of existing licensed entities. For example, California law prohibits the California Department of Public Health from approving a change of ownership of a hospice agency license within five years of its initial issuance. In addition, some states require healthcare entities to make disclosures to or receive approval from state attorneys general or other designated entities in advance of sales or other transactions. The failure to obtain any required CON or license or other required approvals or make required disclosure could impair our ability to operate or expand our business. The increasingly challenging regulatory environment may negatively impact our ability to acquire healthcare businesses if they are found to have material unresolved compliance issues. Resolving any such issues and completing applicable review or approval processes could significantly delay or prevent us from acquiring other businesses and increase our acquisition costs.

The implementation of alternative payment models and any increases in enrollment in Medicare Advantage or Medicaid managed care plans may limit our market share and could adversely affect our revenues.

Many government and commercial payors have transitioned or are transitioning providers to alternative payment models that are designed to promote cost-efficiency, quality and coordination of care. For example, ACOs incentivize hospitals, physician groups, and other providers to organize and coordinate patient care while reducing unnecessary costs. Some states have implemented, or plan to implement, accountable care models for their Medicaid populations. If we are not included in these programs, or if ACOs establish programs that overlap with our services, we risk losing market share. Further, if we fail to effectively provide or coordinate the efficient delivery of quality services, our reputation may be negatively impacted, we may receive reduced reimbursement amounts and we may owe repayments to payors, which could cause our revenues to decline.

We may be similarly impacted by increases in enrollment of Medicare and Medicaid beneficiaries in managed care plans, which are part of the general shift away from traditional fee-for-service models. If more of our services are offered under Medicare Advantage or Medicaid managed care plans in the future, we could experience reduced reimbursement, limited utilization, and increased competition for managed care contracts. These adverse effects could also result from changes in federal and state laws, regulations and programs.

We cannot assure you that we will be successful in our efforts to be included in plan networks, that we will be able to secure favorable contracts with all or some of the managed care organizations, that our reimbursement under these programs will remain at current levels, that the authorizations for services will remain at current levels or that our profitability will remain at levels consistent with past performance. In addition, we may encounter difficulties with operational processes, such as delays in authorizations for services, which may result in delays in service delivery to consumers or in payment for services rendered. Difficulties with operational processes may negatively affect our revenue growth rates, cash flow and profitability for services provided. Other alternative payment models may be presented by the government and commercial payors that subject our Company to financial risk. It is difficult to predict the nature and success of any such models. We cannot predict at this time what effect alternative payment models may have on our Company.

Our industry is highly competitive, fragmented and market-specific.

The healthcare industry, including the long-term care industry, is highly competitive among service providers and care models for patients, personnel and acquisitions. We compete with personal care service providers, hospice providers, home health providers, private caregivers, publicly held companies, privately held companies, privately held single-site agencies, hospital-based agencies, not-for-profit organizations, community-based organizations and self-directed care programs. Some of these providers and competitive care models may have greater financial, technical, political and marketing resources, name recognition or a larger number of consumers and payors than we do. In addition, some of our competitors offer more services than we do in the markets in which we operate. If consumers obtain services we do not offer from other providers, they may shift their preferences to those providers for services we do provide. These competitive advantages may limit our ability to attract and retain referrals in local markets and to increase our overall market share.

In some states, there are limited barriers to entry in providing personal care services. However, many states require entities to obtain a license before providing home care services. Licensure is generally required of agencies providing home health and hospice services, though requirements vary by state. Some states also require a provider to obtain a CON or other type of approval before establishing, purchasing, or expanding certain health services, operations or facilities. CON restrictions may reduce the level of competition in a given industry or in a particular geographic region. Changes in licensure and CON requirements and recognition of new provider types or payment models could remove or reduce barriers to entry. In addition, economic changes such as increases in minimum wage and changes in Department of Labor rules can also impact the ease of entry into a market. For example, in July 2025, the Department of Labor published guidance suspending enforcement of a 2013 final rule that expanded minimum wage and overtime protections to home health aides. These and other factors affecting barriers to entry in a market may affect competition in the states in which we operate.

Often our contracts with payors are not exclusive. Local competitors may develop strategic relationships with referral sources and payors. Further, consolidation within the payor industry, vertical integration efforts involving payors and healthcare providers, and cost-reduction strategies by payors continue to increase, and there are increasing efforts by payors to influence the consumer's choice of provider through the use of narrow networks or other strategies. Legislative and regulatory initiatives, such as changes in state law eliminating restrictions on tiered networks and steering patients to particular providers, may accelerate or otherwise impact these trends. In addition, competitors may offer new or enhanced services that we do not provide or be viewed by consumers as a more desirable local alternative. These and other factors could impact our ability to contract with payors on favorable terms, result in pricing pressures, loss of or failure to gain market share or loss of consumers or payors, or otherwise affect our competitive position, any of which could cause a decline in revenue and negatively impact our results of operations.

Trends toward clinical and price transparency and value-based purchasing may have an impact on our competitive position, ability to obtain and maintain favorable contract terms, and consumer volumes. For example, health insurers must provide online price comparison tools to help individuals get personalized cost estimates for covered items and services. HHS also requires health insurers to publish online the charges negotiated with providers for healthcare services. In addition, CMS websites make publicly available certain data on home health agency and hospice performance on quality measures and patient satisfaction. It is unclear how price transparency requirements, value-based purchasing and similar initiatives will affect consumer behavior, our relationships with payors, or our ability to set and negotiate prices, but our competitive position could be negatively affected if our prices are higher or perceived to be higher than the prices of our competitors.

We expect these competitive trends to continue. We pursue various strategies intended to ensure our business is competitive, but the markets in which we operate are fragmented and factors affecting competition may be market-specific, which may impact our ability to compete effectively. If we are unable to compete effectively, consumers may seek services from other providers, which could have a negative impact on our business and results of operations.

If we fail to comply with the extensive laws and regulations governing our business, we could be subject to penalties or be required to make changes to our operations, which could negatively impact our business and profitability.

Our industry is extensively regulated at the federal and state government levels. The laws and regulations governing our operations, along with the terms of participation in various government programs, affect the way in which we do business, the services we offer, and our interactions with providers and consumers. These legal and regulatory requirements relate to, among other matters:

- facility and personnel licensure, certification and enrollment with government programs;
- eligibility for services;
- appropriateness and necessity of services;
- adequacy and quality of services;
- qualifications, training and supervision of personnel;
- confidentiality, maintenance, interoperability, exchange and security of medical records and other health-related and personal information, including information blocking, data breach, ransomware, identify theft and online tracking of personal information;
- the provision of services via telehealth, including technological standards and coverage restrictions or other limitations on reimbursement;
- distribution, maintenance and dispensing of pharmaceuticals and controlled substances;
- the development and use of AI and other predictive algorithms, including those used in clinical decision support tools;
- environmental protection, health and safety;
- relationships with physicians, other referral sources and recipients of referrals;
- operating policies and procedures;
- addition of, and changes to, facilities and services;
- adequacy and manner of documentation for services provided;
- billing and coding for services;
- timely and proper handling of overpayments; and
- debt collection and communications with consumers.

These laws include, but are not limited to, the federal Anti-Kickback Statute, the federal Stark Law, the federal FCA, the federal Civil Monetary Penalties Law, other federal and state fraud and abuse, insurance fraud, and fee-splitting laws, which may extend to services reimbursable by any payor, including private insurers, the No Surprises Act, and federal and state laws governing the security and privacy of health information.

We currently have contractual relationships with current and potential referral sources and recipients, including hospitals and health systems, skilled nursing facilities and certain physicians who provide medical director and clinical services to our Company. We attempt to structure our relationships to meet applicable regulatory requirements, but we cannot provide assurance that every relationship is fully compliant. Further, we may fail to discover instances of noncompliance by businesses we acquire.

If we fail to comply with applicable laws and regulations, which are subject to change, we could be subject to civil sanctions and criminal penalties, including substantial monetary penalties, exclusion from participation in Medicare, Medicaid and other federal and state healthcare programs, the suspension or revocation of licenses, we could face nonpayment or encounter delays in our ability to bill and collect for services provided, and we could be subject to civil lawsuits, any of which could adversely affect our business, results of operations, or financial results. Actions taken against one of our entities may subject our other entities to adverse consequences. While we endeavor to comply with applicable laws and regulations and government program requirements, we cannot ensure you that our practices are fully compliant or that courts or regulatory agencies will not interpret those laws and regulations in ways that will adversely affect our practices. Further, the laws and regulations and program requirements governing our business are subject to change, interpretations may evolve and enforcement focus may shift. These changes could subject us to allegations of impropriety or illegality, require restructuring of relationships with referral sources and recipients or otherwise require changes to our operations. Changes could also reduce authorizations for services to be provided or result in reductions in consumer eligibility for our services, which could decrease our revenues and operating performance. The costs of compliance with, and the other burdens imposed by, applicable laws and regulations and program requirements may be substantial and could increase our operational costs, pose challenges for our management team, result in interruptions or delays in the availability of systems and/or result in a patient volume decline, any of which could adversely affect our business.

Federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts throughout the healthcare industry. We may face audits or investigations by government agencies or third parties, including under certain of our contractual relationships. An adverse outcome under any such audit or investigation, a determination that we have violated applicable laws and regulations, or a public announcement that we are being investigated for possible violations could result in liability, adverse publicity, and interruptions to payment, require us to change our operations and/or to implement plans of correction for alleged deficiencies, and result in other negative consequences that could adversely affect our business, financial condition, or results of operations.

We are subject to federal, state and local laws and regulations that govern our employment practices, including minimum wage, living wage, and paid time-off requirements. Failure to comply with these laws and regulations, or changes to these laws and regulations that increase our employment-related expenses, could adversely impact our operations.

We are required to comply with all applicable federal, state and local laws and regulations relating to employment, including OSHA requirements, wage and hour and other compensation requirements (including disclosure requirements), employee benefits, providing leave and sick pay, employment insurance, proper classification of workers as employees or independent contractors, immigration and equal employment opportunity laws. These laws and regulations can vary significantly among jurisdictions and can be highly technical. Costs and expenses related to these requirements are a significant operating expense and may increase as a result of, among other things, changes in federal, state or local laws or regulations, or the interpretation thereof, requiring employers to provide specified benefits or rights to employees, increases in the minimum wage and local living wage ordinances, increases in the level of existing benefits or the lengthening of periods for which unemployment benefits are available. Each of our subsidiaries that employ an average of at least 50 full-time employees in a calendar year are required to offer a minimum level of health coverage for 95% of our full-time employees or be subject to an annual penalty, for example. Since our personal care operations are concentrated in Illinois, New Mexico and Texas, we are also particularly sensitive to changes in laws and regulations in these states. We may not be able to offset any increased costs and expenses. Furthermore, any failure to comply with these laws, including even a seemingly minor infraction, can result in significant penalties which could harm our reputation and have a material adverse effect on our business.

In addition, individuals and entities excluded by the OIG from federal healthcare programs, including Medicare and Medicaid, are prohibited from receiving payment from federal healthcare programs for any items or services they furnish, order or provide, and providers who employ or contract with excluded individuals are subject to significant penalties. If we inadvertently hire or contract with an excluded person, or if any of our current employees or contractors becomes an excluded person in the future without our knowledge, we may be subject to substantial civil penalties, including civil monetary penalties, an assessment of up to three times the amount claimed and exclusion from the program, and may also face liability under the FCA.

Our business may be adversely impacted by changes and uncertainty in the healthcare industry, including healthcare public policy developments and other changes to laws and regulations.

The healthcare industry is subject to changing political, regulatory and other influences. Federal agencies oversee, regulate and otherwise affect many aspects of our business, including through Medicare and Medicaid policies, policies affecting size of the uninsured population, and enforcement and interpretation of fraud and abuse laws. The outcome of the 2024 federal elections increased regulatory uncertainty and the potential for significant policy changes. The President has issued executive orders that impact or may impact the healthcare industry, including an order establishing a presidential advisory commission tasked with restructuring government agencies and reducing government expenditures, although this commission was disbanded in mid-2025. Other actions by the executive branch have resulted in holds on or cancellations of congressionally authorized spending as well as interruptions in the distribution of government funds. In addition, the executive branch has significant influence over healthcare policy changes through government agency regulation. Federal agencies oversee, regulate and otherwise affect many aspects of our business, including through Medicare and Medicaid policies, policies affecting the size of the uninsured population and interpretation and enforcement of fraud and abuse laws. In March 2025, HHS announced a significant agency restructuring intended to reduce the HHS workforce and consolidate divisions of the agency, including by integrating some functions of the Administration for Community Living, which administers programs that support older adults, into other HHS agencies. HHS also announced a change in its policy on public participation in rulemaking that may negatively affect the ability of industry participants to receive advance notice of and offer feedback on some policy changes. Regulatory uncertainty has also increased as a result of recent decisions issued by the U.S. Supreme Court that affect review of federal agency actions. These decisions increase judicial scrutiny of agency authority, shift greater responsibility for statutory interpretation to courts, expand the time period during which a plaintiff can sue regulators, and may result in inconsistent judicial interpretations and delays in agency rulemaking processes. These decisions may increase legal challenges to healthcare regulations and agency guidance and decisions. Impacts of the recent Supreme Court decisions could require us to make changes to our operations and have a material negative impact on our business.

The healthcare industry has been and continues to be impacted by healthcare reform efforts. Many recent reform initiatives have been focused on reducing government spending and increasing or, more recently, decreasing access to health insurance. For example, the ACA expanded health insurance coverage through a combination of public program expansion and private sector health insurance reforms. Changes in the law's implementation, subsequent legislation and regulations, state initiatives and other factors have affected and may continue to affect the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if obtained, and may impact our payor mix. Other legislative and executive branch initiatives related to health insurance, such as permitting the sale of insurance plans that lack currently required consumer protections, could significantly affect insurance markets, including by increasing rates of uninsured and underinsured individuals and destabilizing markets. Reductions in the number of insured individuals or the scope of insurance coverage, or an increase in patients covered under governmental health programs or other health plans with lower reimbursement levels, may have an adverse effect on our business.

In addition, the Medicare and Medicaid programs are subject to change. For example, some members of Congress and the executive branch have raised, and may in the future adopt, proposals intended to accelerate the shift from traditional Medicare to Medicare Advantage, restructure the Medicaid program to give states a "block grant" or fixed amount of overall funding for their respective Medicaid programs, or to impose Medicaid spending caps such as per beneficiary limits on federal contributions. Further, changes in governmental administration, including changes in agency structures and staffing, such as reduction or elimination of personnel and agencies, may result in changes to established rulemaking conventions and timelines, including for regularly-issued reimbursement rules, among other effects.

Legislation and administrative actions at the federal level may impact funding for, or the structure of, the Medicaid program and may shape administration of the Medicaid program at the state level, including through changes to waiver programs. For example, the OBBBA includes provisions that are expected to result in Medicaid spending reductions and require changes in administration of state Medicaid programs, including limitations on eligibility. The law requires changes to Medicaid financing mechanisms, including restrictions intended to reduce the federal matching funds received by state Medicaid programs. The OBBBA could also impact the dual eligible population, including as a result of changes affecting enrollment pathways for dual eligibles. It is difficult to predict the ultimate effects of the OBBBA, as it is a complex law that mandates various changes over time and we expect additional rulemaking and guidance from federal agencies regarding implementation. However, reductions in federal matching funds and increased state obligations and administrative burden could put pressure on state budgets, which could result in state limitations on Medicaid eligibility or coverage and payment rate reductions, among other effects, particularly if states are unable to offset reductions in federal funding. Some states have trigger laws that would end their Medicaid expansion or require other changes if the federal funding match rate is reduced or similar funding restrictions are imposed for Medicaid expansion. Although most of these trigger laws are not directly implicated by the OBBBA, some states may nonetheless consider or make changes to Medicaid expansion programs or other changes due to related budgetary pressures. In addition, CMS may impose new restrictions or grant states additional flexibilities in the administration of state Medicaid programs. For example, in May 2024, CMS finalized a rule that requires states to ensure by mid-2030 that at least 80% of all Medicaid payments a provider receives for homemaker, home health aide, and personal care services, less excluded costs, under specified programs are spent on total compensation for direct care workers furnishing these services, subject to limited exceptions. If implemented in its current form, the final rule could negatively impact our business and financial performance by, among other things, increasing our labor costs. Reductions in coverage or payment rates, decreases in Medicaid enrollment, and other changes to state Medicaid programs could adversely affect our business.

Other recent reform initiatives and proposals at the federal and state levels include those focused on price transparency and value-based pricing, which may impact our competitive position, patient volumes, and the relationships between providers, patients, and payors. Other industry participants, such as private payors and large employer groups and their affiliates, may introduce additional financial or delivery system reforms.

There is uncertainty regarding whether, when and what other public policy initiatives will be adopted by federal and state governments and/or the private sector, the timing and implementation of any such efforts, and the impact of those efforts on providers as well as other healthcare industry participants. It is difficult to predict the nature and/or success of current and future public policy changes, any of which may have an adverse effect on our business, financial condition, and operating results.

The industry trend toward value-based payment models may negatively impact our revenues.

There is a trend toward value-based payment of healthcare services among both government and commercial payors. Generally, value-based care programs tie payment to the quality and efficiency of care provided. For example, Medicare requires hospices and home health agencies to report certain quality data in order to receive full reimbursement. Failure to report quality data or poor performance may negatively impact the amount of reimbursement received. CMS publishes home health and hospice quality measure data online to allow consumers and others to search and compare data for Medicare-certified providers. In addition, home health agencies receive, under the HHVBP Model, increases or decreases to their Medicare fee-for-service payments of up to 5% based on performance against specific quality measures relative to the performance of other home health providers. Data collected in each performance year impacts Medicare payments two years later.

CMS may establish new value-based purchasing programs affecting a broader range of providers, some of which may be mandatory. Initiatives aimed at improving quality and cost of care include alternative payment models, such as ACOs and bundled payment arrangements. The strategic direction announced by the CMS Innovation Center in 2025 continues to support the transition from Medicare fee-for-service models to value-based payment and care delivery models. New models and modifications of existing models may include increased requirements for downside risks or require that some financial risk shift to providers. There are also several state-driven value-based care initiatives. For example, some states have aligned quality metrics across payors through legislation or regulation. Commercial payors are shifting toward value-based reimbursement arrangements as well.

We expect value-based payment programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. It is unclear whether alternative models will successfully coordinate care and reduce costs or whether they will decrease overall reimbursement. While we believe we are adapting our business strategies to compete in a value-based reimbursement environment, we are unable at this time to predict how this trend will affect our results of operations. If we perform at a level below the outcomes demonstrated by our competitors, fail to satisfy quality data reporting requirements, are unable to meet or exceed quality performance standards under any applicable value-based models, or otherwise fail to effectively provide or coordinate the efficient delivery of quality healthcare services, our reputation in the industry may be negatively impacted, we may receive reduced reimbursement amounts and we may owe repayments to payors, causing our revenues, financial position, results of operations and cash flows to decline.

Liability Risks

Our operations subject us to risk of litigation.

Operating in the healthcare and personal care services industries exposes us to an inherent risk of wrongful death, personal injury, professional malpractice and other potential claims or litigation brought by our consumers and employees. From time to time, we are subject to claims alleging that we did not properly treat or care for a consumer, that we failed to follow internal or external procedures, resulting in death or harm to a consumer, or that our employees mistreated our consumers, resulting in death or harm. We are also subject to claims arising out of accidents involving vehicle collisions brought by consumers whom we transport, from employees driving to or from home visits or other affected individuals. We may also be subject to lawsuits from patients, employees and others exposed to contagious diseases in connection with the services provided by our workforce in client residences and third party facilities. Some of the actions brought against us may seek large sums of money as damages and involve significant defense costs. Our professional and general liability insurance may not cover all claims against us.

In addition, regulatory agencies have previously brought and may in the future initiate administrative proceedings alleging violations of statutes and regulations arising from our services and seek to impose monetary penalties or other sanctions on us. We could be required to pay substantial amounts to respond to regulatory investigations or, if we do not prevail, damages or penalties arising from these legal proceedings. We also are subject to potential lawsuits under the federal FCA or other federal and state whistleblower statutes designed to combat fraud and abuse in our industry. These and other similar lawsuits can involve significant defense costs, as well as significant monetary awards or penalties that may not be covered by our insurance. If our third-party insurance coverage and self-insurance coverage reserves are not adequate to cover these claims, it could have a material adverse effect on our business, results of operations and financial condition. Even if we are successful in our defense, lawsuits or regulatory proceedings could distract us from running our business or damage our reputation.

Our insurance liability coverage may not be sufficient for our business needs.

Although we maintain insurance consistent with industry practice, the insurance we maintain may not be sufficient to satisfy all claims made against us. We cannot assure you that claims will not be made in the future in excess of the limits of our insurance, and any such claims, if successful and in excess of such limits, may have a material adverse effect on our business or assets. We utilize historical data to estimate our reserves for our insurance programs. If losses on asserted claims exceed the current insurance coverage and accrued reserves, our business, results of operations and financial condition could be adversely affected. Changes in our annual insurance costs and self-insured retention limits depend in large part on the insurance market, and insurance coverage may not continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms.

Data Security and Privacy Risks

Our business depends on the proper functioning, availability, and security of our information systems. Our operations may be disrupted if we are unable to effectively integrate, manage and maintain the security of our information systems.

Our business depends on effective and secure information systems that assist us in, among other things, gathering information to improve the quality of consumer care, optimizing financial performance, adjusting consumer mix, monitoring regulatory compliance and enhancing staff efficiency. The software we license for our various patient information systems supports intake, personnel scheduling, office clinical and centralized billing and receivables management in an integrated database, enabling us to standardize the care delivered across our network of offices and monitor our performance and consumer outcomes. Information systems may be vulnerable to damage from a variety of sources, including telecommunications or network failures, human acts and natural disasters. We rely on external service providers to provide continual maintenance, upgrading, and enhancement of our primary information systems used for our operational needs, and we rely on various third-party technology platforms, which continue to grow in complexity and scope. Failure to adequately and timely manage implementations of new technology, updates or enhancements of such platforms or interfaces between platforms could place us at a competitive disadvantage, disrupt our operations, and adversely impact our business. We have a significant number of administrative employees working remotely, increasing our dependence on systems that facilitate remote access to our system, and we may experience increased risks as a result.

To the extent providers fail to support the software or systems we use, or if we lose our software licenses, our operations could be negatively affected. Our business also depends on a comprehensive payroll and human resources system for basic payroll functions and reporting, payroll tax reporting, managing wage assignments and garnishments. We rely on an external service provider, ADP, to provide continual maintenance, upgrading and enhancement of our primary human resource and payroll systems. To the extent that ADP fails to support the software or systems, or any of the related support services provided by them, our internal operations could be negatively affected.

Our business supports the use of EVV to electronically collect visit information when our caregivers and providers deliver home care services. Our solution uses a combination of IVR and GPS enabled smartphones to capture time in and time out, mileage and travel time, as well as the completed care plan tasks. We license this software through CellTrak and partner with states that utilize other software. We rely on these vendors to provide continual maintenance and enhancements, as well as security of any protected data. To the extent that our EVV vendors fail to support these processes, our internal operations could be negatively affected. Under the 21st Century Cures Act, states must require the use of EVV for all Medicaid-funded personal care services and home health services that require an in-home visit by a provider. States that failed to meet the deadlines for implementation are subject to incremental reductions in federal Medicaid funding, which may negatively impact the reimbursement we receive for our services. In addition, if states adopt new or modify existing standards for EVV that are not compatible with our operations, our internal operations could be negatively affected. Further, to the extent that the EVV solutions that we use are determined to be noncompliant with federal or state EVV requirements, we could be subject to penalties.

We have taken and continue to take precautionary measures designed to prevent problems that could affect our information systems. We have implemented backup of our key information systems that is designed to allow our operations to failover to our geographically separate disaster recovery datacenter with a quick return to operations for all sites and systems in the event our main datacenter becomes inoperable because of a natural disaster, attacks or other cause. All of our sites and branch offices have redundant connections to our primary and backup datacenters using data lines and cellular connections through VPN or MPLS. The key business functions for our main sites also have redundancies with key functions geographically split between our two main facilities, should one not be available due to the above-mentioned scenarios. While we believe these measures are reasonable, no system of information security is able to eliminate the risk of business disruptions, and we or our third-party vendors that we rely upon may experience system failures.

If we experience a reduction in the performance, reliability, or availability of our information systems, our operations and ability to process transactions and produce timely and accurate reports could be adversely affected. If we experience difficulties with the transition and integration of information systems or are unable to implement, maintain, or expand our systems properly, we could suffer from, among other things, operational disruptions, regulatory problems, and increases in administrative expenses. The occurrence of any system failure could result in harm to consumers, interruptions, delays, the loss or corruption of data and cessations or interruptions 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.

A cyber-attack or security breach could cause a loss of confidential consumer data, give rise to remediation and other expenses, expose us to liability under privacy laws, consumer protection laws, common law and other legal theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, result in interruptions or delays to services, adversely impact our financial results, and otherwise be disruptive to our business.

We, directly and through our vendors and other third parties, collect and store sensitive information, including proprietary business information, protected health information of our patients and personally identifiable information of our employees, patients and consumers. We rely extensively on computer systems to manage clinical and financial data, to communicate with our consumers, payors, vendors and other third parties, and to summarize and analyze our operating results. Our personnel use devices that store or transmit information integral to the provision of services, and we frequently exchange clinical and financial data with third parties in connection with our routine operations and in order to meet our contractual and regulatory obligations. The secure maintenance of this information and technology is critical to our business operations, and we are required to comply with the federal and state privacy and security laws and requirements, including HIPAA and state privacy laws.

We have invested in security measures designed to protect against the threat of security breaches and cyber-attacks, as well as cybersecurity systems, protocols and monitoring procedures. Each of these steps is intended to protect the confidentiality, integrity and availability of our data and the systems and devices that store and transmit such data. Despite these efforts, our technology, and that of our third-party service providers, may fail to adequately secure the protected health information, personally identifiable information and other sensitive information we create, receive, transmit and maintain in our databases, compromising the privacy, integrity or availability of such information. Cybersecurity incidents involving us or our third-party vendors could also disrupt information systems, devices or business, including by limiting our ability to provide various services. We may be at increased risk because we outsource certain services or functions to, or have systems that interface with, third parties. These third parties may store or have access to our data. The information systems of third parties are also subject to various risks, and a breach or attack affecting any of these third parties could harm our business.

The current cyber threat environment presents increased risk for all companies, including companies in our industry. Threats from malicious persons and groups, new vulnerabilities and advanced new attacks against our, or our vendors', information systems and devices create risk of cybersecurity incidents, including ransomware, malware and phishing incidents, in which third parties attempt to fraudulently induce our employees or our vendors' employees into disclosing usernames, passwords or other sensitive information, which can in turn be used for unauthorized access to our or our vendors' systems. We are regularly the target of attempted cybersecurity and other threats that could have a security impact, and we expect to continue to experience an increase in cybersecurity threats in the future, as the volume and intensity of cyber-attacks on healthcare entities and vendors continue to increase. Furthermore, because the tools and techniques used in cyber-attacks change frequently and may not be immediately recognized, we may be unable to anticipate techniques or implement adequate preventative measures, and we may experience or be affected by security or data breaches that remain undetected for an extended time. Even if identified, we may be unable to adequately investigate or remediate incidents or breaches due to attackers increasingly using tools and techniques that are designed to circumvent controls, to avoid detection, and to remove or obfuscate forensic evidence. The rapid evolution and increased adoption of AI technologies internally and by our third-party vendors may intensify cybersecurity risks, including by making cyber-attacks more difficult to detect, contain or mitigate. Internal access management failures or vulnerabilities in hardware, software or applications could also result in the compromise of confidential data.

We continue to prioritize the development and enhancement of controls and processes designed to protect our business, information systems and data from attack, damage or unauthorized access. As cyber threats continue to evolve and increase in volume and sophistication, we may be required to expend significant additional resources to continue to enhance our protective measures or to investigate and remediate security incidents or vulnerabilities. We may also be required to expend additional resources to comply with evolving federal and state requirements related to cybersecurity.

In spite of our policies, procedures and other security measures used to protect our computer systems and data, occasionally, we have experienced breaches that have required us to notify affected consumers and the government, and we have worked with consumers and the government to resolve such issues. Although, to date, no cyber-attack or other information or security breach has had a significant adverse impact on our business or results of operations, there can be no assurance that our controls and procedures in place to monitor and mitigate the risks of cybersecurity threats will be sufficient and/or timely and that we will not suffer material losses or consequences as a result of cyber-attacks or security breaches in the future. If we or any of our third-party service providers or certain other third-parties are subject to cyber-attacks or experience security or data breaches in the future, this could result in harm to consumers, interruptions and delays in services provided to consumers, loss, misappropriation, corruption, or unauthorized access of protected patient medical data or other information subject to privacy laws, disruption to our information technology systems and/or business, the inability to access data, reputational harm, or adverse impacts to our financial results. We may also be subject to litigation and governmental enforcement actions (including under HIPAA and other applicable laws) as a result of cyber-attacks or security or data breaches, which could result in fines, settlement agreements, corrective action plans, and of which could have a material adverse effect on our business, financial position and results of operations. Some state laws provide a private right of action for data breaches, which may increase data breach litigation. In addition, any significant cybersecurity event may require us to devote significant management time and resources to address and respond to any such event, interfere with the pursuit of other important business strategies and initiatives, and cause us to incur additional expenditures, which could be material, including to investigate such events, remedy cybersecurity problems, recover lost data, attempt to prevent future compromises and adapt systems and practices in response to such events.. Further, our insurance coverage intended to address cybersecurity and data breach risks may not be sufficient to cover all losses or the types of claims that may arise.

Human Capital Risks

We may not be able to attract and retain qualified personnel or we may incur increased costs in doing so.

We must attract and retain qualified non-executive personnel in the markets in which we operate in order to provide our services. We compete for personnel with other providers of social and medical services as well as companies in other service-based industries. As the labor market continues to be tight and unemployment remains at low levels, the competition for employees has increased, which will continue to impact our ability to attract and retain new caregivers. In addition, the competition for skilled healthcare staff has increased significantly, which continues to impact our ability to attract and retain qualified skilled healthcare staff. Changes in immigration policies and enforcement, including the increased enforcement efforts, could further exacerbate labor challenges, particularly with regard to the home health and personal care workforce. To the extent that the United States experiences low unemployment levels and shortages of caregivers and skilled healthcare staff, it may continue to hinder our ability to attract and retain sufficient caregivers and skilled healthcare staff to meet the continuing demand for both our non-clinical and clinical services. Staffing challenges may be exacerbated by the imposition of minimum staffing requirements at the federal or state level. Increased staffing challenges have resulted in, and may continue to result in, increased labor costs to satisfy our staffing requirements.

We may not be able to offset higher labor costs by increasing the rates we charge for our services. In addition, if we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations effectively and our results of operations would be harmed.

Competition may be greater for managers, such as regional and agency directors. Our ability to attract and retain personnel depends on several factors, including our ability to provide employees with attractive assignments and competitive benefits and salaries. If we are unable to attract and retain qualified personnel, we may be unable to provide our services, the quality of our services may decline, and we could lose consumers and referral sources.

We depend on the services of our executive team members.

Our success depends upon the continued employment of certain members of our executive team to manage several of our key functional areas, including operations, business development, accounting, finance, human resources, marketing, information systems, contracting and compliance. Moreover, the current competitive labor market may make it more difficult to retain or hire members of our executive team. The departure of any member of our executive team may materially adversely affect our operations, and any replacement for a departed member of our executive team may be unable to execute our strategies at the same level.

Risk Related to Our Indebtedness

Restrictive covenants in the agreements governing our indebtedness may adversely affect us.

Our credit facility contains various covenants that limit our ability to take certain actions, including our ability to:

- make, create, incur, assume or suffer to exist any lien;
- sell or otherwise dispose of assets, including capital stock of subsidiaries;
- merge, consolidate, sell or otherwise dispose of all or substantially all our assets;
- make restricted payments, including paying dividends and making certain loans and investments;
- create, incur, assume, permit to exist, or otherwise become or remain directly or indirectly liable with respect to any additional indebtedness;
- enter into transactions with affiliates;
- engage in any additional line of business;
- amend our organization documents;
- make a change in accounting treatment or reporting practices, change our name or change our jurisdiction of organization or formation;
- make any payment or prepayment of certain subordinated indebtedness;
- enter into agreements that restrict dividends and certain other payments from subsidiaries; and
- engage in a sale leaseback or similar transaction.

In addition, our credit facility contains restrictive covenants and requires us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet these restrictive covenants and financial ratios and tests may be affected by events beyond our control, and we cannot assure you that we will meet those tests.

A breach of any of these covenants could result in a default under our credit facility. Upon the occurrence of an event of default under our credit facility, all amounts outstanding under our credit facility may become immediately due and payable and all commitments under our credit facility to extend further credit may be terminated. The acceleration of any such indebtedness will result in an event of default under all of our other long-term indebtedness.

General Risks

Factors beyond our control, including inclement weather, natural disasters, acts of terrorism, pandemics, riots, civil insurrection or social unrest, looting, protests, strikes and street demonstrations, may impact our ability to provide services.

Adverse weather conditions, natural disasters, acts of terrorism, military conflict, pandemics, riots, civil insurrection or social unrest, looting, protests, strikes or street demonstrations may prevent our employees from providing authorized services. We are not paid for authorized services that are not delivered due to these events. Furthermore, prolonged disruptions as a result of such events in the markets in which we operate could disrupt our relationships with consumers, patients, caregivers and employees and referral sources located in affected areas and, in the case of our corporate office, our ability to provide administrative support services, including billing and collection services. The impact of disasters and similar events is inherently uncertain. Moreover, adverse weather conditions may become more frequent and/or severe as the result of climate change. We could be affected by climate change and other environmental issues to the extent such issues adversely affect the general economy, adversely impact our supply chain or increase the costs of supplies needed for our operations, or otherwise result in disruptions impacting the communities in which our facilities are located. In addition, legal requirements regulating greenhouse gas emissions and energy inputs or otherwise associated with the transition to a lower carbon economy may increase in the future, which could increase our costs associated with compliance and otherwise disrupt and adversely affect our operations. The impact of these or other factors beyond our control could have an adverse effect on our business, financial position and results of operations.

The emergence and effects related to a potential future pandemic, epidemic, or outbreak of infectious disease could adversely impact our business and future results of operations and financial condition, and we may be more vulnerable to the effects of a public health crisis than other businesses due to the nature of our business and consumers.

As a provider of healthcare and personal care services, we are subject to the health and economic effects of public health conditions. If a pandemic, epidemic, or outbreak of an infectious disease or other public health crisis were to affect our markets, our business could be adversely affected. Any such crisis could diminish public trust in healthcare providers, particularly those that are treating or have treated patients affected by contagious diseases. Patient volumes may decline or volumes of uninsured and underinsured patients may increase, depending on the economic circumstances surrounding the pandemic, epidemic or outbreak. Further, a pandemic, epidemic or outbreak could adversely impact our business by causing a temporary shutdown or difficulty accessing patients, particularly facility-based patients, by causing disruption or delays in supply chains for materials and products, or by causing staffing shortages. Our business may be more vulnerable to the effects of a public health crisis than other businesses due to the health status of our typical consumer and patient populations. The majority of our consumers and patients are older individuals who may experience complex medical conditions or socioeconomic factors. Our employees may also be at greater risk of contracting contagious diseases due to their increased exposure to vulnerable consumers. Due to the physical proximity required to offer many of our services, our employees could have difficulty attending to our consumers if social distancing policies or quarantines are instituted in response to a public health crisis. Further, we could face litigation if our employees or customers contract contagious diseases while our employees perform their duties. Although we have contingency plans in place, including infection control plans, the potential impact of, as well as the public's response and governmental responses to, any such future pandemic, epidemic or outbreak of infectious disease with respect to our markets is difficult to predict and could adversely impact our business and future results of operations and financial condition.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 1C. CYBERSECURITY

Risk Management and Strategy

We recognize that cybersecurity threats pose a risk to our business. As part of the Company's overall risk management systems and processes, we employ a risk management framework designed with the goals of identifying, assessing and managing material risks from cybersecurity threats. Key aspects of this risk management framework include, but are not limited to:

- Maintaining a cybersecurity incident response plan, coordinated by the Company's IT department and Chief Information Security Officer, which includes controls and procedures for identifying, reporting and responding to cybersecurity incidents;
- Partnering with outside cybersecurity vendors periodically to gain an independent view of our cybersecurity and information security program;
- Providing our employees with regular training on cybersecurity and the protection of our information systems;
- Maintaining and testing a business continuity and disaster recovery program;
- Database activity monitoring, encryption, secure file transfer protocols and application firewalls; and
- Maintaining insurance coverage intended to address cybersecurity and data breach risks.

We have also implemented processes to help identify, assess and manage cybersecurity risks associated with our use of third-party service providers.

We do not believe that risks from cybersecurity threats of which we are currently aware, including as a result of any previous cybersecurity incidents, have materially affected or are reasonably likely to materially affect us, including our business strategy, results of operations or financial condition. For additional information, see "A cyber-attack or security breach could cause a loss of confidential consumer data, give rise to remediation and other expenses, expose us to liability under privacy laws, consumer protection laws, common law and other legal theories, subject us to litigation and federal and state governmental inquiries, damage our reputation, result in interruptions or delays to services, adversely impact our financial results, and otherwise be disruptive to our business" included in Part I, Item 1A of this Form 10-K.

Governance

Our cybersecurity risk management program is integrated into our overall risk management system and processes. Together with the Board's standing committees, the Company's Board of Directors is responsible for ensuring that material risks, including material cybersecurity risks, are identified and managed appropriately. The Board receives updates at least bi-annually from our Chief Information Officer concerning our information security and cyber risk strategy, cyber defense initiatives, cyber event preparedness and cybersecurity risk assessments. The Chief Information Officer has extensive IT and program management experience and works closely with our Chief Information Security Officer, who oversees our cybersecurity program on a day-to-day basis. The Chief Information Security Officer has extensive cybersecurity experience, including more than 15 years working in senior IT infrastructure and IT security roles in the healthcare sector (seven of which years were spent as the Chief Information Security Officer). Our cybersecurity incident response plan provides that the Chief Information Security Officer will work with our IT Department and the impacted segment of our business to investigate and respond to any identified incident (including by escalating the incident to the Company's senior management and the Board depending on the nature and scope).

ITEM 2. PROPERTIES

We do not own any real property. We lease administrative offices for our local branches, none of which are individually material. We lease approximately 18,000 and 75,000 square feet of office space in Lisle, Illinois and Frisco, Texas, respectively, which serve as our support centers.

ITEM 3. LEGAL PROCEEDINGS

From time to time, we are subject to legal and/or administrative proceedings incidental to our business. It is the opinion of management that the outcome of pending legal and/or administrative proceedings will not have a material effect on our financial position and results of operations.

Further information with respect to this item may be found in Note 11 to the Consolidated Financial Statements in Part II, Item 8—"Financial Statements and Supplementary Data," which is incorporated herein by reference.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

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

Market Information

Our common stock is listed on The Nasdaq Global Market under the symbol "ADUS."

Holders

As of December 31, 2025, 2.6% of our shares of common stock were held by our officers and directors and approximately 97.4% of our common stock was held by 419 institutional investors. An insignificant amount of common stock is held by individual holders. As of February 17, 2026, Addus HomeCare Corporation had approximately 45,726 shareholders of its common stock, including 86 shareholders of record.

Dividends

We have never paid dividends on our common stock, including in the two most recent fiscal years, and we do not intend to pay any dividends on our common stock in the foreseeable future. We currently plan to retain any earnings to support the operation, and to finance the growth, of our business rather than to pay cash dividends. Payments of any cash dividends in the future will depend on our financial condition, capital requirements, credit facility limitations, earnings, as well as other factors deemed relevant by our Board. Our credit facility restricts our ability to declare or pay any dividend or other distribution to Holdings unless no default or event of default has occurred and is continuing or would arise as a result thereof and the aggregate amount of dividends and distributions paid in any fiscal year does not exceed $10.0 million per annum.

ITEM 6. [Reserved]

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

You should read the following discussion together with our Consolidated Financial Statements and the related notes included elsewhere in this Annual Report on Form 10-K. This discussion contains forward-looking statements about our business and operations. Our actual results may differ materially from those we currently anticipate as a result of the factors we describe under "Risk Factors" and elsewhere in this Annual Report on Form 10-K and other risks as well as other factors that are not currently known to us, that we currently consider immaterial or that are not specific to us, such as general economic conditions. The discussion of our financial condition and results of operations for the year ended December 31, 2024 compared to the year ended December 31, 2023, included in Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") can be found in the Annual Report on Form 10-K for the year ended December 31, 2024.

Overview

We are a home care services provider operating three segments: personal care, hospice and home health. Our services are principally provided in-home under agreements with federal, state and local government agencies, managed care organizations, commercial insurers and private individuals. Our consumers are predominantly "dual eligible," meaning they are eligible to receive both Medicare and Medicaid benefits. Managed care revenues accounted for 37.0%, 34.8% and 36.6% of our revenue during the years ended December 31, 2025, 2024, and 2023 respectively.

A summary of certain consolidated financial and statistical data results for 2025, 2024 and 2023 are provided in the table below.

	For the Years Ended December 31,		
	2025	2024	2023
	(Amounts in Thousands, except States and Locations)		
Net service revenues	$ 1,422,530	$ 1,154,599	$ 1,058,651
Net income	$ 95,910	$ 73,598	$ 62,516
Total assets	$ 1,437,308	$ 1,412,634	$ 1,024,426
Adjusted EBITDA [(1)]	$ 179,984	$ 140,290	$ 121,020
States served at period end	23	23	22
Locations at period end	262	258	219

(1) The Company defines adjusted EBITDA as earnings before net interest expense, taxes, depreciation, amortization, acquisition expense, stock-based compensation expense, restructuring and other non-recurring costs, the gain or loss on the sale of assets, the impairment of operating lease assets, the impact of New York retroactive rate increases, and the impact of New York accounts receivable settlements. Adjusted EBITDA is a performance measure used by management that is not calculated in accordance with generally accepted accounting principles in the United States ("GAAP"). It should not be considered in isolation or as a substitute for net income, operating income or any other measure of financial performance calculated in accordance with GAAP. Additionally, our calculation of Adjusted EBITDA may not be comparable to similarly titled measures reported by other companies. Management believes that Adjusted EBITDA is useful to investors, management and others in evaluating the Company's operating performance, to provide investors with insight and consistency in the Company's financial reporting and to present a basis for comparison of the Company's business operations among periods, and to facilitate comparison with the results of the Company's peers. Additionally, we believe that Adjusted EBITDA is a measure widely used by securities analysts, investors and others to evaluate the financial performance of other public companies. The financial results presented in accordance with U.S. GAAP and a reconciliation of this non-GAAP measure included within this Annual Report on Form 10-K should be carefully evaluated.

Acquisitions

In addition to our organic growth, we have grown through acquisitions that have expanded our presence in current markets, with the goal of having all three levels of in-home care in our markets, or facilitating our entry into new markets where in-home care has been moving to managed care organizations.

On March 9, 2024, we completed the Upstate Acquisition for $0.4 million, with funding provided by available cash. With the Upstate Acquisition, the Company expanded its personal care segment in South Carolina.

On December 2, 2024, we completed the Gentiva Acquisition for approximately $353.6 million, with funding primarily provided by drawing on the Company's revolving credit facility and a portion of the net proceeds of the Company's public offering of common stock. With the Gentiva Acquisition, the Company expanded its services within its personal care segment in Arizona, Arkansas, California, and North Carolina, and entered the market in Missouri and Texas. The home health segment also was expanded in Tennessee.

On January 1, 2025, we completed the Jacksonville Acquisition for approximately $0.8 million, with funding provided by available cash. With the Jacksonville Acquisition, the Company expanded its personal care segment in Florida and recorded goodwill of $0.8 million.

On March 1, 2025, we completed the Great Lakes Acquisition for $2.6 million, with funding provided by available cash. With the Great Lakes Acquisition, the Company expanded its personal care segment in Michigan and recognized goodwill in its personal care segment of $2.6 million.

On August 1, 2025, we completed the Helping Hands Acquisition, for approximately $21.4 million, with funding through the Company's revolving credit facility and available cash. With the Helping Hands Acquisition, the Company expanded its services within its personal care segment and entered the hospice and home health markets in Pennsylvania and recognized goodwill in its personal care segment of $19.0 million.

On October 1, 2025, we completed the Gold Horses Acquisition, for approximately $7.4 million, with funding provided by available cash. With the Gold Horses Acquisition, the Company expanded its services within its personal care segment in Texas and recognized goodwill in its personal care segment of $7.4 million.

Divestiture

Effective May 20, 2024, we entered into a definitive asset purchase agreement to sell all of the Company's New York operations for a purchase price of up to $23.0 million in cash, subject to certain adjustments, including adjustments for future operating requirements (the "New York Asset Sale"). The purchase price included 50% cash consideration, paid out as an initial payment of $4.6 million and $6.9 million paid pro rata as a deferred payment as caregivers are transferred, and 50% in the form of contingent consideration for the Company's New York Consumer Directed Personal Assistance Program ("CDPAP") business. The Company entered into a consulting agreement with the purchaser effective May 20, 2024, as the transfer of clients and caregivers and payment for assets pursuant to the New York Asset Sale is occurring over time as regulatory approvals are received, coordination of the transfer of clients and caregivers occurs, and the change of control takes place. The Company determined that the consulting agreement gave it the ability to control the business until October 2024, when the Company determined that it no longer controlled the business as it transferred more than 50% of the clients and caregivers and therefore qualified for sale consideration of the New York Asset Sale. As a result, the Company deconsolidated the results of its New York operations and recorded a gain on divestiture of $3.7 million during the year ended December 31, 2024. The gain was reflected within general and administrative expenses on the consolidated statement of operations.

Revenue by Payor and Significant States

Our payor clients are principally federal, state and local governmental agencies and managed care organizations. The federal, state and local programs under which the agencies operate are subject to legislative, administrative and budgetary changes and other risks that can influence reimbursement rates. We have experienced a transition of business from government payors to managed care organizations, which we believe aligns with our emphasis on coordinated care and the reduction of the need for acute care. Medicare advantage revenue is included within Medicare.

For the years ended December 31, 2025, 2024 and 2023, our revenue by payor and significant states by segment were as follows:

	Personal Care					
	2025		2024		2023	
	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues
State, local and other governmental programs	$ 553,475	50.8%	$ 456,885	53.3%	$ 400,753	50.4%
Managed care organizations	501,528	46.0	376,604	44.0	367,557	46.2
Private pay	27,871	2.6	15,589	1.8	16,268	2.0
Commercial insurance	5,609	0.5	5,593	0.7	6,321	0.8
Other	732	0.1	1,910	0.2	3,819	0.6
Total personal care segment net service revenues	$ 1,089,215	100.0%	$ 856,581	100.0%	$ 794,718	100.0%
Illinois	$ 458,828	42.1%	$ 441,012	51.5%	$ 411,081	51.7%
Texas	216,712	19.9	17,936	2.0	—	—
New Mexico	118,588	10.9	115,381	13.5	115,986	14.6
New York	—	—	71,763	8.4	92,469	11.6
All other states	295,087	27.1	210,489	24.6	175,182	22.1
Total personal care segment net service revenues	$ 1,089,215	100.0%	$ 856,581	100.0%	$ 794,718	100.0%

With the Jacksonville Acquisition, the Great Lakes Acquisition, the Helping Hands Acquisition and the Gold Horses Acquisition in 2025, the Company expanded its personal care services to consumers in the state of Florida, Michigan, Pennsylvania and Texas. With the acquisition of Upstate and the Gentiva Acquisition in 2024, the Company expanded its personal care services to consumers in the state of Arizona, Arkansas, California, Missouri, North Carolina, South Carolina and Texas.

	Hospice					
	2025		2024		2023	
	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues
Medicare	$ 244,344	93.1%	$ 208,099	91.2%	$ 186,317	89.9%
Commercial insurance	8,558	3.3	11,744	5.2	12,385	6.0
Managed care organizations	8,155	3.1	7,603	3.3	7,037	3.4
Other	1,485	0.5	745	0.3	1,416	0.7
Total hospice segment net service revenues	$ 262,542	100.0%	$ 228,191	100.0%	$ 207,155	100.0%
Ohio	$ 101,833	38.8%	$ 84,811	37.2%	$ 74,871	36.1%
Illinois	60,427	23.0	52,560	23.0	47,247	22.8
New Mexico	32,865	12.5	28,532	12.5	30,782	14.9
All other states	67,417	25.7	62,288	27.3	54,255	26.2
Total hospice segment net service revenues	$ 262,542	100.0%	$ 228,191	100.0%	$ 207,155	100.0%

With the Helping Hands Acquisition, the Company entered the hospice market in Pennsylvania, and with the acquisition of Tennessee Quality Care in 2023, the Company expanded its hospice services to patients in the state of Tennessee.

	Home Health					
	2025		2024		2023	
	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues
Medicare	$ 47,701	67.4%	$ 48,562	69.5%	$ 41,078	72.3%
Managed care organizations	17,010	24.0	17,603	25.2	12,613	22.2
State, local and other governmental programs (excluding Medicare)	4,001	5.7	639	1.0	440	0.8
Other	2,061	2.9	3,023	4.3	2,647	4.7
Total home health segment net service revenues	$ 70,773	100.0%	$ 69,827	100.0%	$ 56,778	100.0%
New Mexico	$ 34,724	49.1%	$ 32,766	46.9%	$ 32,949	58.0%
Tennessee	28,209	39.9	26,497	38.0	10,978	19.4
Illinois	7,171	10.1	10,564	15.1	12,851	22.6
All other states	669	0.9	—	—	—	—
Total home health segment net service revenues	$ 70,773	100.0%	$ 69,827	100.0%	$ 56,778	100.0%

With the Gentiva Acquisition and the acquisition of Tennessee Quality Care in 2023 expanded the Company's home health operations in Tennessee.

We derive a significant amount of our net service revenues in Illinois, which represented 37.0% and 43.7% of our net service revenues for the years ended December 31, 2025 and 2024, respectively. A significant amount of our revenue is derived from one payor client, the Illinois Department on Aging, the largest payor program for our Illinois personal care operations, which accounted for 18.1% and 21.0% of our net service revenues for the years ended December 31, 2025 and 2024, respectively.

Changes in Illinois Reimbursement

As noted above, we derive a significant amount of our net service revenues in Illinois. Changes to reimbursement rates and minimum wage requirements may materially impact our revenues. For example, the Illinois fiscal year 2025 budget included an increase in hourly rates for in-home care services to $29.63, effective January 1, 2025, and required a minimum wage of $18.00 per hour for direct service workers. CMS approved an amendment to the Illinois HCBS Waiver for Persons Who are Elderly that included this rate increase, effective January 1, 2025. The Illinois fiscal year 2026 budget includes an increase in hourly rates for in-home care services to $30.80, effective January 1, 2026. This rate sustains a minimum wage of $18.75 per hour for direct service workers.

The City of Chicago requires the Chicago minimum wage to be adjusted annually based on increases in the Consumer Price Index ("CPI"), subject to a cap and other requirements. Effective July 1, 2025, the rate was adjusted to $16.60 based on the increase in the CPI.

Our business will benefit from the rate increases noted above as planned for 2026, but there is no assurance that there will be additional rate increases in Illinois for fiscal years beyond fiscal year 2026 to offset increases to minimum wage, and our financial performance will be adversely impacted for any periods in which an additional offsetting reimbursement rate increase is not in effect.

Changes in Texas Reimbursement

The Texas fiscal year 2026 budget included an increase in hourly rates to $17.13 for in-home care services effective September 1, 2025.

Changes in Medicare Reimbursement

Hospice

Hospice services provided to Medicare beneficiaries are paid under the Medicare Hospice Prospective Payment System, under which CMS sets a daily rate for each day a patient is enrolled in the hospice benefit. The daily rate depends on the level of care provided to a patient (routine home care, continuous home care, inpatient respite care, or general inpatient care). Daily rates are adjusted for factors such as area wage levels. CMS updates hospice payment rates each federal fiscal year. Effective October 1, 2025, CMS increased hospice payment rates by 2.6%. This reflects a 3.3% market basket increase and a negative 0.7 percentage point productivity adjustment. Hospices that do not satisfy quality reporting requirements are subject to a 4-percentage point reduction to the market basket update.

Overall payments made by Medicare to each hospice provider number are subject to an inpatient cap and an aggregate cap. The inpatient cap limits the number of days of inpatient care for which Medicare will pay to no more than 20% of total patient care days. Days in excess of the limitation are paid at the routine home care rate. The aggregate cap limits the total Medicare reimbursement that a hospice may receive in a cap year (typically the federal fiscal year), based on an annual per-beneficiary cap amount, which is set each federal fiscal year, and the number of Medicare patients served. The per-beneficiary cap amount was updated to $35,361.44 for federal fiscal year 2026. If a hospice's Medicare payments exceed its inpatient or aggregate caps, it must repay Medicare the excess amount.

Home Health

Home health services provided to Medicare beneficiaries are paid under the Medicare Home Health Prospective Payment System ("HHPPS"), which uses national, standardized 30-day period payment rates for periods of care that meet a certain threshold of home health visits (periods of care that do not meet the visit threshold are paid a per-visit payment rate for the discipline providing care). Although payment is made for each 30-day period, the HHPPS permits continuous 60-day certification periods through which beneficiaries are verified as eligible for the home health benefit. The daily home health payment rate is adjusted for case-mix and area wage levels. CMS uses the Patient-Driven Groupings Model ("PDGM") as the case-mix classification model to place periods of care into payment categories, classifying patients based on clinical characteristics and their resource needs. An outlier adjustment may be paid for periods of care where costs exceed a specific threshold amount.

CMS updates the HHPPS payment rates each calendar year. For calendar year 2026, CMS estimates that Medicare payments to home health agencies will decrease by 1.3%. This is based on a home health payment update percentage of 2.4%, which reflects a 3.2% market basket update, reduced by a productivity adjustment of 0.8 percentage points, among other changes. Home health providers that do not comply with quality data reporting requirements are subject to a 2-percentage point reduction to their market basket update. In addition, Medicare requires home health agencies to submit a one-time Notice of Admission ("NOA") for each patient that establishes that the beneficiary is under a Medicare home health period of care. Failure to submit the NOA within five calendar days from the start of care will result in a reduction to the 30-day period payment amount for each day from the start of care date until the date the NOA is submitted.

Under the nationwide Home Health Value-Based Purchasing ("HHVBP") Model, home health agencies receive increases or decreases to their Medicare fee-for-service payments of up to 5% based on performance against specific quality measures relative to the performance of other home health providers. Data collected in each performance year will impact Medicare payments two years later.

Payment of claims may be impacted by the Review Choice Demonstration for Home Health Services, a program intended to identify and prevent fraud, reduce the number of Medicare appeals and improve provider compliance with Medicare program requirements. The program is currently limited to home health agencies in Illinois, Ohio, Oklahoma, North Carolina, Florida and Texas. Providers in states subject to the Review Choice Demonstration for Home Health Services may initially select either pre-claim review or post-payment review. Home health agencies that maintain high compliance levels are eligible for additional options that may be less burdensome. This program has not had a material impact on our results of operations or financial position.

***CMS Final Rule:* "*Ensuring Access to Medicaid Services*"**

In May 2024, CMS finalized a rule intended to improve access to services and quality of care for Medicaid beneficiaries across fee-for-service and managed care delivery systems. The final rule includes significant provisions related to HCBS, including the "80/20" or "payment adequacy" requirement, which will require states to ensure by mid-2030 that at least 80% of all Medicaid payments a provider receives for homemaker, home health aide, and personal care services, less certain excluded costs, under specified programs are spent on total compensation (including benefits) for direct care workers furnishing these services, rather than administrative overhead or profit, subject to limited exceptions. The final rule includes several other measures intended to promote transparency and enhance quality and access to services, including a variety of reporting requirements for states. Given the long implementation period and the likelihood of further changes as a result of litigation, administration and congressional changes, further rule-making and state changes in response to the final rule, it is premature to predict the ultimate impact of the final rule on our business. Some states have adopted or may consider adopting similar caregiver compensation restrictions.

Potential Developments

Home care and other healthcare providers may be significantly impacted by changes to the Medicaid program, including changes resulting from the OBBBA and other legislation and administrative actions at the federal and state levels. Federal actions may impact funding for, or the structure of, the Medicaid program, including through changes to Medicaid waiver programs, and may shape provider reimbursement rates, eligibility and coverage policies, waiver programs and other aspects of state Medicaid programs at the state level. For example, the OBBBA includes provisions that are expected to result in Medicaid spending reductions and changes in administration of state Medicaid programs. Among other changes, the law requires changes to Medicaid financing mechanisms, including restrictions intended to reduce the federal matching funds received by state Medicaid programs, with greater restrictions in states that have expanded Medicaid. In addition, some members of Congress and the executive branch have raised, and Congress may in the future adopt, other proposals intended to reduce Medicaid expenditures such as restructuring the Medicaid program to give states a "block grant" or fixed amount of overall funding for their respective Medicaid programs or to impose spending caps such as per Medicaid beneficiary limits on federal contributions. Reductions in federal funding or changes to the federal funding formula for Medicaid under the OBBBA or future initiatives could have a significant impact, particularly in states that expanded Medicaid under the ACA and especially if federal contributions for Medicaid expansion populations decrease and states are unable to offset the reductions. Decreased federal funding and increased state obligations and administrative burden could strain state budgets, which could result in state limitations on Medicaid eligibility or coverage, payment rate reductions, and changes to Medicaid waiver programs, among other effects.

The outcome of the 2024 federal elections, affecting both the executive and legislative branches, increased regulatory uncertainty and the potential for significant policy changes. The executive branch has significant influence over healthcare policy changes through government agency regulation and executive orders have been issued that impact or may impact the healthcare industry. Further, some members of Congress and the executive branch have raised potential measures intended to accelerate the shift from traditional Medicare to Medicare Advantage or eliminating some or all of the consumer protections established by the ACA.

Components of our Statements of Income

Net Service Revenues

We generate net service revenues by providing our services directly to consumers and primarily on an hourly basis in our personal care segment, on a daily basis in our hospice segment and on an episodic basis in our home health segment. We receive payment for providing such services from our payor clients, including federal, state and local governmental agencies, managed care organizations, commercial insurers and private consumers.

In our personal care segment, net service revenues are principally provided based on authorized hours, determined by the relevant agency, at an hourly rate, which is either contractual or fixed by legislation, and are recognized at the time services are rendered. In our hospice segment, net service revenues are provided based on daily rates for each of the levels of care and are recognized as services are provided. In our home health segment, net service revenues are based on an episodic basis at a stated rate and recognized based on the number of days elapsed during a period of care within the reporting period. We also record estimated implicit price concessions (based primarily on historical collection experience) related to uninsured accounts to record revenues.

Cost of Service Revenues

We incur direct care wages, payroll taxes and benefit-related costs in connection with providing our services. We also provide workers' compensation and general liability coverage for our employees. Employees are also reimbursed for their travel time and related travel costs in certain instances.

General and Administrative Expenses

Our general and administrative expenses include our costs for operating our network of local agencies and our administrative offices. Our agency expenses consist of costs for supervisory personnel, our community care supervisors and office administrative costs. Personnel costs include wages, payroll taxes and employee benefits. Facility costs include rents, utilities, and postage, telephone and office expenses. Our corporate and support center expenses include costs for accounting, information systems, human resources, billing and collections, contracting, marketing and executive leadership. These expenses consist of compensation, including stock-based compensation, payroll taxes, employee benefits, legal, accounting and other professional fees, travel, general insurance, rents, provision for credit losses and related facility costs. Expenses related to streamlining our operations such as costs related to terminated employees, termination of professional services relationships, other contract termination costs and asset write-offs are also included in general and administrative expenses.

Depreciation and Amortization Expenses

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

Interest Expense

Interest expense is reported when incurred and principally consists of interest and unused credit line fees on the credit facility.

Income Tax Expense

All of our income is from domestic sources. We incur state and local taxes in states in which we operate. Our effective income tax rate was 24.7% and 25.9% for the years ended December 31, 2025 and 2024, respectively. The difference between our federal statutory and effective income tax rates was principally due to the inclusion of state taxes, non-deductible compensation, partially offset by the use of federal employment tax credits and an excess tax benefit.

Results of Operations

Year Ended December 31, 2025 Compared to Year Ended December 31, 2024

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

	2025		2024		Change	
	Amount	Net Service Revenues	Amount	Net Service Revenues	Amount	%
Net service revenues	$ 1,422,530	100.0%	$ 1,154,599	100.0%	$ 267,931	23.2%
Cost of service revenues	960,656	67.5	779,578	67.5	181,078	23.2
Gross profit	461,874	32.5	375,021	32.5	86,853	23.2
General and administrative expenses	306,847	21.6	258,800	22.4	48,047	18.6
Depreciation and amortization	16,412	1.2	13,530	1.2	2,882	21.3
Total operating expenses	323,259	22.7	272,330	23.6	50,929	18.7
Operating income	138,615	9.7	102,691	8.9	35,924	35.0
Interest income	(2,442)	(0.2)	(4,394)	(0.4)	1,952	(44.4)
Interest expense	13,612	1.0	7,732	0.7	5,880	76.0
Total interest expense, net	11,170	0.8	3,338	0.3	7,832	234.6
Income before income taxes	127,445	8.9	99,353	8.6	28,092	28.3
Income tax expense	31,535	2.2	25,755	2.2	5,780	22.4
Net income	$ 95,910	6.7%	$ 73,598	6.4%	$ 22,312	30.3%

Net service revenues increased by 23.2% to $1,422.5 million for the year ended December 31, 2025, compared to $1,154.6 million in 2024. Net service revenues increased by $232.6 million, $34.4 million and $0.9 million in the personal care, hospice and home health segments, respectively, for the year ended December 31, 2025, compared to 2024. Net service revenue in our personal care segment increased, primarily due to a 36.3% increase in billable hours, offset by a 6.4% decrease in revenues per billable hour due to lower reimbursement rates attributable to the Gentiva and Helping Hands Acquisitions for the year ended December 31, 2025 compared to 2024. The increase in our hospice segment revenue was primarily due to organic growth, driven by an increase in average daily census and higher revenue per patient day.

Gross profit, expressed as a percentage of net service revenues, was 32.5% for the year ended December 31, 2025, unchanged from 2024.

General and administrative expenses increased to $306.8 million for the year ended December 31, 2025, compared to $258.8 million in 2024. The increase in general and administrative expenses was primarily due to the full-year effect of the Gentiva acquisition that resulted in an increase in administrative employee wages, taxes and benefit costs of $35.0 million. General and administrative expenses, expressed as a percentage of net service revenues, decreased to 21.6% for 2025, from 22.4% in 2024.

Depreciation and amortization increased to $16.4 million for the year ended December 31, 2025, from $13.5 million in 2024, primarily due to the increase of intangible asset amortization related to the full-year effect in 2025 of our fiscal year 2024 acquisitions and fiscal year 2025 acquisitions.

Interest expense increased to $13.6 million from $7.7 million for the year ended December 31, 2025, compared to 2024, primarily due to higher outstanding borrowings held under our credit facility. Interest income decreased to $2.4 million from $4.4 million for the year ended December 31, 2025, compared to 2024, due to an increase in cash investment into interest bearing accounts from the Company's public offering of common stock in 2024.

All of our income is from domestic sources. We incur state and local taxes in states in which we operate. The effective income tax rate was 24.7% and 25.9% for the years ended December 31, 2025 and 2024, respectively. Our lower effective income tax rate in 2025 was principally due to a higher excess tax benefit. For the years ended December 31, 2025 and 2024, the excess tax benefit were 2.3% and 0.5%, respectively.

Results of Operations – Segments

The following tables and related analysis summarize our operating results and business metrics by segment:

Personal Care Segment

	For the Years Ended December 31,					
	2025		2024		Change	
	Amount	% of Segment Net Service Revenues	Amount	% of Segment Net Service Revenues	Amount	%
	(Amounts in Thousands, Except Percentages)					
Operating Results						
Net service revenues	$ 1,089,215	100.0%	$ 856,581	100.0%	$ 232,634	27.2%
Cost of services revenues	784,820	72.1	614,541	71.7	170,279	27.7
Gross profit	304,395	27.9	242,040	28.3	62,355	25.8
General and administrative expenses	97,194	8.9	67,823	7.9	29,371	43.3
Segment operating income	$ 207,201	19.0%	$ 174,217	20.4%	$ 32,984	18.9%
Business Metrics (Actual Numbers, Except Billable Hours in Thousands)						
Locations at period end	201		196			
Average billable census * [1]	51,249		52,019		(770)	(1.5)%
Billable hours * [2]	42,670		31,309		11,361	36.3
Average billable hours per census per month * [2]	70.1		71.5		(1.4)	(2.0)
Billable hours per business day * [2]	163,487		119,498		43,989	36.8
Revenues per billable hour * [2]	$ 25.48		$ 27.21		$ (1.73)	(6.4)
Same store growth revenue % * [3]	7.0%		7.7%		(0.7)	(9.1)%

(1) Average billable census is the number of unique clients receiving a billable service during the year and is the total census divided by months in operation during the period. Average billable census did not include New York operations for the year ended December 31, 2025, and included 964 for the year ended December 31, 2024, respectively (See Note 5 to the Notes to Condensed Consolidated Financial Statements, Divesture).

(2) Billable hours is the total number of hours served to clients during the period. Average billable hours per census per month is billable hours divided by average billable census. Billable hours per day is total billable hours divided by the number of business days in the period. Revenues per billable hour is revenue, attributed to billable hours, divided by billable hours.

(3) Same store growth reflects the change in year-over-year revenue for the same store base. We define the same store base to include those stores open for at least 52 full weeks. This measure highlights the performance of existing stores, while excluding the impact of acquisitions, new store openings and closures, and American Rescue Plan Act of 2021 associated revenue from this calculation.

* Management deems these metrics to be key performance indicators. Management uses these metrics to monitor our performance, both in our existing operations and acquisitions. Many of these metrics serve as the basis of reported revenues and assessment of these, provide direct correlation to the results of operations from period to period and facilitate comparison with the results of our peers. Historical trends established in these metrics can be used to evaluate current operating results, identify trends affecting our business, determine the allocation of resources and assess the quality and potential variability of our cash flows and earnings. We believe they are useful to investors in evaluating and understanding our business but should not be used solely in assessing the Company's performance. These key performance indicators should not be considered superior to, as a substitute for or as an alternative to, and should be considered in conjunction with, the GAAP financial measures presented herein to fully evaluate and understand the business as a whole. These measures may not be comparable to similarly-titled performance indicators used by other companies.

The personal care segment derives a significant amount of its net service revenues from operations in Illinois, which represented 42.1% and 51.5% of our net service revenues for the years ended December 31, 2025 and 2024, respectively. One payor client, the Illinois Department on Aging, accounted for 18.1% and 21.0% of net service revenues for the years ended December 31, 2025 and 2024, respectively. Net service revenues from state, local and other governmental programs accounted for 50.8% and 53.3% of net service revenues for the years ended December 31, 2025 and 2024, respectively. Managed care organizations accounted for 46.0% and 44.0% of net service revenues for the years ended December 31, 2025 and 2024, respectively, with commercial insurance, private pay and other payors accounting for the remainder of net service revenues.

Net service revenues increased by 27.2% for the year ended December 31, 2025 compared to the year ended December 31, 2024 primarily as a result of a 36.3% increase in billable hours, which more than offset a 6.4% decrease in revenues per billable hour discussed above.

Gross profit, expressed as a percentage of net service revenues, was relatively consistent at 27.9% for the year ended December 31, 2025, compared to 28.3% in 2024.

The personal care segment's general and administrative expenses primarily consist of administrative employee wages, taxes and benefit costs, rent, information technology and office expenses. General and administrative expenses, expressed as a percentage of net service revenues, was 8.9% and 7.9% for the years ended December 31, 2025 and 2024, respectively.

Hospice Segment

	For the Years Ended December 31,					
	2025		2024		Change	
	Amount	% of Segment Net Service Revenues	Amount	% of Segment Net Service Revenues	Amount	%
	(Amounts in Thousands, Except Percentages)					
Operating Results						
Net service revenues	$ 262,542	100.0%	$ 228,191	100.0%	$ 34,351	15.1%
Cost of services revenues	134,618	51.3	120,922	53.0	13,696	11.3
Gross profit	127,924	48.7	107,269	47.0	20,655	19.3
General and administrative expenses	60,510	23.0	55,338	24.3	5,172	9.3
Segment operating income	$ 67,414	25.7%	$ 51,931	22.7%	$ 15,483	29.8%
Business Metrics (Actual Numbers)						
Locations at period end	39		38			
Admissions * [(1)]	13,240		12,866		374	2.9%
Average daily census * [(2)]	3,760		3,461		299	8.6
Average length of stay * [(3)]	95.6		94.1		1.5	1.5
Patient days * [(4)]	1,369,425		1,266,701		102,724	8.1
Revenue per patient day * [(5)]	$ 191.06		$ 181.08		$ 9.98	5.5%
Organic growth						
- Revenue * [(6)]	14.1%		5.9%		8.2	139.0%
- Average daily census * [(6)]	8.2%		1.3%		6.9	530.8%

(1) Represents referral process and new patients on service during the period.
(2) Average daily census is total patient days divided by the number of days in the period, adjusted for patient days for acquisitions beginning on date of acquisition.
(3) Average length of stay is the average number of days a patient is on service, calculated upon discharge, and is total patient days divided by total discharges in the period.
(4) Patient days is days of service for all patients in the period.

(5) Revenue per patient day is hospice revenue divided by the number of patient days in the period.

(6) Revenue organic growth and average daily census organic growth reflect the change in year-over-year revenue and average daily census for the same store base. We define the same store base to include those stores open for at least 52 full weeks. These measures highlight the performance of existing stores, while excluding the impact of acquisitions, new store openings, closures and cap reserves.

* Management deems these metrics to be key performance indicators. Management uses these metrics to monitor our performance, both in our existing operations and acquisitions. Many of these metrics serve as the basis of reported revenues and assessment of these, provide direct correlation to the results of operations from period to period and facilitate comparison with the results of our peers. Historical trends established in these metrics can be used to evaluate current operating results, identify trends affecting our business, determine the allocation of resources and assess the quality and potential variability of our cash flows and earnings. We believe they are useful to investors in evaluating and understanding our business but should not be used solely in assessing the Company's performance. These key performance indicators should not be considered superior to, as a substitute for or as an alternative to, and should be considered in conjunction with, the GAAP financial measures presented herein to fully evaluate and understand the business as a whole. These measures may not be comparable to similarly-titled performance indicators used by other companies.

The hospice segment generates revenue by providing care to patients with a life expectancy of six months or less, as well as related services for their families. Hospice offers four levels of care, as defined by Medicare, to meet the varying needs of patients and their families. The four levels of hospice include routine care, continuous care, general inpatient care and respite care. Our hospice segment principally provides routine care.

Net service revenues from Medicare accounted for 93.1% and 91.2% and managed care organizations accounted for 3.1% and 3.3% for the years ended December 31, 2025 and 2024, respectively. Net service revenues increased by $34.4 million for the year ended December 31, 2025, compared to the year ended December 31, 2024 primarily driven by organic growth, reflected in an increase in average daily census and higher revenue per patient day.

Gross profit, expressed as a percentage of net service revenues, increased from 47.0% for the year ended December 31, 2024 to 48.7% for the year ended December 31, 2025, primarily due to higher net service revenues and improved operating leverage within direct service costs.

The hospice segment's general and administrative expenses primarily consist of administrative employee wages, taxes and benefit costs, rent, information technology and office expenses. General and administrative expenses, expressed as a percentage of net service revenues, was 23.0% and 24.3% for the years ended December 31, 2025 and 2024, respectively. The decrease in general and administrative expenses was primarily due to improved operating leverage within administrative functions.

Home Health Segment

	For the Years Ended December 31,					
	2025		2024		Change	
	Amount	% of Segment Net Service Revenues	Amount	% of Segment Net Service Revenues	Amount	%
	(Amounts in Thousands, Except Percentages)					
Operating Results						
Net service revenues	$ 70,773	100.0%	$ 69,827	100.0%	$ 946	1.4%
Cost of services revenues	41,219	58.2	44,115	63.2	(2,896)	(6.6)
Gross profit	29,554	41.8	25,712	36.8	3,842	14.9
General and administrative expenses	17,103	24.2	17,778	25.5	(675)	(3.8)
Segment operating income	$ 12,451	17.6%	$ 7,934	11.3%	$ 4,517	56.9%
Business Metrics (Actual Numbers)						
Locations at period end	22		24			
New admissions * [(1)]	18,474		18,622		(148)	(0.8)%
Recertifications * [(2)]	11,010		13,047		(2,037)	(15.6)
Total volume * [(3)]	29,484		31,669		(2,185)	(6.9)
Visits * [(4)]	366,228		422,516		(56,288)	(13.3)%
Organic growth						
- Revenue * [(5)]	(3.6)%		(3.1)%		(0.5)	16.1%

(1) Represents new patients during the period.

(2) A home health certification period begins with a start of care visit and continues for 60 days. If at the end of the initial certification, the patient continues to require home health services, a recertification is required. This represents the number of recertifications during the period.

(3) Total volume is total admissions and total recertifications in the period.

(4) Represents number of services to patients in the period.

(5) Revenue organic growth and new admissions organic growth reflect the change in year-over-year revenue and new admissions for the same store base. We define the same store base to include those stores open for at least 52 full weeks. These measures highlight the performance of existing stores, while excluding the impact of acquisitions, new store openings and closures.

* Management deems these metrics to be key performance indicators. Management uses these metrics to monitor our performance, both in our existing operations and acquisitions. Many of these metrics serve as the basis of reported revenues and assessment of these, provide direct correlation to the results of operations from period to period and facilitate comparison with the results of our peers. Historical trends established in these metrics can be used to evaluate current operating results, identify trends affecting our business, determine the allocation of resources and assess the quality and potential variability of our cash flows and earnings. We believe they are useful to investors in evaluating and understanding our business but should not be used solely in assessing the Company's performance. These key performance indicators should not be considered superior to, as a substitute for or as an alternative to, and should be considered in conjunction with, the GAAP financial measures presented herein to fully evaluate and understand the business as a whole. These measures may not be comparable to similarly-titled performance indicators used by other companies.

The home health segment generates revenue by providing home health services on a short-term, intermittent or episodic basis to individuals, generally to treat an illness or injury. Net service revenues from Medicare accounted for 67.4% and 69.5% and managed care organizations accounted for 24.0% and 25.2% for the years ended December 31, 2025 and 2024, respectively. Home health services provided to Medicare beneficiaries are paid under the Medicare HHPPS, which uses national, standardized 30-day period payment rates for periods of care. CMS uses the PDGM as the case-mix classification model to place periods of care into payment categories, classifying patients based on clinical characteristics. An outlier adjustment may be paid for periods of care in which costs exceed a specific threshold amount.

Net service revenues were relatively flat for the year ended December 31, 2025, compared to 2024, despite declines in visits and total volume during the year. The decrease in visits and total volume was due to concerted effort around reducing patient census from contracts with no margin.

Gross profit, expressed as a percentage of net service revenues, increased from 36.8% for the year ended December 31, 2024 to 41.8% for the year ended December 31, 2025, primarily due to a decrease of 6.1% in direct service employee wages, taxes and benefit costs.

The home health segment's general and administrative expenses consist of administrative employee wages, taxes and benefit costs, rent, information technology and office expenses. General and administrative expenses, expressed as a percentage of net service revenues, were 24.2% and 25.5% for the years ended December 31, 2025 and 2024, respectively. The decrease in general and administrative expenses was primarily due to more efficient operations for administrative employees for the year ended December 31, 2025.

Non-GAAP Financial Measures

Adjusted EBITDA is a non-GAAP measure that has limitations as an analytical tool and should not be considered in isolation or as a substitute for analysis of our results of operations as reported under generally accepted accounting principles in the United States ("GAAP"). The financial results presented in accordance with U.S. GAAP and a reconciliation of this non-GAAP measure included within this Annual Report on Form 10-K should be carefully evaluated.

We define Adjusted EBITDA as earnings before net interest expense, taxes, depreciation, amortization, acquisition expense, stock-based compensation expense, restructuring and other non-recurring costs, the gain or loss on the sale of assets, the impairment of operating lease assets, the impact of New York retroactive rate increases, and the impact of New York accounts receivable settlements. Adjusted EBITDA is a performance measure used by management that is not calculated in accordance with GAAP. It should not be considered in isolation or as a substitute for net income, operating income or any other measure of financial performance calculated in accordance with GAAP. Additionally, our calculation of Adjusted EBITDA may not be comparable to similarly titled measures reported by other companies.

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

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

- We believe that Adjusted EBITDA is a measure widely used by securities analysts, investors and others to evaluate the financial performance of other public companies.

- We recorded stock-based compensation expense of $16.4 million, $11.2 million and $10.3 million for the years ended December 31, 2025, 2024 and 2023, respectively. By comparing our Adjusted EBITDA in different periods, our investors can evaluate our operating results without stock-based compensation expense, which is a non-cash expense which we believe is not a key measure of our operations.

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

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

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

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

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

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

- in communications with our Board concerning our financial performance.

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

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

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

- Adjusted EBITDA does not reflect interest expense or interest income;

- Adjusted EBITDA does not reflect cash requirements for income taxes;

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

- Adjusted EBITDA does not reflect any acquisition expenses;

- Adjusted EBITDA does not reflect any stock-based compensation;

- Adjusted EBITDA does not reflect any restructure expense and other non-recurring costs; and

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

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

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

	For the Years Ended December 31,		
	2025	2024	2023
	(Amounts In Thousands)		
Reconciliation of net income to Adjusted EBITDA [(a)]:			
Net income	$ 95,910	$ 73,598	$ 62,516
Interest expense, net	11,170	3,338	9,630
Impact of New York retroactive rate increases	—	(3,004)	(868)
Impact of New York accounts receivable settlements	(1,864)	—	—
Income tax expense	31,535	25,755	18,810
Depreciation and amortization	16,412	13,530	14,126
Acquisition expense	8,899	14,678	6,220
Stock-based compensation expense	16,424	11,165	10,319
Restructuring and other non-recurring costs	1,500	—	269
Impairment of operating lease assets	—	4,968	—
Gain on sale of assets	(2)	(3,738)	(2)
Adjusted EBITDA*	$ 179,984	$ 140,290	$ 121,020

(a) The selected historical Consolidated Statements of Income data for the fiscal years ended December 31, 2025, 2024 and 2023, were derived from our audited Consolidated Financial Statements.

* Management deems Adjusted EBITDA to be a key performance indicator. Management uses key performance indicators to monitor our performance, both in our existing operations and acquisitions. Many of these metrics serve as the basis of reported revenues and assessment of these, provide direct correlation to the results of operations from period to period and facilitate comparison with the results of our peers. Historical trends established in these metrics can be used to evaluate current operating results, identify trends affecting our business, determine the allocation of resources and assess the quality and potential variability of our cash flows and earnings. We believe they are useful to investors in evaluating and understanding our business but should not be used solely in assessing the Company's performance. These key performance indicators should not be considered superior to, as a substitute for or as an alternative to, and should be considered in conjunction with, the GAAP financial measures presented herein to fully evaluate and understand the business as a whole. These measures may not be comparable to similarly-titled performance indicators used by other companies.

Liquidity and Capital Resources

Overview

Our primary sources of liquidity are cash on hand and cash from operations and borrowings under our credit facility. At December 31, 2025 and 2024, we had cash balances of $81.6 million and $98.9 million, respectively. Cash flows from operating activities represent the inflow of cash from our payor clients and the outflow of cash for payroll and payroll taxes, operating expenses, interest and taxes.

We drew approximately $11.3 million on the revolver portion of our credit facility to fund, in part, the purchase price paid in connection with the Helping Hands Acquisition and repaid $110.0 million under our revolving credit facility in 2025. At December 31, 2025, we had a total of $124.3 million in revolving loans, with an interest rate of 5.48% outstanding on our credit facility. After giving effect to the amounts drawn on our credit facility, approximately $7.9 million of outstanding letters of credit and borrowing limits based on an advance multiple of Adjusted EBITDA (as defined in the Credit Agreement), we had $650.0 million of capacity and $517.7 million available for borrowing under our credit facility. At December 31, 2024, we had a total of $223.0 million of revolving loans, with an interest rate of 6.34%. During the year ended December 31, 2024, the Company drew approximately $233.0 million on the revolver portion of its credit facility to fund, in part, the purchase price paid in connection with the Gentiva Acquisition and repaid $136.4 million under our revolving credit facility.

Our credit facility requires us to maintain a total net leverage ratio not exceeding 3.75:1.00. At December 31, 2025, we were in compliance with our financial covenants under the Credit Agreement. Although we believe our liquidity position remains strong, we can provide no assurance that we will remain in compliance with the covenants in our Credit Agreement, and in the future, it may prove necessary to seek an amendment with the bank lending group under our credit facility. Additionally, there can be no assurance that we will be able to raise additional funds on terms acceptable to us, if at all.

Borrowing Capacity

The Company's Credit Agreement provides for a $650.0 million revolving credit facility and a $150.0 million incremental loan facility, which incremental loan facility may be for term loans or an increase to the revolving loan commitments. The maturity of the credit facility is July 30, 2028.

See Note 9, Long-Term Debt, to the Notes to Consolidated Financial Statements for additional details of our long-term debt.

Public Offering

On June 28, 2024, the Company completed a public offering of an aggregate 1,725,000 shares of common stock, par value $0.001 per share, including 225,000 shares of common stock sold pursuant to the exercise in full by the underwriters of their option to purchase additional shares, at a public offering price of $108.00 per share (the "Public Offering"). The Company received net proceeds of approximately $175.6 million, after deducting underwriting discounts and estimated offering expenses of approximately $10.7 million. The Company used approximately $81.4 million from the net proceeds of the Public Offering for the repayment of indebtedness outstanding under its credit facility and may use any remaining net proceeds of the Public Offering for general corporate purposes, including the Gentiva Acquisition and any future acquisitions or investments. The Public Offering resulted in an increase to additional paid in capital of approximately $175.6 million on the Company's Consolidated Balance Sheet at December 31, 2024.

Current Macroeconomic Conditions and American Rescue Plan Act of 2021 Relief Funding

Economic conditions in the United States continue to be challenging in certain respects. For example, the United States economy continues to experience inflationary pressures, elevated interest rates and challenging labor market conditions. Any economic downturn would pose a risk to states' revenues, which in turn could affect our reimbursements and collections received for services rendered. Depending on the severity and length of any potential economic downturn as well as the extent of any federal support, states could face significant fiscal challenges and revise their revenue forecasts and adjust their budgets, and sales tax collections and income tax withholdings could be depressed. State budgetary challenges may be augmented by other factors, including the impact of the OBBBA and other federal legislation.

ARPA Spending Plans

To mitigate the fiscal effects of the COVID-19 public health emergency, the American Rescue Plan Act of 2021 ("ARPA") provided for a 10-percentage point increase in federal matching funds for Medicaid HCBS from April 1, 2021, through March 31, 2022, provided the state satisfied certain conditions. States were generally required to use the state funds equivalent to the additional federal funds on activities to enhance Medicaid HCBS by March 31, 2025, but CMS granted extensions to several states, permitting some states spending plans to continue until as late as September 30, 2026.

HCBS spending plans for the additional matching funds vary by state, but common initiatives in which the Company participates include those aimed at strengthening the provider workforce (e.g., efforts to recruit, retain, and train direct service providers). The Company is required to properly and fully document the use of such funds in reports to the state in which the funds originated. Funds may be subject to recoupment if not expended or if they are expended on non-approved uses.

The Company received state funding provided by the ARPA in an aggregate amount of $7.2 million and $15.7 million for the years ended December 31, 2025 and 2024, respectively. The Company utilized $6.8 million and $10.2 million of these funds during the years ended December 31, 2025 and 2024, respectively, primarily for caregivers and adding support to recruiting and retention efforts. The deferred portion of ARPA funding was $11.7 million and $11.2 million for the years ended December 31, 2025 and 2024, respectively, which is included within Government stimulus advances on the Company's Consolidated Balance Sheets.

Cash Flows

The following table summarizes historical changes in our cash flows for the years ended December 31, 2025, 2024 and 2023:

	2025	2024	2023
	(Amounts in Thousands)		
Net cash provided by operating activities	$ 111,507	$ 116,434	$ 112,247
Net cash used in investing activities	(32,500)	(354,610)	(119,236)
Net cash (used in) provided by financing activities	(96,301)	272,296	(8,181)

Net cash provided by operating activities was $111.5 million for the year ended December 31, 2025, compared to $116.4 million in 2024, primarily due to the increase in net income offset by a decrease in cash flows from changes in operating assets and liabilities. The changes in accounts receivable were primarily related to the growth in revenue during the year ended December 31, 2025, compared to 2024, as described below. The related receivables due from the Illinois Department on Aging represented 25.2% and 21.7% of net accounts receivable at December 31, 2025 and 2024, respectively.

Net cash used in investing activities was $32.5 million for the year ended December 31, 2025, compared to $354.6 million for the year ended December 31, 2024. Our investing activities for the year ended December 31, 2025 primarily consisted of $31.6 million of net cash used for the Jacksonville Acquisition, the Great Lakes Acquisition, the Helping Hands Acquisition and the Gold Horses Acquisition, $7.7 million in purchases of property and equipment related to technology infrastructure, offset by $3.8 million in proceeds received relating to the New York Asset Sale and $2.9 million in proceeds received relating to the Gentiva Acquisition. Our investing activities for the year ended December 31, 2024, primarily consisted of $0.4 for the acquisition of Upstate, $353.5 million for the Gentiva Acquisition, $6.1 million in purchases of property and equipment related to technology infrastructure, offset by $5.4 million in proceeds received on the sale of our New York Asset Sale.

Net cash used in financing activities was $96.3 million for the year ended December 31, 2025, compared to net cash provided by $272.3 million for the year ended December 31, 2024. Our financing activities for the year ended December 31, 2025, included borrowings of $11.3 million on the revolver portion of our credit facility to fund the Helping Hands Acquisition and cash received from the exercise of stock options of $2.5 million, offset by $110.0 million payment on the revolver portion of our credit facility. Our financing activities for the year ended December 31, 2024 included borrowings of $233.0 million on the revolver portion of our credit facility to fund the Gentiva Acquisition, $175.6 million in net proceeds received from the Public Offering and cash received from the exercise of stock options of $3.4 million, offset by $136.4 million payment on the revolver portion of our credit facility and cash paid for debt issuance costs of $3.4 million.

Outstanding Accounts Receivable

Outstanding accounts receivable, net of the allowance for credit losses as of December 31, 2025 and 2024 were $151.7 million and $122.9 million, respectively, increased by $28.8 million. The open receivable balance from the Illinois Department on Aging, the largest payor program for the Company's Illinois personal care operation, increased by $11.6 million from $26.7 million as of December 31, 2024 to $38.3 million as of December 31, 2025. Our collection procedures include review of account aging and direct contact with our payors. We have historically not used collection agencies. An uncollectible amount is written off to the allowance account after reasonable collection efforts have been exhausted.

We calculate our DSO by taking the accounts receivable outstanding, net of the allowance for credit losses, divided by the net service revenues for the last quarter, multiplied by the number of days in that quarter. Our DSOs were 38 days and 39 days at December 31, 2025 and 2024, respectively. The DSOs for our largest payor, the Illinois Department on Aging, at December 31, 2025 and 2024 were 55 days and 40 days, respectively.

Off-Balance Sheet Arrangements

As of December 31, 2025, we did not have any off-balance sheet guarantees or arrangements with unconsolidated entities.

Critical Accounting Policies and Estimates

The discussion and analysis of our financial condition and results of operations are based on our Consolidated Financial Statements prepared in accordance with GAAP. The preparation of the financial statements requires us to make estimates and assumptions that affect the reported amounts of assets and liabilities, revenues and expense and related disclosures.

Our significant accounting policies are described in Note 1 to the Notes to Consolidated Financial Statements. An accounting policy is deemed to be critical if it involves a significant level of estimation uncertainty and has had or is reasonably likely to have a material impact on our financial condition or results of operations. We base our estimates and judgments on historical experience and other sources and factors that we believe to be reasonable under the circumstances, however, actual results may differ from these estimates. Our critical accounting policies requiring estimates, assumptions and judgments that we believe have the most significant impact on our consolidated financial statements are described below.

Revenue Recognition, Accounts Receivable and Allowances

Net service revenue is recognized at the amount that reflects the consideration the Company expects to receive in exchange for providing services directly to consumers. Receipts are from federal, state and local governmental agencies, managed care organizations, commercial insurers and private consumers for services rendered. The Company assesses the consumers' ability to pay at the time of their admission based on the Company's verification of the customer's insurance coverage under the Medicare, Medicaid, and other commercial or managed care insurance programs. Laws and regulations governing the governmental programs in which we participate are complex and subject to interpretation. Net service revenues related to uninsured accounts, or self-pay, is recorded net of implicit price concessions estimated based on historical collection experience to reduce revenue to the estimated amount we expect to collect. Amounts collected from all sources may be less than amounts billed due to implicit price concessions resulting from client eligibility issues, insufficient or incomplete documentation, services at levels other than authorized, pricing differences and other reasons unrelated to credit risk. We monitor our net service revenues and collections from these sources and record any necessary adjustment to net service revenues based upon management's assessment of historical write offs and expected net collections, business and economic conditions, trends in federal, state and private employer healthcare coverage and other collection indicators.

Accounts receivable is reduced to the amount expected to be collected in future periods for services rendered to customers prior to the balance sheet date. Management estimates the value of accounts receivable, net of allowances for implicit price concessions based upon historical experience and other factors, including an aging of accounts receivable, evaluation of expected adjustments, past adjustments and collection experience in relation to amounts billed, current contract and reimbursement terms, shifts in payors and other relevant information. Collection of net service revenues we expect to receive is normally a function of providing complete and correct billing information to the payors within the various filing deadlines. The evaluation of these historical and other factors involves complex, subjective judgments impacting the determination of the implicit price concession assumption. In addition, we compare our cash collections to recorded net service revenues and evaluate our historical allowances, including implicit price concessions, based upon the ultimate resolution of the accounts receivable balance.

Goodwill and Intangible Assets

Under business combination accounting, assets and liabilities are generally recognized at their fair values and the difference between the consideration transferred, excluding transaction costs, and the fair values of the assets and liabilities is recognized as goodwill. The Company's significant identifiable intangible assets consist of customer and referral relationships, trade names and trademarks and state licenses. The Company uses various valuation techniques to determine initial fair value of its intangible assets, including relief-from-royalty, income approach, discounted cash flow analysis, and multi-period excess earnings, which use significant unobservable inputs, or Level 3 inputs, as defined by the fair value hierarchy. Under these valuation approaches, we are required to make estimates and assumptions about future market growth and trends, forecasted revenue and costs, expected periods over which the assets will be utilized, appropriate discount rates and other variables. The Company estimates the fair values of the trade names using the relief-from-royalty method, which requires assumptions such as the long-term growth rates of future revenues, the relief from royalty rate for such revenue, the tax rate and the discount rate. The Company estimates the fair value of existing indefinite-lived state licenses based on a blended approach of the replacement cost method and cost savings method, which involves estimating the total process costs and opportunity costs to obtain a license, by estimating future earnings before interest and taxes and applying an estimated discount rate, tax rate and time to obtain the license. The Company estimates the fair value of existing finite-lived state licenses based on a method of analyzing the definite revenue streams with the license and without the license, which involves estimating revenues and expenses, estimated time to build up to a current revenue base, which is market specific, and the non-licensed revenue allocation, revenue growth rates, discount rate and tax amortization benefits. The Company estimates the fair value of customer and referral relationships based on a multi-period excess earnings method, which involves identifying revenue streams associated with the assets, estimating the attrition rates based upon historical financial data, expenses and cash flows associated with the assets, contributory asset charges, rates of return for specific assets, growth rates, discount rate and tax amortization benefits. The Company estimates the fair value of non-competition agreements based on a method of analyzing the factors to compete and factors not to compete, which involves estimating historical financial data, forecasted financial statements, growth rates, tax amortization benefit, discount rate, review of factors to compete and factors not to compete as well as an assessment of the probability of successful enforcement for each non-competition agreement.

As of December 31, 2025 and 2024, goodwill was $996.7 million and $970.6 million, respectively, included in our Consolidated Balance Sheets. The carrying value of our goodwill is the excess of the purchase price over the fair value of the net assets acquired from various acquisitions. In accordance with ASC Topic 350, *Goodwill and Other Intangible Assets*, goodwill and intangible assets with indefinite useful lives are not amortized. We test goodwill for impairment at the reporting unit level on an annual basis, as of October 1, or whenever potential impairment triggers occur, such as a significant change in business climate or regulatory changes that would indicate that an impairment may have occurred. We may elect to use a qualitative test to determine whether impairment has occurred, focused on various factors including macroeconomic conditions, market trends, specific reporting unit financial performance and other entity specific events, to determine if it is more likely than not that the fair value of a reporting unit exceeds its carrying value, including goodwill. We may also bypass the qualitative assessment and perform a quantitative test. The quantitative goodwill impairment test involves comparing the fair value of a reporting unit with its carrying value, including goodwill. If the fair value of a reporting unit exceeds its carrying value, then goodwill is not impaired. If the fair value of a reporting unit is less than its carrying value, then goodwill is impaired to the extent of the difference.

For the year ended December 31, 2025, the Company elected to perform a qualitative analysis to evaluate whether it was more likely than not that the fair value of its reporting units exceeded their carrying values. Based on the results of the qualitative analysis, the Company concluded that threshold was met, and no further quantitative goodwill impairment testing was required.

For the years ended December 31, 2024 and 2023, we performed the quantitative analysis to evaluate whether an impairment occurred. Since quoted market prices for our reporting units are not available, we rely on widely accepted valuation techniques to determine fair value, including discounted cash flow and market multiple approaches, which capture both the future income potential of the reporting unit and the market behaviors and actions of market participants in the industry that includes the reporting unit. These types of models require us to make assumptions and estimates regarding future cash flows, industry-specific economic factors and the profitability of future business strategies. The discounted cash flow model uses a projection of estimated operating results and cash flows that are discounted using a weighted average cost of capital. The market multiple model estimates fair value based on market multiples of earnings before interest, taxes and depreciation and amortization. Under the discounted cash flow model, the projection uses management's best estimates of economic and market conditions over the projected period for each reporting unit using significant assumptions such as revenue growth rates, operating margins and the weighted-average cost of capital.

Based on the totality of the information available, we concluded that it was more likely than not that the estimated fair values of our reporting units were greater than their carrying values. Consequently, we concluded that there were no impairments for the years ended December 31, 2025, 2024 or 2023. The Company bases its fair value estimates on assumptions management believes to be reasonable but which are unpredictable and inherently uncertain. Actual future results may differ from those estimates.

As of December 31, 2025 and 2024, intangibles, net of accumulated amortization, was $102.4 million and $109.6 million, respectively, included in our Consolidated Balance Sheets. Our identifiable intangible assets consist of customer and referral relationships, trade names, trademarks, state licenses and non-competition agreements. Definite-lived intangible assets are amortized using straight-line and accelerated methods based upon the estimated useful lives of the respective assets, which range from one to twenty-five years, and assessed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. Customer and referral relationships are amortized systematically over the periods of expected economic benefit, which range from five to ten years. We would recognize an impairment loss when the estimated future non-discounted cash flows associated with the intangible asset are less than the carrying value. An impairment charge would then be recorded for the excess of the carrying value over the fair value. We estimate the fair value of these intangible assets using the income approach. In accordance with ASC Topic 350, *Goodwill and Other Intangible Assets*, intangible assets with indefinite useful lives are not amortized. We test intangible assets with indefinite useful lives for impairment at the reporting unit level on an annual basis, as of October 1, or whenever potential impairment triggers occur, such as a significant change in business climate or regulatory changes that would indicate that an impairment may have occurred. No impairment charge was recorded for the years ended December 31, 2025, 2024 or 2023. Amortization of intangible assets is reported in the statement of income caption, “Depreciation and amortization” and not included in the income statement caption cost of service revenues.

Recent Accounting Pronouncements

Refer to Note 1 to the Notes to Consolidated Financial Statements for further discussion.

Standby Letters of Credit

We had outstanding letters of credit of $7.9 million at December 31, 2025. These standby letters of credit benefit our third-party insurer for our high deductible workers’ compensation insurance program. The amount of the letters of credit is negotiated annually in conjunction with the insurance renewals.

Material Cash Requirements

We believe that our existing cash on hand, our anticipated cash flows from operations and amounts available under our Credit Agreement will be sufficient to fund our anticipated operating and investing needs for the next 12 months and for the foreseeable future thereafter. Cash from operations could also be affected by various risks and uncertainties, including, but not limited to the effects of risks detailed in Part I, Item 1A—”Risk Factors”.

Debt

As of December 31, 2025, the Company had outstanding debt on our revolving loan under our credit facility of $124.3 million, payable on July 30, 2028. Interest payments associated with the debt aggregate to $21.4 million, with $8.5 million payable within 12 months. As described in Note 9 to the Notes to Consolidated Financial Statements, interest on borrowings under the revolving loan are variable. The calculated interest payable amounts use actual rates available through January 2026 and assumes the January rates of 5.48%, for all future interest payable on the revolving loans. See Note 9, Long-Term Debt, to the Notes to Consolidated Financial Statements for additional details of our long-term debt.

Leases

The Company has lease arrangements for local branches, our corporate headquarters and certain equipment. As of December 31, 2025, the Company had fixed lease payment obligations aggregating to $59.5 million, with $15.8 million payable within 12 months. See Note 2, Leases, to the Notes to Consolidated Financial Statements for additional details of our leases.

Impact of Inflation

The United States has recently experienced high rates of inflation. These inflationary conditions have resulted in, and may continue to result in, increased operating costs, particularly as the result of increased wages we have paid and may continue to pay our caregivers and other personnel and our ability to attract and retain personnel. Increased price levels might allow us to increase our fees to private pay clients, but our ability to realize rate increases from government programs might be limited despite inflation. Inflation may also raise our financing costs. For additional information regarding the risks to us from the current competitive labor market and increasing labor costs, see Item 1A—Risk Factors — "*We may not be able to attract and retain qualified personnel or we may incur increased costs in doing so.*"

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are exposed to market risk associated with changes in interest rates on our variable rate long-term debt. As of December 31, 2025, we had outstanding borrowings of approximately $124.3 million on our credit facility, all of which was subject to variable interest rates. As of December 31, 2024, we had outstanding borrowings of approximately $223.0 million on our credit facility, all of which was subject to variable interest rates. If the variable rates on this debt were 100 basis points higher than the rate applicable to the borrowing during the year ended December 31, 2025, our net income would have decreased by $1.4 million, or $0.08 per diluted share. We do not currently have any derivative or hedging arrangements, or other known exposures, to changes in interest rates.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Our Consolidated Financial Statements together with the related Notes to Consolidated Financial Statements and the report of our independent registered public accounting firm, are set forth on the pages indicated in Part IV, Item 15—"Exhibits and Financial Statement Schedules."

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, conducted an evaluation of our disclosure controls and procedures, as such term is defined under Rule 13a-15(e) promulgated under the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by an issuer in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to the issuer's management, including its principal executive and principal financial officers, or persons performing similar functions, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures.

Based on the evaluation of our disclosure controls and procedures, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective as of December 31, 2025.

Management's Annual Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rule 13a-15(f). Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, we conducted an assessment of the effectiveness of our internal control over financial reporting based on the framework in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework). Based on our assessment under the framework in Internal Control — Integrated Framework, our management concluded that our internal control over financial reporting was effective as of December 31, 2025.

Under SEC Staff guidance, companies are permitted to exclude acquisitions from their first assessment of internal control over financial reporting which covers the period in which such acquisition was completed. We excluded Helping Hands Home Care Service, Inc., a Pennsylvania corporation ("Helping Hands") and Gold Horses, LLC, a Texas limited liability company ("Gold Horses") from our assessment of internal control over financial reporting as of December 31, 2025 because they were acquired in purchase business combinations on August 1, 2025 and October 1, 2025, respectively.

- Helping Hands represented 0.5% of our revenues, 0.5% of our operating income and 0.2% of our assets as of and for the year ended December 31, 2025.

- Gold Horses represented 0.2% of our revenues, 0.4% of our operating income and 0.0% of our assets as of and for the year ended December 31, 2025.

The effectiveness of our internal control over financial reporting as of December 31, 2025, has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in its report which appears within Part IV, Item 15—"Exhibits and Financial Statement Schedules."

Changes in Internal Control Over Financial Reporting

There were no changes in our internal control over financial reporting identified in connection with the evaluation required by Rule 13a-15(d) and 15d-15(d) of the Exchange Act that occurred during the fiscal quarter ended December 31, 2025 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

During the quarter ended December 31, 2025, each of the following directors and Section 16 officers adopted a Rule 10b5-1 Trading Arrangement (as defined in Item 408(a) of Regulation S-K) to sell common shares:

Name	Title	Adoption Date	Expiration Date (1)	Shares Vesting and Subject to Sell-To-Cover (2)	Other Shares Being Sold (Subject to Certain Conditions)
Heather Dixon	President and Chief Operating Officer	November 6, 2025	September 15, 2026	10,629	n/a

(1) Each plan will expire on the date represented in the table or upon the earlier completion of all transactions contemplated by the arrangement.

(2) This column indicates the total number of shares vesting in connection with equity awards, not the number of shares to be sold. The actual number of shares to be sold will be a smaller number based on whatever is required to satisfy payment of applicable withholding taxes under sell-to-cover arrangements.

ITEM 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS

Not applicable.

PART III

Certain information required by Part III is omitted from this Annual Report on Form 10-K as we intend to file our definitive Proxy Statement for the 2026 Annual Meeting of Stockholders pursuant to Regulation 14A of the Exchange Act not later than 120 days after the end of the fiscal year covered by this Annual Report, and certain information included in the Proxy Statement is incorporated herein by reference.

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information required by this item is incorporated by reference to the 2026 Proxy Statement to be filed with the SEC not later than 120 days after the end of the fiscal year ended December 31, 2025.

We have adopted a Code of Business Conduct and Ethics ("Code of Conduct") that is applicable to all of our employees, officers and members of our Board of Directors, and our subsidiaries. The Code of Conduct addresses, among other things, legal compliance, conflicts of interest, corporate opportunities, protection and proper use of Company assets, confidential and proprietary information, integrity of records, compliance with accounting principles and relations with government agencies. A copy of the current version of our Code of Conduct is available in the Investors—Corporate Governance section of our internet website located at www.addus.com. A copy of the Code of Conduct is also available in print, free of charge, to any stockholder who requests it by writing to Addus HomeCare Corporation, 6303 Cowboys Way, Suite 600, Frisco, TX 75034. We intend to post amendments to or waivers from, if any, our Code of Conduct at this location on our website, in each case to the extent such amendment or waiver would otherwise require the filing of a Current Report on Form 8-K pursuant to Item 5.05 thereof.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this item is incorporated by reference to the 2026 Proxy Statement to be filed with the SEC not later than 120 days after the end of the fiscal year ended December 31, 2025.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by this item is incorporated by reference to the 2026 Proxy Statement to be filed with the SEC not later than 120 days after the end of the fiscal year ended December 31, 2025.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this item is incorporated by reference to the 2026 Proxy Statement to be filed with the SEC not later than 120 days after the end of the fiscal year ended December 31, 2025.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this item is incorporated by reference to the 2026 Proxy Statement to be filed with the SEC not later than 120 days after the end of the fiscal year ended December 31, 2025.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) (1), (2) The Financial Statements listed on the index on page F-1 following are included herein. All schedules are omitted, either because they are not applicable or because the required information is shown in the financial statements or the notes thereto.

(b) Exhibits

EXHIBIT INDEX

Exhibit Number	Description of Document	Incorporated by Reference			
		Form	File No.	Date Filing	Exhibit Number
3.1	Amended and Restated Certificate of Incorporation of Addus HomeCare Corporation dated as of October 27, 2009.	10-Q	001-34504	11/20/2009	3.1
3.2	Amended and Restated Bylaws of Addus HomeCare Corporation, as amended by the First Amendment to Amended and Restated Bylaws.	10-Q	001-34504	05/9/2013	3.2
4.1	Form of Common Stock Certificate.	S-1	333-160634	10/2/2009	4.1
4.2	Description of Securities of Addus HomeCare Corporation Registered under Section 12 of the Exchange Act.	10-K	001-34504	8/10/2020	4.2
10.1*	Addus Holding Corporation 2006 Stock Incentive Plan.	S-1	333-160634	7/17/2009	10.12
10.2*	Director Form of Non-Qualified Stock Option Certificate under the 2006 Stock Incentive Plan.	S-1	333-160634	7/17/2009	10.13
10.3*	Executive Form of Non-Qualified Stock Option Certificate under the 2006 Stock Incentive Plan.	S-1	333-160634	7/17/2009	10.14
10.4	2009 Form of Indemnification Agreement.	S-1	333-160634	7/17/2009	10.16
10.5*	Form of Addus HomeCare Corporation 2009 Stock Incentive Plan.	S-1	333-160634	9/21/2009	10.20
10.6*	Form of Nonqualified Stock Option Award Agreement pursuant to the 2009 Stock Incentive Plan.	S-1	333-160634	9/21/2009	10.20(a)
10.7*	Form of Restricted Stock Award Agreement pursuant to the 2009 Stock Incentive Plan.	S-1	333-160634	9/21/2009	10.20(b)
10.8	Securities Purchase Agreement, dated as of April 24, 2015, by and among Addus HealthCare, Inc., Margaret Coffey, Carol Kolar, South Shore Home Health Service, Inc. and Acaring Home Care, LLC.	10-Q	001-34504	5/8/2015	10.1

10.9	Credit Agreement, dated as of May 8, 2017, by and among Addus Healthcare, Inc., as the Borrower, the other parties from time to time a party thereto, and Capital One, National Association, as a Lender and Swing Lender and as Agent for all Lenders, Suntrust Bank, as Documentation Agent, Bank of the West, Compass Bank, Fifth Third Bank and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, the other financial institutions party thereto, as Lenders, Capital One, National Association, Bank of the West, Compass Bank, Fifth Third Bank and JPMorgan Chase Bank, N.A. and Suntrust Robinson Humphrey as Joint Lead Arrangers and Capital One, National Association, as Sole Bookrunner.	10-Q	001-34504	5/9/2017	10.3
10.10*	Addus HomeCare Corporation's 2017 Omnibus Incentive Plan, effective as of April 27, 2017.	8-K	001-34504	6/16/2017	10.1
10.11*	Form of Nonqualified Stock Option Award Agreement pursuant to the 2017 Omnibus Incentive Plan.	10-K	001-34504	3/14/2018	10.28
10.12*	Form of Restricted Stock Award Agreement pursuant to the 2017 Omnibus Incentive Plan.	10-K	001-34504	3/14/2018	10.29
10.13	Stock Purchase Agreement, dated February 27, 2018, by and among Addus Healthcare, Inc., Michael J. Merrell and Mary E. Merrell, individually, Michael J. Merrell and Mary E. Merrell, as Trustees of the Merrell Revocable Trust UTA dated June 3, 2012, and Michael J. Merrell and Mary E. Merrell, as Trustees of the Ambercare Corporation Employee Stock Ownership Plan Trust.	8-K	001-34504	3/5/2018	10.1
10.14	Amended and Restated Credit Agreement by and among Addus HealthCare, Inc., as borrower, the Company, the other Credit Parties party thereto, the Lenders and L/C Issuers party thereto, and Capital One, National Association, as administrative agent.	10-Q	001-34504	8/11/2018	10.2
10.15*	Second Amended and Restated Employment and Non-Competition Agreement, dated November 5, 2018, by and between Addus HealthCare, Inc. and R. Dirk Allison.	10-Q	001-34504	8/11/2018	10.3
10.16*	Second Amended and Restated Employment and Non-Competition Agreement, dated November 5, 2018, by and between Addus HealthCare, Inc. and Brian Poff.	10-Q	001-34504	8/11/2018	10.4
10.17*	Second Amended and Restated Employment and Non-Competition Agreement, dated November 5, 2018, by and between Addus HealthCare, Inc. and Darby Anderson.	10-Q	001-34504	8/11/2018	10.6
10.18*	Second Amended and Restated Employment and Non-Competition Agreement, dated November 5, 2018, by and between Addus HealthCare, Inc. and W. Bradley Bickham.	10-Q	001-34504	8/11/2018	10.7
10.19	Amended and Restated Credit Agreement, dated as of October 31, 2018, by and among Addus HealthCare, Inc., as borrower, the Company, the other Credit Parties party thereto, the Lenders and L/C Issuers party thereto, and Capital One, National Association, as administrative agent.	10-Q	001-34504	11/8/2018	10.2
10.20*	Employment and Non-Competition Agreement, effective April 29, 2019, by and between Addus HealthCare, Inc. and Sean Gaffney.	8-K	001-34504	4/8/2019	99.2

10.21*	Employment and Non-Competition Agreement, effective November 7, 2019, by and between Addus HealthCare, Inc. and David Tucker.	10-K	001-34504	8/10/2020	10.40
10.22*	Employment and Non-Competition Agreement, effective November 7, 2019, by and between Addus HealthCare, Inc. and Mike Wattenbarger.	10-K	001-34504	8/10/2020	10.41
10.23	Equity Purchase Agreement, dated August 25, 2019, by and among Addus Healthcare, Inc., Hospice Partners of America, LLC, New Capital Partners II – HS, Inc., Senior Care Services, LLC, Eastside Partners II, L.P., and New Capital Partners II, LLC.	S-3ASR	333-233600	9/3/2019	2.1
10.24	First Amendment to Amended and Restated Credit Agreement, dated as of September 12, 2019, by and among Addus HealthCare, Inc., as the Borrower, Addus HomeCare Corporation, other Credit Parties party thereto, Capital One, National Association, as administrative agent and as a Lender, and the other Lenders party thereto.	10-Q	001-34504	9/13/2019	10.1
10.25	Unit Purchase Agreement, dated November 10, 2020, by and among Addus Healthcare, Inc., Queen City Hospice, LLC, Miracle City Hospice, LLC, and QCH Holdings LLC.	10-K	001-34504	3/1/2021	10.45
10.26	Amendment to Unit Purchase Agreement, dated December 3, 2020, by and among Addus Healthcare, Inc., Queen City Hospice, LLC, Miracle City Hospice, LLC, and QCH Holdings LLC.	10-K	001-34504	3/1/2021	10.46
10.27*	Employment and Non-Competition Agreement, effective June 14, 2021, by and between Addus HealthCare, Inc. and Roberton James Stevenson.	10-Q	001-34504	8/4/2021	10.2
10.28**	Second Amendment to Amended and Restated Credit Agreement, dated as of July 30, 2021, by and among Addus HealthCare, Inc., as the Borrower, Addus HomeCare Corporation, the other Credit Parties party thereto, Capital One, National Association, as administrative agent and as a Lender, and the other Lenders party thereto.	8-K	001-34504	8/4/2021	10.1
10.29*	2022 Form of Indemnification Agreement.	10-K	001-34504	2/25/2022	10.50
10.30*	Amended and Restated Employment and Non-Competition Agreement, effective March 1, 2022, by and between Addus HealthCare, Inc. and Monica Raines.	10-Q	001-34504	5/23/2022	10.1
10.31*	Employment and Non-Competition Agreement, effective April 20, 2022, by and between Addus HealthCare, Inc. and Cliff Blessing.	10-Q	001-34504	8/2/2022	10.1
10.32	Third Amendment to Amended and Restated Credit Agreement, dated as of April 26, 2023, by and among Addus HealthCare, Inc., as the Borrower, Addus HomeCare Corporation, the other Credit Parties party thereto, Capital One, National Association, as administrative agent and as a Lender, and the other Lenders party thereto.	10-Q	001-34504	5/2/2023	10.1
10.33*	Addus HomeCare Corporation Amended and Restated 2017 Omnibus Incentive Plan.	10-Q	001-34504	8/1/2023	10.1

10.34**	Membership Interests Purchase Agreement, dated June 28, 2023, by and among Addus HealthCare, Inc., HHH Newco Holdings, LLC, American Health Companies, LLC, American Home Care, LLC, Homecare, LLC, Tennessee Valley Home Care, LLC, and Tri-County Home Health and Hospice, LLC.	10-Q	001-34504	8/1/2023	10.1
10.35	Stock and Asset Purchase Agreement, dated June 8, 2024, by and between Addus HealthCare, Inc. and Curo Health Services, LLC.	8-K/A	001-34504	6/26/2024	10.1
10.36**	Fourth Amendment to Amended and Restated Credit Agreement, dated as of October 22, 2024, by and among Addus HealthCare, Inc., as the Borrower, Addus HomeCare Corporation, the other Credit Parties party thereto, Capital One, National Association, as administrative agent and as a Lender, and the other Lenders party thereto.	8-K	001-34504	10/22/2024	10.1
10.37*	Retention and Transition Agreement, dated March 10, 2025, by and between Addus Healthcare, Inc. and Heather Dixon.	8-K	001-34504	3/11/2025	10.1
10.38*	Third Amended and Restated Employment and Non-Competition Agreement, dated March 10, 2025, by and between Addus Healthcare, Inc. and Heather Dixon.	8-K	001-34504	3/11/2025	10.2
10.39*	Employment and Non-Competition Agreement, dated August 4, 2025, by and between Addus Healthcare, Inc. and Heather Dixon.	8-K	001-34504	8/7/2025	10.1
10.40*	Amended and Restated Retention and Transition Agreement, dated August 4, 2025, by and between Addus Healthcare, Inc. and W. Bradley Bickham.	8-K	001-34504	8/7/2025	10.2
21.1	Subsidiaries of Addus HomeCare Corporation.				
23.1	Consent of PricewaterhouseCoopers LLP, Independent Registered Public Accounting Firm.				
31.1	Certification of Chief Executive Officer Pursuant to Rule 13-14(a) of the Securities Exchange Act of 1934 as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.				
31.2	Certification of Chief Financial Officer Pursuant to Rule 13-14(a) of the Securities Exchange Act of 1934 as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.				
32.1	Certification of Chief Executive Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.				
32.2	Certification of Chief Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.				

101.INS	Inline XBRL Instance Document (the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document).
101.SCH	Inline XBRL Taxonomy Extension Schema Document.
101.CAL	Inline XBRL Taxonomy Calculation Linkbase Document.
101.LAB	Inline XBRL Taxonomy Label Linkbase Document.
101.PRE	Inline XBRL Presentation Linkbase Document.
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document.
104	Cover Page Interactive Data File (embedded within the Inline XBRL document and contained in Exhibit 101).

* Management compensatory plan or arrangement

** Schedules and exhibits have been omitted pursuant to Item 601 of Regulation S-K. The Company hereby undertakes to furnish supplementally a copy of any of the omitted schedules and exhibits upon request by the Securities and Exchange Commission.

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Addus HomeCare Corporation

By: /s/ R. DIRK ALLISON

R. Dirk Allison,
Chief Executive Officer and
Chairman of the Board

Date: February 24, 2026

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the date indicated:

Signature	Title	Date
/s/ R. DIRK ALLISON **R. Dirk Allison**	Chief Executive Officer and Chairman of the Board (Principal Executive Officer)	February 24, 2026
/s/ BRIAN POFF **Brian Poff**	Chief Financial Officer (Principal Financial and Accounting Officer)	February 24, 2026
/s/ MICHAEL EARLEY **Michael Earley**	Director	February 24, 2026
/s/ MARK L. FIRST **Mark L. First**	Director	February 24, 2026
/s/ DARIN J. GORDON **Darin J. Gordon**	Director	February 24, 2026
/s/ VERONICA HILL-MILBOURNE **Veronica Hill-Milbourne**	Director	February 24, 2026
/s/ ESTEBAN LÓPEZ, M.D. **Esteban López, M.D.**	Director	February 24, 2026
/s/ JEAN RUSH **Jean Rush**	Director	February 24, 2026
/s/ SUSAN T. WEAVER, M.D., FACP **Susan T. Weaver, M.D., FACP**	Director	February 24, 2026

INDEX TO CONSOLIDATED FINANCIAL INFORMATION

All schedules for which provision is made in the applicable accounting regulation of the Securities and Exchange Commission are not required under the related instructions or are inapplicable and therefore have been omitted.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Addus HomeCare Corporation

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Addus HomeCare Corporation and its subsidiaries (the "Company") as of December 31, 2025 and 2024, and the related consolidated statements of income, of stockholders' equity and of cash flows for each of the three years in the period ended December 31, 2025, including the related notes (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2025, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2025 and 2024, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2025 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2025, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the COSO.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Annual Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

As described in Management's Annual Report on Internal Control Over Financial Reporting, management has excluded Helping Hands Home Care Service, Inc., a Pennsylvania corporation ("Helping Hands") and Gold Horses, LLC, a Texas limited liability company ("Gold Horses") from its assessment of internal control over financial reporting as of December 31, 2025 because they were acquired by the Company in purchase business combinations during 2025. We have also excluded Helping Hands and Gold Horses from our audit of internal control over financial reporting. Helping Hands and Gold Horses are wholly-owned subsidiaries whose total revenues, total operating income, and total assets excluded from management's assessment and our audit of internal control over financial reporting represent approximately 0.5% and 0.2% of total revenues, respectively, approximately 0.5% and 0.4% of total operating income, respectively and approximately 0.2% and 0.0% of total assets, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2025.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Critical Audit Matters

The critical audit matter communicated below is a matter arising from the current period audit of the consolidated financial statements that was communicated or required to be communicated to the audit committee and that (i) relates to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the accounts or disclosures to which it relates.

Valuation of Accounts Receivable, Net of Allowances for Implicit Price Concessions

As described in Note 1 to the consolidated financial statements, net service revenue is recognized at the amount that reflects the consideration the Company expects to receive in exchange for providing services directly to consumers. Amounts collected may be less than amounts billed due to implicit price concessions, resulting from client eligibility issues, insufficient or incomplete documentation, services at levels other than authorized, pricing differences and other reasons unrelated to credit risk. Management estimates the value of accounts receivable, net of allowances for implicit price concessions, based upon historical experience and other factors, including an aging of accounts receivable, evaluation of expected adjustments, past adjustments and collection experience in relation to amounts billed, current contract and reimbursement terms, shifts in payors and other relevant information. The evaluation of these historical and other factors involves complex, subjective judgments. Accounts receivable, net of allowances for implicit price concessions (before the allowance for credit losses) were $155.0 million as of December 31, 2025.

The principal considerations for our determination that performing procedures relating to the valuation of accounts receivable, net of allowances for implicit price concessions is a critical audit matter are (i) the significant judgment by management when developing the estimate of accounts receivable, net of allowances for implicit price concessions and (ii) a high degree of auditor judgment, subjectivity, and effort in performing procedures and evaluating audit evidence related to the estimate.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to management's estimate of accounts receivable, net of implicit price concessions, including controls over the allowance for implicit price concessions. These procedures also included, among others (i) testing management's process for developing the estimate of accounts receivable, net of allowances for implicit price concessions; (ii) evaluating the relevance and use of historical experience data as an input into management's estimate; (iii) testing the completeness and accuracy of underlying historical collection data used as an input into management's estimate; (iv) testing, on a sample basis, the accuracy of revenue transactions and cash collections from the billing and collection data used as an input into the estimate; (v) evaluating the historical accuracy of management's estimate of the amount expected to be collected by performing a retrospective comparison of actual cash collections to the related accounts receivable; and (vi) performing a comparison of the remaining uncollected accounts receivable balance as of a date subsequent to year end, to expected future cash collections based on the Company's historical collection patterns.

/s/ PricewaterhouseCoopers LLP
Dallas, Texas
February 24, 2026

We have served as the Company's auditor since 2019.

ADDUS HOMECARE CORPORATION
AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
As of December 31, 2025 and 2024
(amounts and shares in thousands, except per share data)

	2025	2024
Assets		
Current assets		
Cash	$ 81,617	$ 98,911
Accounts receivable, net of allowances for credit losses	151,695	122,880
Prepaid expenses and other current assets	36,179	38,591
Total current assets	269,491	260,382
Property and equipment, net of accumulated depreciation and amortization	24,998	24,703
Other assets		
Goodwill	996,696	970,558
Intangibles, net of accumulated amortization	102,410	109,643
Operating lease assets, net	43,713	47,348
Total other assets	1,142,819	1,127,549
Total assets	$ 1,437,308	$ 1,412,634
Liabilities and stockholders' equity		
Current liabilities		
Accounts payable	$ 16,832	$ 27,176
Accrued payroll	65,941	62,053
Accrued expenses	28,191	28,959
Operating lease liabilities, current portion	13,144	12,800
Government stimulus advances	11,699	11,239
Accrued workers' compensation insurance	13,680	13,644
Total current liabilities	149,487	155,871
Long-term liabilities		
Long-term debt, net of debt issuance costs	120,959	218,443
Long-term operating lease liabilities	37,259	41,883
Deferred income tax	44,065	25,820
Other long-term liabilities	235	125
Total long-term liabilities	202,518	286,271
Total liabilities	$ 352,005	$ 442,142
Stockholders' equity		
Common stock—$.001 par value; 40,000 authorized and 18,518 and 18,148 shares issued and outstanding as of December 31, 2025 and 2024, respectively	$ 18	$ 18
Additional paid-in capital	612,945	594,044
Retained earnings	472,340	376,430
Total stockholders' equity	1,085,303	970,492
Total liabilities and stockholders' equity	$ 1,437,308	$ 1,412,634

See accompanying Notes to Consolidated Financial Statements

ADDUS HOMECARE CORPORATION
AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME
For the years ended December 31, 2025, 2024 and 2023
(amounts and shares in thousands, except per share data)

	For the Years Ended December 31,		
	2025	2024	2023
Net service revenues	$ 1,422,530	$ 1,154,599	$ 1,058,651
Cost of service revenues	960,656	779,578	718,775
Gross profit	461,874	375,021	339,876
General and administrative expenses	306,847	258,800	234,794
Depreciation and amortization	16,412	13,530	14,126
Total operating expenses	323,259	272,330	248,920
Operating income	138,615	102,691	90,956
Interest income	(2,442)	(4,394)	(1,476)
Interest expense	13,612	7,732	11,106
Total interest expense, net	11,170	3,338	9,630
Income before income taxes	127,445	99,353	81,326
Income tax expense	31,535	25,755	18,810
Net income	$ 95,910	$ 73,598	$ 62,516
Net income per common share			
Basic net income per share	$ 5.31	$ 4.33	$ 3.91
Diluted net income per share	$ 5.22	$ 4.23	$ 3.83
Weighted average number of common shares and potential common shares outstanding:			
Basic	18,053	17,006	15,996
Diluted	18,391	17,380	16,311

See accompanying Notes to Consolidated Financial Statements

ADDUS HOMECARE CORPORATION
AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
For the years ended December 31, 2025, 2024 and 2023
(amounts and shares in thousands)

	Common Stock		Additional Paid in Capital	Retained Earnings	Total Stockholders' Equity
	Shares	Amount			
Balance at January 1, 2023	16,128	$ 16	$ 393,208	$ 240,316	$ 633,540
Issuance of shares of common stock under restricted stock award agreements	86	—	—	—	—
Stock-based compensation	—	—	10,319	—	10,319
Shares issued for exercise of stock options	13	—	319	—	319
Net income	—	—	—	62,516	62,516
Balance at December 31, 2023	16,227	$ 16	$ 403,846	$ 302,832	$ 706,694
Issuance of shares of common stock under restricted stock award agreements	151	—	—	—	—
Forfeiture of shares of common stock under restricted stock award agreements	(5)	—	—	—	—
Stock-based compensation	—	—	11,165	—	11,165
Shares issued for exercise of stock options	50	—	3,435	—	3,435
Shares issued in public offering, net of offering costs	1,725	2	175,598	—	175,600
Net income	—	—	—	73,598	73,598
Balance at December 31, 2024	18,148	$ 18	$ 594,044	$ 376,430	$ 970,492
Issuance of shares of common stock under restricted stock award agreements	265	—	—	—	—
Forfeiture of shares of common stock under restricted stock award agreements	(5)	—	—	—	—
Stock-based compensation	—	—	16,424	—	16,424
Shares issued for exercise of stock options	110	—	2,477	—	2,477
Net income	—	—	—	95,910	95,910
Balance at December 31, 2025	18,518	$ 18	$ 612,945	$ 472,340	$ 1,085,303

See accompanying Notes to Consolidated Financial Statements

ADDUS HOMECARE CORPORATION
AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
For the years ended December 31, 2025, 2024 and 2023
(amounts in thousands)

	For the Years Ended December 31,		
	2025	**2024**	**2023**
Cash flows from operating activities:			
Net income	$ 95,910	$ 73,598	$ 62,516
Adjustments to reconcile net income to net cash provided by operating activities, net of acquisitions:			
Depreciation and amortization	16,412	13,530	14,126
Deferred income taxes	17,867	13,192	2,819
Stock-based compensation	16,424	11,165	10,319
Amortization of debt issuance costs under the credit facility	1,294	1,050	860
Provision for credit losses	1,563	1,121	731
Gain on disposal of assets	(2)	(13)	—
Impairment of operating lease assets	—	4,968	13
(Gain) loss on termination of operating leases	21	42	(23)
Gain on divestiture of business	—	(3,725)	—
Changes in operating assets and liabilities, net of acquisitions:			
Accounts receivable	(26,650)	22,137	15,666
Prepaid expenses and other current assets	(1,753)	(19,065)	(3,113)
Government stimulus advances	460	5,474	(7,577)
Accounts payable	(12,656)	(1,909)	2,025
Accrued payroll	3,250	(146)	9,176
Accrued expenses and other liabilities	(633)	(4,985)	4,709
Net cash provided by operating activities	111,507	116,434	112,247
Cash flows from investing activities:			
Acquisition of businesses, net of cash acquired	(31,581)	(353,946)	(109,797)
Purchases of property and equipment	(7,719)	(6,050)	(9,454)
Proceeds received from disposal of assets	15	29	15
Proceeds received from previous acquisition	2,937	—	—
Proceeds received from divestiture of business	3,848	5,357	—
Net cash used in investing activities	(32,500)	(354,610)	(119,236)
Cash flows from financing activities:			
Proceeds from borrowings on revolver — credit facility	11,335	233,000	110,000
Payments on revolver loan — credit facility	(110,000)	(136,353)	(118,500)
Proceeds from public offering	—	175,600	—
Payments for debt issuance costs under the credit facility	(113)	(3,386)	—
Cash received from exercise of stock options	2,477	3,435	319
Net cash (used in) provided by financing activities	(96,301)	272,296	(8,181)
Net change in cash	(17,294)	34,120	(15,170)
Cash, at beginning of period	98,911	64,791	79,961
Cash, at end of period	$ 81,617	$ 98,911	$ 64,791
Supplemental disclosures of cash flow information:			
Cash paid for interest	$ 12,461	$ 6,520	$ 10,254
Cash paid for income taxes	12,620	26,251	14,985
Supplemental disclosures of non-cash investing and financing activities			
Leasehold improvements acquired through tenant allowances	363	130	—
Licensing fees included in Fixed assets	—	—	4,000

See accompanying Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Basis of Presentation and Description of Business

The Consolidated Financial Statements include the accounts of Addus HomeCare Corporation ("Holdings") and its subsidiaries (together with Holdings, the "Company," "we," "us," or "our"). The Company operates as a multi-state provider of three distinct but related business segments providing in-home services. In its personal care services segment, the Company provides non-medical assistance with activities of daily living, primarily to persons who are at increased risk of hospitalization or institutionalization, such as the elderly, chronically ill or disabled. In its hospice segment, the Company provides physical, emotional and spiritual care for people who are terminally ill as well as related services for their families. In its home health segment, the Company provides services that are primarily medical in nature to individuals who may require assistance during an illness or after hospitalization and include skilled nursing and physical, occupational and speech therapy. The Company's payor clients include federal, state and local governmental agencies, managed care organizations, commercial insurers and private individuals.

Principles of Consolidation

All intercompany balances and transactions have been eliminated in consolidation.

Reclassification of Prior Balances

Certain reclassifications have been made to prior period amounts to conform to the current-year presentation including the reporting of Texas as a separate line item in personal care, commercial insurance as a separate line item in hospice, and state, local and other governmental programs (excluding Medicare) as a separate line item in home health. These reclassifications have no effect on the reported net income for the years ended December 31, 2025, 2024 and 2023.

Revenue Recognition

Net service revenue is recognized at the amount that reflects the consideration the Company expects to receive in exchange for providing services directly to consumers. Receipts are from federal, state and local governmental agencies, managed care organizations, commercial insurers and private consumers for services rendered. The Company assesses the consumers' ability to pay at the time of their admission based on the Company's verification of the customer's insurance coverage under the Medicare, Medicaid, and other commercial or managed care insurance programs. Laws and regulations governing the governmental programs in which the Company participates are complex and subject to interpretation. Net service revenues related to uninsured accounts, or self-pay, is recorded net of implicit price concessions estimated based on historical collection experience to reduce revenue to the estimated amount the Company expects to collect. Amounts collected from all sources may be less than amounts billed due to implicit price concessions, resulting from client eligibility issues, insufficient or incomplete documentation, services at levels other than authorized, pricing differences and other reasons unrelated to credit risk. The Company monitors our net service revenues and collections from these sources and records any necessary adjustment to net service revenues based upon management's assessment of historical write offs and expected net collections, business and economic conditions, trends in federal, state and private employer healthcare coverage and other collection indicators.

The initial estimate of net service revenues is determined by reducing the standard charge by any contractual adjustments, discounts and implicit price concessions. Subsequent changes to the estimate of net service revenues are generally recorded in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense.

Personal Care

The majority of the Company's net service revenues are generated from providing personal care services directly to consumers under contracts with state, local and other governmental agencies, managed care organizations, commercial insurers and private consumers. Generally, these contracts, which are negotiated based on current contracting practices as appropriate for the payor, establish the terms of a customer relationship and set the broad range of terms for services to be performed at a stated rate. However, the contracts do not give rise to rights and obligations until an order is placed with the Company. When an order is placed, it creates the performance obligation to provide a defined quantity of service hours, or authorized hours, per consumer. The Company satisfies its performance obligations over time, given that consumers simultaneously receive and consume the benefits provided by the Company as the services are performed. As the Company has a right to consideration from customers commensurate with the value provided to customers from the performance completed over a given invoice period, the Company has elected to use the practical expedient for measuring progress toward satisfaction of performance obligations and recognizes patient service revenue in the amount to which the Company has a right to invoice.

Hospice Revenue

The Company generates net service revenues from providing hospice services to consumers who are terminally ill as well as related services for their families. Net service revenues are recognized as services are provided and costs for delivery of such services are incurred. The estimated payment rates are daily rates for each of the levels of care the Company delivers. Hospice companies are subject to two specific payment limit caps under the Medicare program each federal fiscal year, the inpatient cap and the aggregate cap. The inpatient cap limits the number of inpatient care days provided to no more than 20% of the total days of hospice care provided to Medicare patients for the year. If a hospice exceeds the number of allowable inpatient care days, the hospice must refund any amounts received for inpatient care that exceed the total of: (i) the product of the total reimbursement paid to the hospice for inpatient care multiplied by the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicare patients; and (ii) the product of the number of actual inpatient days in excess of the limitation multiplied by the routine home care rate. The aggregate cap, which is calculated each federal fiscal year, limits the amount of Medicare reimbursement a hospice may receive, based on the number of Medicare patients served. If a hospice's Medicare payments exceed its aggregate cap, it must repay Medicare for the excess amount. In federal fiscal year 2026, the aggregate cap is $35,361.44. For both the years ended December 31, 2025 and 2024, the Company recorded a liability of $1.7 million, related to the Medicare aggregate cap limit.

Home Health Revenue

The Company also generates net service revenues from providing home healthcare services directly to consumers mainly under contracts with Medicare and managed care organizations. Generally, these contracts, which are negotiated based on current contracting practices as appropriate for the payor, establish the terms of a relationship and set the broad range of terms for services to be performed on an episodic basis at a stated rate. Home health Medicare services are paid under the Medicare Home Health Prospective Payment System ("HHPPS"), which is based on 30-day periods of care as a unit of service. The HHPPS permits multiple, continuous periods per patient. Medicare payment rates for periods under HHPPS are determined through use of a case-mix classification system, the Patient-Driven Groupings Model ("PDGM"), which assigns patients to resource groups based on a patient's clinical characteristics.

The Company elects to use the same 30-day periods that Medicare recognizes as standard but accelerates revenue upon discharge to align with a patient's episode length if less than the expected 30 days, which depicts the transfer of services and related benefits received by the patient over the term of the contract necessary to satisfy the obligations. The Company recognizes revenue based on the number of days elapsed during a period of care within the reporting period. The Company satisfies its performance obligations as consumers receive and consume the benefits provided by the Company as the services are performed. As the Company has a right to consideration from Medicare commensurate with the services provided to customers from the performance completed over a given episodic period, the Company has elected to use the practical expedient for measuring progress toward satisfaction of performance obligations. Under this method recognizing revenue ratably over the episode based on beginning and ending dates is a reasonable proxy for the transfer of benefit of the service.

Accounts Receivable and Allowances

Accounts receivable is reduced to the amount expected to be collected in future periods for services rendered to customers prior to the balance sheet date. Management estimates the value of accounts receivable, net of allowances for implicit price concessions, based upon historical experience and other factors, including an aging of accounts receivable, evaluation of expected adjustments, past adjustments and collection experience in relation to amounts billed, current contract and reimbursement terms, shifts in payors and other relevant information. Collection of net service revenues the Company expects to receive is normally a function of providing complete and correct billing information to the payors within the various filing deadlines. The evaluation of these historical and other factors involves complex, subjective judgments impacting the determination of the implicit price concession assumption. In addition, the Company compares its cash collections to recorded net service revenues and evaluates its historical allowance, including implicit price concessions, based upon the ultimate resolution of the accounts receivable balance.

Subsequent adjustments to accounts receivable determined to be the result of an adverse change in the payor's ability to pay are recognized as provision for credit losses. The majority of what historically was classified as provision for credit losses under operating expenses is now treated as an implicit price concession factored into the determination of net service revenues discussed above. Our collection procedures include review of account aging and direct contact with our payors. We have historically not used collection agencies. An uncollectible amount is written off to the allowance account after reasonable collection efforts have been exhausted. As of December 31, 2025 and 2024, the allowance for credit losses balance was $3.3 million and $3.5 million, respectively, which is included in accounts receivable, net of allowances for credit losses on the Company's Consolidated Balance Sheets.

Activity in the allowance for credit losses is as follows (in thousands):

Allowance for credit losses	Balance at beginning of period	Additions/ charges	Deductions [1]	Balance at end of period
Year ended December 31, 2025				
Allowance for credit losses	$ 3,532	1,563	1,792	$ 3,303
Year ended December 31, 2024				
Allowance for credit losses	$ 2,310	1,121	(101)	$ 3,532
Year ended December 31, 2023				
Allowance for credit losses	$ 1,634	731	55	$ 2,310

[1] Write-offs, net of recoveries

Property and Equipment

Property and equipment are recorded at cost and depreciated over the estimated useful lives of the related assets by use of the straight-line method. Maintenance and repairs are charged to expense as incurred. The estimated useful lives of the property and equipment are as follows:

	In Years
Computer equipment	3 - 5
Furniture and equipment	5 - 7
Transportation equipment	5
Computer software	3 - 10
Leasehold improvements	Lesser of useful life or lease term

Leases

The Company recognizes a lease liability and a right-of-use ("ROU") asset for all leases, including operating leases, with a term greater than twelve months on the balance sheet. We have historically entered into operating leases for local branches, our corporate headquarters and certain equipment. The Company's current leases have expiration dates through 2036. Certain of our arrangements have free rent periods and/or escalating rent payment provisions. We recognize rent expense on a straight-line basis over the lease term. Certain of the Company's leases include termination options and renewal options for periods ranging from one to five years. Renewal options generally are not considered in determining the lease term, and payments associated with the option years are excluded from lease payments unless we are reasonably certain to exercise the renewal option.

The operating lease liabilities are calculated using the present value of lease payments. If available, we use the rate implicit in the lease to discount lease payments to present value; however, most of our leases do not provide a readily determinable implicit rate. Therefore, we must estimate our incremental borrowing rate to discount the lease payments based on information available at lease commencement.

Operating lease assets are valued based on the initial operating lease liabilities plus any prepaid rent, reduced by tenant improvement allowances. Operating lease assets are tested for impairment in the same manner as our long-lived assets. For the year ended December 31, 2025, the Company did not record material impairment charges on operating lease assets. For the years ended December 31, 2024 and 2023, the Company recorded $5.0 million and $13,000 respectively, in impairment charges on operating lease assets, included within general administrative expenses.

Goodwill and Intangible Assets

Under business combination accounting, assets and liabilities are generally recognized at their fair values and the difference between the consideration transferred, excluding transaction costs, and the fair values of the assets and liabilities is recognized as goodwill. The Company's significant identifiable intangible assets consist of customer and referral relationships, trade names and trademarks and state licenses. The Company uses various valuation techniques to determine initial fair value of its intangible assets, including relief-from-royalty, income approach, discounted cash flow analysis, and multi-period excess earnings, which use significant unobservable inputs, or Level 3 inputs, as defined by the fair value hierarchy. Under these valuation approaches, we are required to make estimates and assumptions about future market growth and trends, forecasted revenue and costs, expected periods over which the assets will be utilized, appropriate discount rates and other variables. The Company estimates the fair values of the trade names using the relief-from-royalty method, which requires assumptions such as the long-term growth rates of future revenues, the relief from royalty rate for such revenue, the tax rate and the discount rate. The Company estimates the fair value of existing indefinite-lived state licenses based on a blended approach of the replacement cost method and cost savings method, which involves estimating the total process costs and opportunity costs to obtain a license, by estimating future earnings before interest and taxes and applying an estimated discount rate, tax rate and time to obtain the license. The Company estimates the fair value of existing finite-lived state licenses based on a method of analyzing the definite revenue streams with the license and without the license, which involves estimating revenues and expenses, estimated time to build up to a current revenue base, which is market specific, and the non-licensed revenue allocation, revenue growth rates, discount rate and tax amortization benefits. The Company estimates the fair value of customer and referral relationships based on a multi-period excess earnings method, which involves identifying revenue streams associated with the assets, estimating the attrition rates based upon historical financial data, expenses and cash flows associated with the assets, contributory asset charges, rates of return for specific assets, growth rates, discount rate and tax amortization benefits. The Company estimates the fair value of non-competition agreements based on a method of analyzing the factors to compete and factors not to compete, which involves estimating historical financial data, forecasted financial statements, growth rates, tax amortization benefit, discount rate, review of factors to compete and factors not to compete as well as an assessment of the probability of successful enforcement for each non-competition agreement.

As of December 31, 2025 and 2024, goodwill was $996.7 million and $970.6 million, respectively, included on the Company's Consolidated Balance Sheets. The Company's carrying value of goodwill is the excess of the purchase price over the fair value of the net assets acquired from various acquisitions. In accordance with Accounting Standards Codification ("ASC") Topic 350, *Goodwill and Other Intangible Assets*, goodwill and intangible assets with indefinite useful lives are not amortized. The Company tests goodwill for impairment at the reporting unit level on an annual basis, as of October 1, or whenever potential impairment triggers occur, such as a significant change in business climate or regulatory changes that would indicate that an impairment may have occurred. The Company may elect to use a qualitative test to determine whether impairment has occurred, focused on various factors including macroeconomic conditions, market trends, specific reporting unit financial performance and other entity specific events, to determine if it is more likely than not that the fair value of a reporting unit exceeds its carrying value, including goodwill. The Company may also bypass the qualitative assessment and perform a quantitative test. The quantitative goodwill impairment test involves comparing the fair value of a reporting unit with its carrying value, including goodwill. If the fair value of a reporting unit exceeds its carrying value, then goodwill is not impaired. If the fair value of a reporting unit is less than its carrying value, then goodwill is impaired to the extent of the difference.

For the year ended December 31, 2025, the Company elected to perform a qualitative analysis to evaluate whether it was more likely than not that the fair value of its reporting units exceeded their carrying values. Based on the results of the qualitative analysis, the Company concluded that threshold was met, and no further quantitative goodwill impairment testing was required.

For the years ended December 31, 2024 and 2023, the Company performed the quantitative analysis to evaluate whether an impairment occurred. Since quoted market prices for our reporting units are not available, the Company relies on widely accepted valuation techniques to determine fair value, including discounted cash flow and market multiple approaches, which capture both the future income potential of the reporting unit and the market behaviors and actions of market participants in the industry that includes the reporting unit. These types of models require us to make assumptions and estimates regarding future cash flows, industry-specific economic factors and the profitability of future business strategies. The discounted cash flow model uses a projection of estimated operating results and cash flows that are discounted using a weighted average cost of capital. The market multiple model estimates fair value based on market multiples of earnings before interest, taxes and depreciation and amortization. Under the discounted cash flow model, the projection uses management's best estimates of economic and market conditions over the projected period for each reporting unit using significant assumptions such as revenue growth rates, operating margins and the weighted-average cost of capital.

Based on the totality of the information available, the Company concluded that it was more likely than not that the estimated fair values of our reporting units were greater than their carrying values. Consequently, the Company concluded that there were no impairments for the years ended December 31, 2025, 2024 or 2023. The Company bases its fair value estimates on assumptions management believes to be reasonable but which are unpredictable and inherently uncertain. Actual future results may differ from those estimates.

As of December 31, 2025 and 2024, intangibles, net of accumulated amortization, was $102.4 million and $109.6 million, respectively, included on the Company's Consolidated Balance Sheets. The Company's identifiable intangible assets consist of customer and referral relationships, trade names, trademarks, state licenses and non-competition agreements. Definite-lived intangible assets are amortized using straight-line and accelerated methods based upon the estimated useful lives of the respective assets, which range from one to twenty years, and assessed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. Customer and referral relationships are amortized systematically over the periods of expected economic benefit, which range from three to fifteen years. The Company would recognize an impairment loss when the estimated future non-discounted cash flows associated with the intangible asset are less than the carrying value. An impairment charge would then be recorded for the excess of the carrying value over the fair value. The Company estimates the fair value of these intangible assets using the income approach. In accordance with ASC Topic 350, *Goodwill and Other Intangible Assets*, intangible assets with indefinite useful lives are not amortized. We test intangible assets with indefinite useful lives for impairment at the reporting unit level on an annual basis, as of October 1, or whenever potential impairment triggers occur, such as a significant change in business climate or regulatory changes that would indicate that an impairment may have occurred. No impairment charge was recorded for the years ended December 31, 2025, 2024 or 2023. Amortization of intangible assets is reported in the statement of income caption, "Depreciation and amortization" and not included in the income statement caption cost of service revenues.

Debt Issuance Costs

The Company amortizes debt issuance costs on a straight-line method over the term of the related debt. This method approximates the effective interest method. The Company has classified the debt issuance costs as a direct deduction from the carrying amount of the related liability.

Workers' Compensation Program

The Company's workers' compensation insurance program has a $0.4 million deductible component. The Company recognizes its obligations associated with this program in the period the claim is incurred. The cost of both the claims reported and claims incurred but not reported, up to the deductible, have been accrued based on historical claims experience, industry statistics and an actuarial analysis. The future claims payments related to the workers' compensation program are secured by letters of credit. These letters of credit totaled $7.9 million at December 31, 2025 and $8.0 million at December 31, 2024. The Company monitors its claims quarterly and adjusts its reserves as necessary in the current period. These costs are recorded primarily as cost of services on the Consolidated Statements of Income. As of December 31, 2025 and 2024, the Company recorded $13.7 million and $13.6 million, respectively, in accrued workers' compensation insurance on the Company's Consolidated Balance Sheets. As of December 31, 2025 and 2024, the Company recorded $0.5 million and $0.8 million, respectively, in workers' compensation insurance receivables. The workers' compensation insurance receivable is included in prepaid expenses and other current assets on the Company's Consolidated Balance Sheets.

Interest Expense

Interest expense is reported in the Consolidated Statements of Income when incurred and consists of interest and unused credit line fees on the credit facility.

Income Tax Expense

The Company accounts for income taxes under the provisions of ASC Topic 740, *Income Taxes.* The objective of accounting for income taxes is to recognize the amount of taxes payable or refundable for the current year and deferred tax assets and liabilities for the future tax consequences of events that have been recognized in its financial statements or tax returns. Deferred taxes, resulting from differences between the financial and tax basis of the Company's assets and liabilities, are also adjusted for changes in tax rates and tax laws when changes are enacted. ASC Topic 740 also requires that deferred tax assets be reduced by a valuation allowance if it is more likely than not that some portion or all of the deferred tax assets will not be realized. ASC Topic 740 also prescribes a recognition threshold and measurement process for recording in the financial statements uncertain tax positions taken or expected to be taken in a tax return. In addition, ASC Topic 740 provides guidance on derecognition, classification, accounting in interim periods and disclosure requirements for uncertain tax positions. The Company recognizes interest and penalties accrued related to uncertain tax positions in interest expense and penalties within operating expenses on the Consolidated Statements of Income. Uncertain tax positions are immaterial for all periods presented.

Stock-based Compensation

The Company currently has one stock incentive plan, the Amended and Restated 2017 Omnibus Incentive Plan (the "A&R 2017 Plan"), under which new grants of stock-based employee compensation are made. The Company accounts for stock-based compensation in accordance with ASC Topic 718, *Stock Compensation*. Compensation expense is recognized on a straight-line basis under the A&R 2017 Plan over the vesting period of the equity awards based on the grant date fair value of the options and restricted stock awards. The Company utilizes the Black-Scholes Option Pricing Model to value the Company's options. Forfeitures are recognized when they occur. Stock-based compensation expense was $16.4 million, $11.2 million and $10.3 million for the years ended December 31, 2025, 2024 and 2023, respectively, included within general and administrative expenses on the Consolidated Statements of Income.

Diluted Net Income Per Common Share

Diluted net income per common share, calculated on the treasury stock method, is based on the weighted average number of shares outstanding during the period. The Company's outstanding securities that may potentially dilute the common stock are stock options and restricted stock awards.

Included in the Company's calculation of diluted earnings per share for the year ended December 31, 2025 were approximately 296,000 stock options outstanding, of which approximately 208,000 were dilutive. In addition, there were approximately 381,000 restricted stock awards outstanding, of which approximately 131,000 were dilutive for the year ended December 31, 2025.

Included in the Company's calculation of diluted earnings per share for the year ended December 31, 2024 were approximately 406,000 stock options outstanding, of which approximately 259,000 were dilutive. In addition, there were approximately 244,000 restricted stock awards outstanding, of which approximately 115,000 were dilutive for the year ended December 31, 2024.

Included in the Company's calculation of diluted earnings per share for the year ended December 31, 2023 were approximately 455,000 stock options outstanding, of which approximately 234,000 were dilutive. In addition, there were approximately 201,000 restricted stock awards outstanding, of which approximately 82,000 were dilutive for the year ended December 31, 2023.

Use of Estimates

The financial statements are prepared by management in conformity with U.S. Generally Accepted Accounting Principles ("GAAP") and include estimated amounts and certain disclosures based on assumptions about future events. The Company's critical accounting estimates include the following areas: revenue recognition, goodwill and intangibles and business combinations and when required, the quantitative assessment of goodwill. Actual results could differ from those estimates.

Fair Value Measurements

The Company's financial instruments consist of cash, accounts receivable, payables and debt. The carrying amounts reported on the Company's Consolidated Balance Sheets for cash, accounts receivable, accounts payable and accrued expenses approximate fair value because of the short-term nature of these instruments. The carrying value of the Company's long-term debt with variable interest rates approximates fair value based on instruments with similar terms using level 2 inputs as defined under ASC Topic 820, *Fair Value Measurement*.

The Company applies fair value techniques on a non-recurring basis associated with valuing potential impairment losses related to goodwill, if required, and indefinite-lived intangible assets and also when determining the fair value of contingent consideration, if applicable. To determine the fair value in these situations, the Company uses Level 3 inputs, under ASC Topic 820 and defined as unobservable inputs in which little or no market data exists; therefore requiring an entity to develop its own assumptions, such as discounted cash flows, or if available, what a market participant would pay on the measurement date.

The Company uses various valuation techniques to determine fair value of its intangible assets, including relief-from-royalty, income approach, discounted cash flow analysis, and multi-period excess earnings, which use significant unobservable inputs, or Level 3 inputs, as defined by the fair value hierarchy. Under these valuation approaches, we are required to make estimates and assumptions about future market growth and trends, forecasted revenue and costs, expected periods over which the assets will be utilized, appropriate discount rates and other variables.

Going Concern

In connection with the preparation of the financial statements for the years ended December 31, 2025 and 2024, the Company conducted an evaluation as to whether there were conditions and events, considered in the aggregate, which raised substantial doubt as to the entity's ability to continue as a going concern within one year after the date of the issuance, of the financial statements. Based on the evaluation, we believe that cash flows from operations will be sufficient to meet our ongoing liquidity requirements for at least twelve months from the date of issuance.

Recently Adopted Accounting Pronouncements

In December 2023, the FASB issued ASU 2023-09, Improvements to Income Tax Disclosures, which requires disclosure of disaggregated income taxes paid, prescribes standard categories for the components of the effective tax rate reconciliation, and modifies other income tax-related disclosures. ASU 2023-09 is effective for fiscal years beginning after December 15, 2024. The Company adopted ASU 2023-09 during the year ended December 31, 2025. Adoption of the standard did not have a material impact on the Company's consolidated financial statements and expanded income tax disclosures.

Recently Issued Accounting Pronouncements

In November 2024, the FASB issued ASU 2024-03, Income Statement - Reporting Comprehensive Income - Expense Disaggregation Disclosures (Subtopic 220-40): Disaggregation of Income Statement Expenses. The new guidance is intended to provide investors more detailed disclosures around specific types of expenses. The new disclosures require certain details for expenses presented on the face of the Consolidated Statements of Operations as well as selling expenses to be presented in the notes to the financial statements. ASU 2024-03 is effective for fiscal years beginning after December 15, 2026, and interim periods within fiscal years beginning after December 15, 2027, with early adoption permitted. The disclosure updates are required to be applied prospectively with the option for retrospective application. The Company is currently evaluating the impact of adopting the updated provisions.

In July 2025, the FASB issued ASU 2025-05, Measurement of Credit Losses for Accounts Receivable and Contract Assets, which replaces the incurred-loss model with a forward-looking current expected credit loss model that requires recognition of lifetime expected credit losses on financial assets measured at amortized cost and certain off-balance-sheet credit exposures (including trade accounts receivable and contract assets), using historical experience, current conditions, and reasonable and supportable forecasts. ASU 2025-05 is effective for annual reporting periods beginning after *December 15, 2025,* and interim reporting periods within those annual reporting periods, with early adoption permitted. The disclosure updates should be applied prospectively. The Company is currently evaluating the impact of the updated provisions.

In September 2025, the FASB issued ASU 2025-06, Intangibles - Goodwill and Other - Internal-Use Software (Subtopic 350-40): Targeted Improvements to the Accounting for Internal-Use Software. The new guidance intends to modernize the guidance related to internal-use software costs to reflect current software development methods. It requires entities to begin capitalizing software costs when management authorizes and commits to funding the software project, and it is probable the project will be completed and the software will be used for its intended purpose. ASU 2025-06 is effective for fiscal years beginning after December 15, 2027, and interim periods within those fiscal years, and may be adopted using a prospective, retrospective, or modified transition approach. Early adoption is permitted. The Company is currently evaluating the impact on its consolidated financial statements.

In December 2025, the FASB issued ASU 2025-10, Government Grants (Topic 832): Accounting for Government Grants Received by Business Entities, which provides guidance on the recognition, measurement, and presentation of government grants. ASU 2025-10 is effective for fiscal years beginning after December 15, 2028, and interim periods within those fiscal years, and permits modified prospective, modified retrospective, or full retrospective adoption, with early adoption permitted. The Company has evaluated the guidance and does not expect adoption to have a material impact on its consolidated financial statements or related disclosures.

In December 2025, the FASB issued ASU 2025-11, Interim Reporting (Topic 270): Narrow-Scope Improvements, which clarifies certain interim reporting guidance. ASU 2025-11 is effective for fiscal years beginning after December 15, 2027, and interim periods within those fiscal years. The Company has evaluated the guidance and does not expect adoption to have a material impact on its consolidated financial statements.

2. Leases

Amounts reported on the Company's Consolidated Balance Sheets for operating leases were as follows:

	December 31,	
	2025	2024
	(Amounts in Thousands)	
Operating lease assets, net	$ 43,713	$ 47,348
Short-term operating lease liabilities	13,144	12,800
Long-term operating lease liabilities	37,259	41,883
Total operating lease liabilities	$ 50,403	$ 54,683

Lease Costs

Components of lease costs were reported in general and administrative expenses in the Company's Consolidated Statements of Income as follows:

	For the Years Ended December 31, (Amounts in Thousands)		
	2025	2024	2023
Operating lease costs	$ 14,658	$ 13,386	$ 13,026
Short-term lease costs	1,118	735	1,147
Total lease costs	15,776	14,121	14,173
Less: sublease income	(226)	(2,267)	(2,770)
Total lease costs, net	$ 15,550	$ 11,854	$ 11,403

Lease Term and Discount Rate

Weighted average remaining lease terms and discount rates were as follows:

	December 31,		
	2025	2024	2023
Operating leases:			
Weighted average remaining lease term	5.05	5.48	6.26
Weighted average discount rate	6.37%	6.20%	5.47%

Maturity of Lease Liabilities

Remaining operating lease payments as of December 31, 2025 were as follows:

	Operating Leases (Amounts in Thousands)
Due in 12-month period ended December 31,	
2026	$ 15,784
2027	12,565
2028	8,920
2029	6,822
2030	5,642
Thereafter	9,779
Total future minimum rental commitments	59,512
Less: Imputed interest	(9,109)
Total lease liabilities	$ 50,403

Supplemental Cash Flow Information

	For the Years Ended December 31, (Amounts in Thousands)		
	2025	2024	2023
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows from operating leases	$ 16,775	$ 14,783	$ 14,396
Right-of-use assets obtained in exchange for lease obligations:			
Operating leases	$ 9,305	$ 15,489	$ 17,221

3. Public Offering

On June 28, 2024, the Company completed a public offering of an aggregate 1,725,000 shares of common stock, par value $0.001 per share, including 225,000 shares of common stock sold pursuant to the exercise in full by the underwriters of their option to purchase additional shares, at a public offering price of $108.00 per share (the "Public Offering"). The Company received net proceeds of approximately $175.6 million, after deducting underwriting discounts and estimated offering expenses of approximately $10.7 million. The Company used approximately $81.4 million from the net proceeds of the Public Offering for the repayment of indebtedness outstanding under its credit facility and may use any remaining net proceeds of the Public Offering for general corporate purposes, including the Gentiva Acquisition and any future acquisitions or investments. The Public Offering resulted in an increase to additional paid in capital of approximately $175.6 million on the Company's Consolidated Balance Sheet at December 31, 2024.

4. Acquisitions

The Company's acquisitions have been accounted for in accordance with ASC Topic 805, *Business Combinations*, and the resulting goodwill and other intangible assets were accounted for under ASC Topic 350, *Goodwill and Other Intangible Assets*. Under business combination accounting, the assets and liabilities are generally recognized at their fair values and the difference between the consideration transferred, excluding transaction costs, and the fair values of the assets and liabilities is recognized as goodwill. The results of each business acquisition are included on the Consolidated Statements of Income from the date of the acquisition.

Management's assessment of qualitative factors affecting goodwill for each acquisition includes estimates of market share at the date of purchase, ability to grow in the market, synergy with existing Company operations and the payor profile in the markets.

Helping Hands Acquisition

On August 1, 2025, the Company completed the acquisition of Helping Hands Home Care Service, Inc., a Pennsylvania corporation (the "Helping Hands Acquisition"), for approximately $21.4 million. The purchase was funded through the Company's revolving credit facility and available cash. With the Helping Hands Acquisition, the Company expanded its services within its personal care segment and entered the hospice markets in Pennsylvania. The related acquisition and integration costs were $0.9 million and $0.3 million for the twelve months ended December 31, 2025, respectively. These costs were included in general and administrative expenses on the Consolidated Statements of Income and were expensed as incurred.

	Total (Amounts in Thousands)
Goodwill	$ 19,022
Identifiable intangible assets	1,150
Cash	584
Accounts receivable	1,365
Property and equipment	19
Operating lease assets, net	282
Other current assets	45
Accounts payable	(98)
Accrued payroll	(697)
Operating lease liabilities, total	(257)
Total purchase price	$ 21,415

Identifiable intangible assets acquired included $1.2 million of definite-lived state licenses. The preliminary estimated fair value of identifiable intangible assets was determined with the assistance of a valuation specialist, using Level 3 inputs as defined under ASC Topic 820. The fair value analysis and related valuations reflect the conclusions of management. All estimates, key assumptions, and forecasts were either provided by or reviewed by the Company. The goodwill and intangible assets acquired are deductible for tax purposes.

The Helpings Hands Acquisition accounted for $7.2 million of net service revenues and $0.8 million of operating income for the year ended December 31, 2025.

Gentiva Acquisition

On December 2, 2024, the Company completed the Gentiva Acquisition. The purchase price was approximately $353.6 million and is subject to the completion of working capital and related adjustments. In 2025, the Company received $2.9 million in proceeds for purchase price adjustments. The purchase was funded with the combination of a $233.0 million draw on the Company's revolving credit facility and a portion of the net proceeds of the Public Offering. With the Gentiva Acquisition, the Company expanded its services within its personal care services segment in Arizona, Arkansas, California and North Carolina, and entered the market in Missouri and Texas. The home health segment also was expanded in Tennessee. The related acquisition and integration costs were $10.8 million and $1.0 million, respectively, for the year ended December 31, 2024. These costs are included in general and administrative expenses on the Consolidated Statements of Income and were expensed as incurred.

Based upon management's valuations, the fair values of the assets and liabilities acquired are as follows:

	Total (Amounts in Thousands)
Goodwill	$ 309,898
Identifiable intangible assets	28,600
Cash	19
Accounts receivable	24,715
Property and equipment	1,112
Operating lease assets, net	6,838
Other current assets	71
Accounts payable	(1,555)
Accrued payroll	(5,648)
Operating lease liabilities, total	(6,386)
Deferred tax liabilities, net	(4,099)
Total purchase price	$ 353,565

Identifiable intangible assets acquired included $4.9 million in a trade name, $23.0 million of definite-lived state licenses and $0.7 million of indefinite-lived state licenses. The preliminary estimated fair value of identifiable intangible assets was determined with the assistance of a valuation specialist, using Level 3 inputs as defined under ASC Topic 820. The fair value analysis and related valuations reflect the conclusions of management. All estimates, key assumptions, and forecasts were either provided by or reviewed by the Company. The goodwill and intangible assets acquired are deductible for tax purposes.

The Gentiva Acquisition accounted for $22.6 million of net service revenues and $3.1 million of operating income for the year ended December 31, 2024.

Tennessee Quality Care

On August 1, 2023, the Company completed the acquisition of Tennessee Quality Care. The purchase price was approximately $111.2 million, including the amount of acquired excess cash held by Tennessee Quality Care at the closing of the acquisition (approximately $2.4 million), and is subject to the completion of working capital and related adjustments. The Tennessee Quality Care acquisition was funded with a combination of a $110.0 million draw on the Company's revolving credit facility and available cash. With the purchase of Tennessee Quality Care, the Company expanded its services within its hospice and home health segments to Tennessee. The related acquisition and integration costs were $2.1 million and $1.0 million, respectively, for the year ended December 31, 2023. These costs are included in general and administrative expenses on the Consolidated Statements of Income and were expensed as incurred.

Based upon management's valuations, the fair values of the assets and liabilities acquired are as follows:

	Total (Amounts in Thousands)
Goodwill	$ 79,346
Identifiable intangible assets	26,740
Cash	2,357
Accounts receivable	5,940
Property and equipment	307
Operating lease assets, net	194
Other assets	200
Accrued expenses	(1,407)
Accrued payroll	(2,368)
Long-term operating lease liabilities	(80)
Total purchase price	$ 111,229

Identifiable intangible assets acquired included $7.5 million in a trade name and $19.2 million of indefinite-lived state licenses. The preliminary estimated fair value of identifiable intangible assets was determined with the assistance of a valuation specialist, using Level 3 inputs as defined under ASC Topic 820. The fair value analysis and related valuations reflect the conclusions of management. All estimates, key assumptions, and forecasts were either provided by or reviewed by the Company. The goodwill and intangible assets acquired are deductible for tax purposes.

The Tennessee Quality Care acquisition accounted for $16.3 million of net service revenues and $3.0 million of operating income for the year ended December 31, 2023.

Other Acquisitions

On October 1, 2025, we completed our acquisition of the assets of Gold Horses, LLC for approximately $7.4 million (the "Gold Horses Acquisition") with funding provided by available cash. With the Gold Horses Acquisition, the Company expanded its personal care segment in Texas and recognized goodwill in its personal care segment of $7.4 million.

On March 1, 2025, we completed our acquisition of the assets of Great Lakes Home Care Unlimited, LLC for $2.6 million (the "Great Lakes Acquisition") with funding provided by available cash. With the Great Lakes Acquisition, the Company expanded its personal care segment in Michigan and recognized goodwill in its personal care segment of $2.6 million.

On January 1, 2025, we completed our acquisition of our Jacksonville affiliate for approximately $0.8 million (the "Jacksonville Acquisition"), with funding provided by available cash. With the Jacksonville Acquisition, the Company expanded its personal care segment in Florida and recorded goodwill of $0.8 million.

On March 9, 2024, we completed our acquisition of the operations of Upstate ("Upstate") for $0.4 million, with funding provided by available cash. With the purchase of Upstate, the Company expanded its personal care services segment in South Carolina.

On January 1, 2023, we completed the acquisition of CareStaff for approximately $1.0 million, with funding provided by available cash. With the purchase of CareStaff, the Company expanded its personal care services segment in Florida and recorded goodwill of $0.6 million.

For the year ended December 31, 2025, the following table contains unaudited pro forma Consolidated Income Statement information of the Company as if the Helping Hands Acquisition closed on January 1, 2024. For the year ended December 31, 2024, the following table contains unaudited pro forma Consolidated Income Statement information of the Company as if the Gentiva Acquisition closed on January 1, 2023. For the year ended December 31, 2023, the following table contains unaudited pro forma Consolidated Income Statement information of the Company as if the acquisition of Tennessee Quality Care closed on January 1, 2022.

	For the Years Ended December 31, (Amounts in Thousands, Unaudited)		
	2025	2024	2023
Net service revenues	$ 1,433,474	$ 1,427,474	$ 1,363,545
Operating income from continuing operations	139,646	140,291	129,103
Net income from continuing operations	96,894	104,334	90,340
Net income per common share			
Basic income per share	$ 5.37	$ 6.14	$ 5.65
Diluted income per share	$ 5.27	$ 6.00	$ 5.54

The pro forma disclosures in the table above include adjustments for amortization of intangible assets, tax expense and acquisition costs to reflect results that are more representative of the combined results of the transactions. This pro forma information is presented for illustrative purposes only and may not be indicative of the results of operations that would have actually occurred. In addition, future results may vary significantly from the results reflected in the pro forma information. The unaudited pro forma financial information does not reflect the impact of future events that may occur after the acquisition, such as anticipated cost savings from operating synergies.

5. Divestiture

Effective May 20, 2024, the Company entered into a definitive asset purchase agreement to sell all of the Company's New York operations for a purchase price of up to $23.0 million in cash, subject to certain adjustments, including adjustments for future operating requirements (the "New York Asset Sale"). The purchase included 50% cash consideration, paid out as an initial payment of $4.6 million, $6.9 million paid pro rata as a deferred payment as caregivers are transferred and 50% in the form of contingent consideration for the Company's New York Consumer Directed Personal Assistance Program ("CDPAP") business. The Company entered into a consulting agreement with the purchaser effective May 20, 2024, as the transfer of clients and caregivers and payment for assets pursuant to the New York Asset Sale is occurring over time as regulatory approvals are received, coordination of the transfer of clients and caregivers occurs, and the change of control takes place. The Company determined that the consulting agreement gave it the ability to control the business until October 2024, when the Company determined that it no longer controlled the business as it transferred more than 50% of the clients and caregivers and therefore qualified for the sale consideration of the New York Asset Sale. As a result, the Company deconsolidated the results of its New York operations and recorded a gain on divestiture of $3.7 million during the year ended December 31, 2024. The gain was reflected within general and administrative expenses on the consolidated statement of operations.

In connection with this transaction, the Company ceased operations in New York. During the twelve months ended December 31, 2025, the Company recorded deferred payments of $3.8 million with the remaining $2.3 million due from the purchaser reflected within prepaid expenses and other current assets on the condensed consolidated balance sheets as of December 31, 2025. No amount was recorded related to the CDPAP business contingent consideration.

The New York Asset Sale did not qualify as a discontinued operation because it did not represent a strategic shift that has or will have a major effect on the Company's operation or financial results.

Goodwill and intangible assets of $2.9 million and $4.2 million, respectively, were derecognized in connection with the divestiture. The carrying amounts of the assets and liabilities associated with the New York personal care operations included in our Consolidated Balance Sheets as of December 31, 2025, were as follows (amounts in thousands):

	December 31, 2025
Assets	
Current assets	
Accounts receivable, net of allowances	$ —
Prepaid expenses and other current assets	13
Total current assets	13
Property and equipment, net of accumulated depreciation and amortization	—
Other assets	
Goodwill	—
Intangibles, net of accumulated amortization	—
Operating lease assets, net	2,548
Total other assets	2,548
Total assets	$ 2,561
Liabilities	
Current liabilities	
Accounts payable	$ 201
Accrued payroll	—
Accrued expenses	—
Operating lease liabilities, current portion	602
Total current liabilities	803
Long-term liabilities	
Operating lease liabilities, long-term portion	1,897
Total liabilities	$ 2,700

6. Property and Equipment

Property and equipment consisted of the following:

	December 31,	
	2025	2024
	(Amounts in Thousands)	
Computer software	$ 30,599	$ 27,208
Computer equipment	16,199	12,809
Leasehold improvements	12,228	11,773
Furniture and equipment	7,147	6,532
Transportation equipment	106	231
	66,279	58,553
Less: accumulated depreciation and amortization	(41,281)	(33,850)
	$ 24,998	$ 24,703

Computer software includes $1.3 million of internally developed software for both the years ended December 31, 2025 and 2024. Depreciation and amortization expense totaled $7.8 million, $6.6 million and $6.9 million for the years ended December 31, 2025, 2024 and 2023, respectively.

7. Goodwill and Intangible Assets

A summary of goodwill by segment and related adjustments is provided below:

	Goodwill			
	Hospice	Personal Care	Home Health	Total
	(Amounts In Thousands)			
Goodwill at December 31, 2023	$ 432,799	$ 153,276	$ 76,920	$ 662,995
Additions for acquisitions	—	292,204	18,094	310,298
Adjustments to previously recorded goodwill	41	(2,954)	178	(2,735)
Goodwill at December 31, 2024	432,840	442,526	95,192	970,558
Additions for acquisitions	—	30,187	—	30,187
Adjustments to previously recorded goodwill	26	(3,732)	(343)	(4,049)
Goodwill at December 31, 2025	$ 432,866	$ 468,981	$ 94,849	$ 996,696

In 2025, the Company recognized goodwill in the personal care services segment of $30.2 million related to the Jacksonville Acquisition, the Great Lakes Acquisition, the Helping Hands Acquisition and the Gold Horses Acquisition. In 2024, the Company recognized goodwill in the personal care services segment of $292.2 million related to the acquisition of Upstate and the Gentiva Acquisition and recognized goodwill in the home health segment of $18.1 million related to the Gentiva Acquisition. In connection with the acquisition of Tennessee Quality Care in 2023, the Company recognized goodwill in its hospice and home health segments of $35.0 million and $44.3 million, respectively. The Company also recognized goodwill of $0.6 million related to the CareStaff acquisition in the personal care services segment in 2023.

Goodwill adjustments to previously recorded goodwill are generally related to accounts receivable and accrued expenses based on the final valuations. See Note 4 to the Notes to Consolidated Financial Statements for additional information regarding the acquisitions made by the Company in 2024 and 2023, and Note 5 for additional information regarding the divestiture for New York Asset Sale.

The Company's identifiable intangible assets consist of customer and referral relationships, trade names and trademarks, non-competition agreements and state licenses. Amortization is computed using straight-line and accelerated methods based upon the estimated useful lives of the respective assets, which range from one to twenty years. Customer and referral relationships are amortized systematically over the periods of expected economic benefit, which range from three to fifteen years.

Goodwill and certain state licenses are not amortized pursuant to ASC Topic 350. We test intangible assets with indefinite useful lives for impairment at the reporting unit level on an annual basis, as of October 1, or whenever potential impairment triggers occur, such as a significant change in business climate or regulatory changes that would indicate that an impairment may have occurred. The Company did not record any impairment charges for the years ended December 31, 2025, 2024 or 2023.

For the years ended December 31, 2024 and 2023, the Company performed its annual goodwill impairment test using a quantitative analysis, which compares the estimated fair value of each reporting unit to its carrying value. The Company estimates the fair value of the reporting unit using both a discounted cash flow model as well as a market multiple model. The cash flow forecasts are adjusted by an appropriate discount rate based on the Company's estimate of a market participant's weighted-average cost of capital. These models are both based on the Company's best estimate of future revenues and operating costs and are reconciled to the Company's consolidated market capitalization, with consideration of the amount a potential acquirer would be required to pay, in the form of a control premium. The determination of fair value in the Company's goodwill impairment analysis is based on an estimate of fair value for each reporting unit utilizing known and estimated inputs at the evaluation date. Some of those inputs include, but are not limited to, the most recent price of the Company's common stock and fair value of long term debt, estimates of future revenue and expense growth, estimated market multiples, expected capital expenditures, income tax rates and cost of invested capital. For the years ended December 31, 2024 and 2023, under the quantitative assessment, the Company's estimated fair values of each of its reporting units exceeded the respective carrying amounts.

For the year ended December 31, 2025, the Company elected to perform a qualitative assessment to evaluate whether it was more likely than not that the fair value of each reporting unit is less than its carrying amount. As part of the qualitative assessments, the Company considered (i) the magnitude of the reporting unit's excess fair value over its carrying amount from the most recent quantitative impairment test, (ii) industry and market conditions, including the impacts of the interest rate environment, (iii) historical financial performance, including our revenue, earnings, and operating cash flow growth trends, (iv) the Company's forecasts of revenue, earnings, and operating cash flows, (v) cost factors, including the effects of inflation and rising prices, (vi) the regulatory environment, (vii) other factors specific to each reporting unit, such as a change in strategy, a change in management, or acquisitions and divestitures affecting the composition of the reporting unit and its future operating results, and (viii) consideration of changes in the Company's market capitalization. For the year ended December 31, 2025, under the qualitative assessment, the Company concluded that it was more likely than not that the fair value of each of its reporting units exceeded its respective carrying amounts as of the annual testing date.

The carrying amount and accumulated amortization of each identifiable intangible asset category consisted of the following at December 31, 2025 and 2024:

		December 31, 2025 (Amounts in Thousands)			December 31, 2024 (Amounts in Thousands)		
	Estimated Useful Life	Gross carrying value	Accumulated amortization	Net carrying value	Gross carrying value	Accumulated amortization	Net carrying value
Customer and referral relationships (in years)	3 - 15	$ 34,201	$ (33,656)	$ 545	$ 34,201	$ (33,255)	$ 946
Trade names and trademarks (in years)	1 - 20	59,366	(26,535)	32,831	59,366	(21,900)	37,466
Non-competition agreement (in years)	3 - 5	6,728	(6,663)	65	6,728	(6,263)	465
State Licenses (in years)	6 - 10	26,529	(4,190)	22,339	24,981	(1,243)	23,738
State Licenses	Indefinite	46,630	—	46,630	47,028	—	47,028
Total intangible assets		$ 173,454	$ (71,044)	$ 102,410	$ 172,304	$ (62,661)	$ 109,643

During the year ended December 31, 2025, the Company acquired state licenses of $1.2 million in connection with the Helping Hands Acquisition.

During the year ended December 31, 2024, the Company acquired state licenses and a trade name of $23.0 million and $4.9 million, respectively, in its personal care services segment related to the Gentiva Acquisition. The Company also acquired indefinite-lived state licenses of $0.7 million in its home health segment in connection with the Gentiva Acquisition.

Amortization expense related to the identifiable intangible assets amounted to $8.4 million, $6.7 million and $7.1 million for the years ended December 31, 2025, 2024 and 2023, respectively.

The weighted average remaining useful life of identifiable intangible assets as of December 31, 2025, is 9.11 years.

The estimated future intangible amortization expense is as follows:

For the year ended December 31,	Total (Amount in Thousands)
2026	$ 7,638
2027	7,312
2028	5,601
2029	5,497
2030	5,423
Thereafter	24,309
Total intangible assets subject to amortization	$ 55,780

8. Details of Certain Balance Sheet Accounts

Prepaid expenses and other current assets consisted of the following:

	December 31,	
	2025	2024
	(Amounts in Thousands)	
Income tax receivable	$ 10,520	$ 11,568
Prepaid payroll	7,960	8,716
Prepaid workers' compensation and liability insurance	5,694	4,254
Prepaid licensing fees	4,167	5,414
Workers' compensation insurance receivable	474	810
Other [(1)]	7,364	7,829
Total prepaid expenses and other current assets	$ 36,179	$ 38,591

(1) Included $2.3 and $6.1 million related to the New York Asset Sale deferred payments as of December 31, 2025, and December 31, 2024, respectively.

Accrued expenses consisted of the following:

	December 31,	
	2025	2024
	(Amounts in Thousands)	
Accrued health benefits	$ 6,643	$ 6,637
Accrued professional fees	6,390	5,368
Accrued payroll and other taxes	2,242	4,516
Other	12,916	12,438
Total accrued expenses	$ 28,191	$ 28,959

9. Long-Term Debt

Long-term debt consisted of the following:

	December 31,	
	2025	2024
	(Amounts in Thousands)	
Revolving loan under the credit facility	$ 124,335	$ 223,000
Less unamortized issuance costs	(3,376)	(4,557)
Long-term debt	$ 120,959	$ 218,443

Amended and Restated Senior Secured Credit Facility

On October 31, 2018, the Company entered into the Amended and Restated Credit Agreement, with certain lenders and Capital One, National Association, as a lender and as agent for all lenders, as amended by the First Amendment to Amended and Restated Credit Agreement, dated as of September 12, 2019, as further amended by the Second Amendment to Amended and Restated Credit Agreement, dated as of July 30, 2021, as further amended by the Third Amendment to Amended and Restated Credit Agreement, dated as of April 26, 2023, and as further amended by the Fourth Amendment to Amended and Restated Credit Agreement, dated as of October 22, 2024 (as described below, the "Fourth Amendment") (as amended, the "Credit Agreement", as used throughout this Annual Report on Form 10-K, "credit facility" shall mean the credit facility evidenced by the Credit Agreement). The credit facility consists of a $650.0 million revolving credit facility and a $150.0 million incremental loan facility, which incremental loan facility may be for term loans or an increase to the revolving loan commitments. The maturity of this credit facility is July 30, 2028.

On October 22, 2024, the Company entered into the Fourth Amendment to, among other things, (a) increase the Company's revolving credit facility to an aggregate amount of $650.0 million, (b) increase the Company's incremental loan facility to an aggregate amount of $150.0 million, and (c) extend the maturity date of the credit facility from July 30, 2026 to July 30, 2028.

Interest on the credit facility may be payable at (x) the sum of (i) an applicable margin ranging from 0.75% to 1.50% based on the applicable senior net leverage ratio plus (ii) a base rate equal to the greatest of (a) the rate of interest last quoted by The Wall Street Journal as the "prime rate," (b) the sum of the federal funds rate plus a margin of 0.50% and (c) the sum of Term SOFR (as published by the CME Group Benchmark Administrative Limited) for an interest period of one month for such applicable day (not to be less than 0.00%), plus a margin of 1.00% or (y) the sum of (i) an applicable margin ranging from 1.75% to 2.50% based on the applicable senior net leverage ratio plus (ii) the rate per annum equal to the sum of Term SOFR (as published by the CME Group Benchmark Administrative Limited) for the applicable interest period (not to be less than 0.00%). Swing loans may not be SOFR loans.

Addus HealthCare, Inc. ("Addus HealthCare") is the borrower, and its parent, Holdings, and substantially all of Holdings' subsidiaries are guarantors under this credit facility, and it is collateralized by a first priority security interest in all of the Company's and the other credit parties' current and future tangible and intangible assets, including the shares of stock of the borrower and subsidiaries. The Credit Agreement contains affirmative and negative covenants customary for credit facilities of this type, including limitations on the Company with respect to liens, indebtedness, guaranties, investments, distributions, mergers and acquisitions and dispositions of assets. The availability of additional draws under this credit facility is conditioned, among other things, upon (after giving effect to such draws) the Total Net Leverage Ratio (as defined in the Credit Agreement) not exceeding 3.75:1.00. In certain circumstances, in connection with a Material Acquisition (as defined in the Credit Agreement), the Company can elect to increase its Total Net Leverage Ratio compliance covenant to 4.25:1.00 for the then current fiscal quarter and the three succeeding fiscal quarters.

The Company pays a fee ranging from 0.20% to 0.35% based on the applicable senior net leverage ratio times the unused portion of the revolving loan portion of the credit facility.

The Credit Agreement contains customary affirmative covenants regarding, among other things, the maintenance of records, compliance with laws, maintenance of permits, maintenance of insurance and property and payment of taxes. The Credit Agreement also contains certain customary financial covenants and negative covenants that, among other things, include a requirement to maintain a minimum Interest Coverage Ratio (as defined in the Credit Agreement) and a requirement to stay below a maximum Total Net Leverage Ratio (as defined in the Credit Agreement). The Credit Agreement also contains restrictions on guarantees, indebtedness, liens, investments and loans, subject to customary carve outs, a restriction on dividends (provided that Addus HealthCare may make distributions to the Company in an amount that does not exceed $10.0 million in any year absent of an event of default, plus limited exceptions for tax and administrative distributions), a restriction on the ability to consummate acquisitions (without the consent of the lenders) under its credit facility subject to compliance with the Total Net Leverage Ratio (as defined in the Credit Agreement) thresholds, restrictions on mergers, dispositions of assets, and affiliate transactions, and restrictions on fundamental changes and lines of business. As of December 31, 2025, the Company was in compliance with all financial covenants under the Credit Agreement.

During the twelve months ended December 31, 2025, the Company (i) drew approximately $11.3 million under its credit facility to fund, in part, the Helping Hands Acquisition and (ii) repaid $110.0 million under the revolving credit facility. At December 31, 2025, the Company had a total of $124.3 million of revolving loans, with an interest rate of 5.48%, outstanding on its credit facility. After giving effect to the amount drawn on its credit facility, approximately $7.9 million of outstanding letters of credit and borrowing limits based on an advance multiple of Adjusted EBITDA (as defined in the Credit Agreement), the Company had $650.0 million of capacity and $517.7 million available for borrowing under its credit facility.

During the twelve months ended December 31, 2024, the Company (i) drew approximately $233.0 million under its credit facility to fund, in part, the Gentiva Acquisition and (ii) repaid $136.4 million under the revolving credit facility. At December 31, 2024, the Company had a total of $223.0 million of revolving loans, with an interest rate of 6.34%, outstanding on its credit facility. After giving effect to the amount drawn on its credit facility, approximately $8.0 million of outstanding letters of credit and borrowing limits based on an advance multiple of Adjusted EBITDA (as defined in the Credit Agreement), the Company had $577.7 million of capacity and $346.6 million available for borrowing under its credit facility.

10. Income Taxes

The current and deferred federal and state income tax provision from continuing operations, are comprised of the following:

	For the Years Ended December 31, (Amounts in Thousands)		
	2025	2024	2023
Current			
Federal	$ 10,775	$ 8,998	$ 11,839
State	2,893	3,533	4,139
Deferred			
Federal	14,732	11,258	2,306
State	3,135	1,966	526
Provision for income taxes	$ 31,535	$ 25,755	$ 18,810

The tax effects of certain temporary differences between the Company's book and tax bases of assets and liabilities give rise to significant portions of the deferred income tax assets (liabilities) at December 31, 2025 and 2024. The deferred tax assets (liabilities) consisted of the following:

	For the Years Ended December 31, (Amounts in Thousands)	
	2025	2024
Deferred tax assets		
Long-term		
Accounts receivable allowances	$ 14,343	$ 20,843
Operating lease liabilities	12,802	14,917
Accrued compensation	5,901	5,683
Accrued workers' compensation	3,355	3,253
Transaction costs	2,610	2,547
Stock-based compensation	1,698	1,400
Net operating loss	59	73
Restructuring costs	—	555
Other	2,865	2,517
Total long-term deferred tax assets	43,633	51,788
Deferred tax liabilities		
Long-term		
Goodwill and intangible assets	(72,059)	(61,177)
Operating lease assets, net	(10,562)	(12,521)
Property and equipment	(3,603)	(2,796)
Insurance premiums	(1,446)	(1,079)
Other	(28)	(35)
Total long-term deferred tax liabilities	(87,698)	(77,608)
Total net deferred tax (liabilities) assets	$ (44,065)	$ (25,820)

Management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management considers all available evidence in making this assessment.

A reconciliation for continuing operations of the statutory federal tax rate of 21.0% to the effective income tax rate is summarized as follows:

	For the Years Ended December 31, (Amounts in Thousands)					
	2025		2024		2023	
U.S. federal statutory tax rate	$ 26,763	21.0%	$ 20,864	21.0%	$ 17,079	21.0%
State and local taxes, net of federal income tax effect*	6,019	4.7	5,469	5.5	4,667	5.7
Tax credits						
Work opportunity tax credits, net of federal taxable income add back	(2,923)	(2.3)	(2,844)	(2.9)	(2,765)	(3.4)
Other credit programs	(711)	(0.6)	(474)	(0.4)	(474)	(0.6)
Nontaxable or nondeductible items						
162(m) compensation	4,830	3.8	1,992	2.0	1,409	1.7
Excess tax benefit	(2,433)	(1.9)	(408)	(0.4)	(320)	(0.4)
Stock acquisition cost	—	—	1,081	1.1	4	0.1
Other nondeductible items	181	0.2	130	0.1	176	0.2
Other adjustments						
Federal RTP	(191)	(0.2)	(55)	(0.1)	(966)	(1.2)
Effective income tax rate	$ 31,535	24.7%	$ 25,755	25.9%	$ 18,810	23.1%

* State taxes in Illinois for 2025, 2024, and 2023 made up the majority (greater than 50 percent) of the tax effect within this category.

Cash income taxes paid for continuing operations, disaggregated by federal and state jurisdictions, are summarized as follows:

	For the Years Ended December 31, (Amounts in Thousands)					
	2025		2024		2023	
Federal income tax paid	$ 8,600	68.1%	$ 18,911	72.0%	$ 9,483	63.3%
State income tax paid						
Illinois	2,060	16.3	4,391	16.7	3,262	21.8
New York	—	—	—	—	836	5.6
Tennessee	713	5.6	—	—	—	—
Other states	1,247	10.0	2,949	11.3	1,404	9.3
Total income tax paid (net of refund)	$ 12,620	100.0%	$ 26,251	100.0%	$ 14,985	100.0%

The effective income tax rate was 24.7%, 25.9% and 23.1% for the years ended December 31, 2025, 2024 and 2023, respectively. The difference between our federal statutory and effective income tax rates was principally due to the inclusion of state taxes, non-deductible compensation, partially offset by the use of federal employment tax credits and an excess tax benefit.

The Company is subject to taxation in the jurisdictions in which it operates. The Company continues to remain subject to examination by U.S. federal authorities for the years 2022 through 2024 and for various state authorities for the years 2020 through 2024.

11. Stock Options and Restricted Stock Awards

The Board approved the A&R 2017 Plan as of April 13, 2023, and our shareholders approved it as of June 14, 2023. The A&R 2017 Plan amended and restated our 2017 Omnibus Incentive Plan (the "2017 Plan"), which in turn was intended to replace our 2009 Stock Incentive Plan (the "2009 Plan"). All awards are now granted from the A&R 2017 Plan. Outstanding awards under the 2009 Plan will continue to be governed by the 2009 Plan and the agreements under which they were granted.

The A&R 2017 Plan allows us to grant performance-based incentive awards and equity-based awards (each, an "Award") to eligible employees, directors and consultants in the form of Stock Options, Stock Appreciation Rights ("SARs"), Restricted Stock Restricted Stock Units, Performance Awards and Other Stock Unit Awards. The Board believes that the A&R 2017 Plan is necessary to continue the Company's effectiveness in attracting, motivating and retaining employees, directors and consultants with appropriate experience and to increase the grantees' alignment of interest with the Company's shareholders.

Under the A&R 2017 Plan, Awards may be made in shares of our common stock. Subject to adjustment as provided by the terms of the A&R 2017 Plan, the maximum aggregate number of shares of common stock with respect to which awards may be granted under the A&R 2017 Plan is 864,215, comprised of 274,215 shares (the number of shares that were available for issuance under the 2017 Plan as of April 13, 2023) and 590,000 shares (the number of shares newly authorized by the Company's shareholders upon their approval of the A&R 2017 Plan).. The aggregate awards granted during any calendar year to any single Participant cannot exceed 500,000 shares subject to stock options or SARs. These individual annual limitations are cumulative in that any shares of common stock or cash for which Awards are permitted to be granted to a Participant during a fiscal year are not covered by an Award in that fiscal year (such shortfall, the "Shortfall Amount"), the number of shares of common stock (or amount of cash, as the case may be) will automatically increase in the subsequent fiscal years during the term of the A&R 2017 Plan until the earlier of the time when the Shortfall Amount has been granted to the Participant, or the end of the third fiscal year following the year to which such Shortfall Amount relates. At December 31, 2025, there were 447,366 shares of common stock available for future grant under the A&R 2017 Plan.

Awards made under the 2017 Plan (and the 2009 Plan) that are forfeited, canceled, settled in cash or otherwise terminated without a distribution of shares to a Participant will be deemed available for Awards under the A&R 2017 Plan; provided, that the A&R 2017 Plan explicitly prohibits shares withheld for payment of taxes for awards, the exercise price for appreciation awards, shares acquired with the proceeds of appreciation awards, and shares from stock settled SARs from being added back to the share reserve. Stock options are awarded with an exercise price equal to the fair market value based on the closing price of our common stock on the date of grant. Options granted typically vest over a service period ranging from three to four years and expire ten years from the date of grant. Restricted shares typically vest over a service period ranging from one to four years and expire ten years from date of grant.

Stock options are awarded with an exercise price equal to the fair market value based on the closing price of our common stock on the date of grant. Options granted typically vest over a service period ranging from three to four years and expire ten years from the date of grant. Restricted shares typically vest over a service period ranging from one to four years and expire ten years from date of grant.

The exercise prices of stock options outstanding on December 31, 2025, range from $34.05 to $92.00. Restricted stock awards are full-value awards.

Stock Options

A summary of stock option activity for the year ended December 31, 2025 follows:

	Options (Amounts in Thousands)	Weighted Average Exercise Price	Weighted Average Remaining Contractual Terms (Years)
Outstanding, beginning of period	406	$ 43.51	3.2
Granted	—	—	
Exercised	(110)	22.52	
Forfeited/Cancelled	—	—	
Outstanding, end of period	296	$ 51.31	2.9
Exercisable, end of period	286	$ 50.08	2.8

The Company did not grant any stock options during 2025, 2024, or 2023.

Stock option compensation expense totaled $0.4 million, $0.5 million and $0.9 million for the years ended December 31, 2025, 2024 and 2023, respectively. As of December 31, 2025, there was $0.1 million of total unrecognized compensation cost that is expected to be recognized over a weighted average period of 0.2 years.

The intrinsic value of exercisable and outstanding stock options was $16.4 million and $16.6 million, respectively, as of December 31, 2025.

As of December 31, 2025, there were 286,195 and 9,500 shares of stock options vested and unvested, respectively.

The intrinsic value of stock options exercised during the years ended December 31, 2025, 2024 and 2023 was $10.3 million, $3.0 million and $0.8 million, respectively.

Restricted Stock Awards

A summary of unvested restricted stock awards activity and weighted average grant date fair value for the year ended December 31, 2025 follows:

	Restricted Stock Awards (Amounts in Thousands)	Weighted Average Grant Date Fair Value
Unvested restricted stock awards, beginning of period	244	$ 91.33
Awarded	265	104.25
Vested	(123)	90.47
Forfeited	(5)	98.33
Unvested restricted stock awards, end of period	381	$ 100.52

The fair value of restricted stock awards that vested during the year ended December 31, 2025, was $13.5 million.

Restricted stock award compensation expense totaled $16.0 million, $10.7 million and $9.4 million for the years ended December 31, 2025, 2024 and 2023, respectively. As of December 31, 2025, there was $24.0 million of total unrecognized compensation cost that is expected to be recognized over a weighted average period of 1.7 years.

12. Employee Benefit Plans

The 401(k) retirement plan is a defined contribution plan that provides for matching contributions by the Company to all non-union employees. Matching contributions are discretionary and subject to change by management. Under the provisions of the 401(k) plan, employees can contribute up to the maximum percentage and limits allowable under the U.S. Revenue Code. The Company provided contributions totaling $0.7 million, $0.8 million and $0.6 million for the years ended December 31, 2025, 2024 and 2023, respectively.

13. Commitments and Contingencies

Legal Proceedings

From time to time, the Company is subject to legal and/or administrative proceedings incidental to its business.

It is the opinion of management that the outcome of pending legal and/or administrative proceedings will not have a material effect on the Company's Consolidated Balance Sheets and Consolidated Statements of Income.

Concentration of Cash

The Company owns financial instruments that potentially subject the Company to significant concentrations of credit risk, including cash. The Company maintains cash with financial institutions which, at times, may exceed federally insured limits. The Company believes it is not exposed to any significant credit risk on cash.

14. Segment Information

Operating segments are defined as components of a company that engage in business activities from which it may earn revenues and incur expenses, and for which separate financial information is available and is regularly reviewed by the Company's chief operating decision makers ("CODM"). The Company identifies its Chief Executive Officer and Chief Operating Officer together as CODM to assess the performance of the individual segments and make decisions about resources to be allocated to the segments. The Company operates as a multi-state provider of three business segments providing in-home services.

In its personal care segment, the Company provides non-medical assistance with activities of daily living, primarily to persons who are at increased risk of hospitalization or institutionalization, such as the elderly, chronically ill or disabled. In its hospice segment, the Company provides physical, emotional and spiritual care for people who are terminally ill as well as related services for their families. In its home health segment, the Company provides services that are primarily medical in nature to individuals who may require assistance during an illness or after hospitalization and include skilled nursing and physical, occupational and speech therapy.

The Company's method for measuring profitability on each reportable segment basis is the same as those described in the summary of significant accounting policies and its CODM frequently reviews the actual result to budget variance to allocate resources to the segment and assess its performance. Segment operating income consists of revenue generated by a segment, less the direct costs of service revenues and general and administrative expenses that are incurred directly by the segment. Unallocated general and administrative costs are those costs for functions performed in a centralized manner and therefore not attributable to a particular segment. These costs include accounting, finance, human resources, legal, information technology, corporate office support and facility costs and overall corporate management.

The CODM does not review disaggregated assets by segment. The measure of segment assets is reported on the balance sheet as total consolidated assets.

The tables below set forth information about the Company's reportable segments, including significant expenses, for the years ended December 31, 2025, 2024 and 2023 along with the items necessary to reconcile the segment information to the totals reported in the accompanying consolidated financial statements.

	For the Year Ended December 31, 2025 (Amounts in Thousands)			
	Personal Care	Hospice	Home Health	Total
Net service revenues	$ 1,089,215	$ 262,542	$ 70,773	$ 1,422,530
Direct service personnel	783,101	109,389	39,708	932,198
General and administrative salaries, wages and benefits	74,161	45,998	13,480	133,639
Other segment items [1]	24,752	39,741	5,134	69,627
Segment operating income	207,201	67,414	12,451	287,066
Segment reconciliation:				
Items not allocated at segment level:				
Other general and administrative expenses				132,039
Depreciation and amortization				16,412
Interest income				(2,442)
Interest expense				13,612
Income before income taxes				$ 127,445

[1] Other segment items include other costs for direct service personnel, office expense, licenses & taxes, communication, medical director fees, travel and bad debt expense.

	For the Year Ended December 31, 2024			
	(Amounts in Thousands)			
	Personal Care	Hospice	Home Health	Total
Net service revenues	$ 856,581	$ 228,191	$ 69,827	$ 1,154,599
Direct service personnel	613,160	97,128	42,631	752,919
General and administrative salaries, wages and benefits	48,485	41,370	14,349	104,204
Other segment items [1]	20,719	37,762	4,913	63,394
Segment operating income	174,217	51,931	7,934	234,082
Segment reconciliation:				
Items not allocated at segment level:				
Other general and administrative expenses				117,861
Depreciation and amortization				13,530
Interest income				(4,394)
Interest expense				7,732
Income before income taxes				$ 99,353

[1] Other segment items include other costs for direct service personnel, office expense, licenses & taxes, communication, medical director fees, travel and bad debt expense.

	For the Year Ended December 31, 2023			
	(Amounts in Thousands)			
	Personal Care	Hospice	Home Health	Total
Net service revenues	$ 794,718	$ 207,155	$ 56,778	$ 1,058,651
Direct service personnel	571,445	87,851	34,244	693,540
General and administrative salaries, wages and benefits	47,302	38,843	11,501	97,646
Other segment items [1]	18,442	35,608	4,021	58,071
Segment operating income	157,529	44,853	7,012	209,394
Segment reconciliation:				
Items not allocated at segment level:				
Other general and administrative expenses				104,312
Depreciation and amortization				14,126
Interest income				(1,476)
Interest expense				11,106
Income before income taxes				$ 81,326

[1] Other segment items include other costs for direct service personnel, office expense, licenses & taxes, communication, medical director fees, travel and bad debt expense.

15. Significant Payors

For 2025, 2024 and 2023, the Company's revenue by payor type was as follows:

	Personal Care					
	For the Years Ended December 31,					
	2025		2024		2023	
	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues
State, local and other governmental programs	$ 553,475	50.8%	$ 456,885	53.3%	$ 400,753	50.4%
Managed care organizations	501,528	46.0	376,604	44.0	367,557	46.2
Private pay	27,871	2.6	15,589	1.8	16,268	2.0
Commercial insurance	5,609	0.5	5,593	0.7	6,321	0.8
Other	732	0.1	1,910	0.2	3,819	0.6
Total personal care segment net service revenues	$ 1,089,215	100.0%	$ 856,581	100.0%	$ 794,718	100.0%

	Hospice					
	For the Years Ended December 31,					
	2025		2024		2023	
	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues
Medicare	$ 244,344	93.1%	$ 208,099	91.2%	$ 186,317	89.9%
Commercial insurance	8,558	3.3	11,744	5.2	12,385	6.0
Managed care organizations	8,155	3.1	7,603	3.3	7,037	3.4
Other	1,485	0.5	745	0.3	1,416	0.7
Total hospice segment net service revenues	$ 262,542	100.0%	$ 228,191	100.0%	$ 207,155	100.0%

	Home Health					
	For the Years Ended December 31,					
	2025		2024		2023	
	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues
Medicare	$ 47,701	67.4%	$ 48,562	69.5%	$ 41,078	72.3%
Managed care organizations	17,010	24.0	17,603	25.2	12,613	22.2
State, local and other governmental programs (excluding Medicare)	4,001	5.7	639	1.0	440	0.8
Other	2,061	2.9	3,023	4.3	2,647	4.7
Total home health segment net service revenues	$ 70,773	100.0%	$ 69,827	100.0%	$ 56,778	100.0%

The Company derives a significant amount of its revenue from its operations in Illinois, New Mexico, Ohio, Tennessee and Texas. The percentages of segment revenue for each of these significant states and New York for 2025, 2024 and 2023 were as follows:

	Personal Care					
	For the Years Ended December 31,					
	2025		2024		2023	
	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues
Illinois	$ 458,828	42.1%	$ 441,012	51.5%	$ 411,081	51.7%
Texas	216,712	19.9	17,936	2.0	—	—
New Mexico	118,588	10.9	115,381	13.5	115,986	14.6
New York [1]	—	—	71,763	8.4	92,469	11.6
All other states	295,087	27.1	210,489	24.6	175,182	22.1
Total personal care segment net service revenues	$ 1,089,215	100.0%	$ 856,581	100.0%	$ 794,718	100.0%

[1] As a result of changes and uncertainty in New York regarding the CDPAP, the Company determined that its New York personal care operations no longer fit its growth strategy and divested these operations. See Note 5 to the Notes to Consolidated Financial Statements, *Divestiture*, for additional details regarding our divestiture.

With the Jacksonville Acquisition, the Great Lakes Acquisition, the Helping Hands Acquisition and the Gold Horses Acquisition in 2025, the Company expanded its personal care services to consumers in the state of Florida, Michigan, Pennsylvania and Texas. With the acquisition of Upstate and the Gentiva Acquisition in 2024, the Company expanded its personal care services to consumers in the state of Arizona, Arkansas, California, Missouri, North Carolina, South Carolina and Texas.

	Hospice					
	For the Years Ended December 31,					
	2025		2024		2023	
	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues
Ohio	$ 101,833	38.8%	$ 84,811	37.2%	$ 74,871	36.1%
New Mexico	32,865	12.5	28,532	12.5	30,782	14.9
Illinois	60,427	23.0	52,560	23.0	47,247	22.8
All other states	67,417	25.7	62,288	27.3	54,255	26.2
Total hospice segment net service revenues	$ 262,542	100.0%	$ 228,191	100.0%	$ 207,155	100.0%

With the Helping Hands Acquisition in 2025, the Company entered the hospice market in Pennsylvania, and with the acquisition of Tennessee Quality Care in 2023, the Company expanded its hospice services to patients in the state of Tennessee.

	Home Health					
	For the Years Ended December 31,					
	2025		2024		2023	
	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues	Amount (in Thousands)	% of Segment Net Service Revenues
New Mexico	$ 34,724	49.1%	$ 32,766	46.9%	$ 32,949	58.0%
Tennessee	28,209	39.9	26,497	38.0	10,978	19.4
Illinois	7,171	10.1	10,564	15.1	12,851	22.6
All other states	669	0.9	—	—	—	—
Total home health segment net service revenues	$ 70,773	100.0%	$ 69,827	100.0%	$ 56,778	100.0%

With the Gentiva Acquisition in 2024 and the acquisition of Tennessee Quality Care in 2023 expanded the Company’s home health operations in Tennessee.

A substantial portion of the Company's revenue and accounts receivable is derived from services performed for state and local governmental agencies. We derive a significant amount of our net service revenues in Illinois, which represented 37.0%, 43.7% and 44.5% of our net service revenues for the years ended December 31, 2025, 2024 and 2023, respectively. The Illinois Department on Aging, the largest payor program for the Company's Illinois personal care operations, accounted for 18.1%, 21.0% and 20.9% of the Company's net service revenues for 2025, 2024 and 2023, respectively.

The related receivables due from the Illinois Department on Aging represented 25.2% and 21.7% of the Company's net accounts receivable at December 31, 2025 and 2024, respectively.

16. ARPA Spending Plans

In recognition of the significant threat to the liquidity of financial markets and challenges to healthcare providers posed by the COVID-19 pandemic, the Federal Reserve and Congress took dramatic actions to provide liquidity to businesses and the banking system in the United States and to assist healthcare providers, including through relief legislation such as the American Rescue Plan Act of 2021 ("ARPA"). The ARPA provides for $350 billion in relief funding for eligible state, local, territorial, and Tribal governments to mitigate the fiscal effects of the COVID-19 public health emergency. Additionally, the law provides for a 10-percentage point increase in federal matching funds for Medicaid home and community-based services ("HCBS") from April 1, 2021, through March 31, 2022, provided the state satisfied certain conditions. States are permitted to use the state funds equivalent to the additional federal funds through March 31, 2025. States must use the monies attributable to this matching fund increase to supplement, not supplant, their level of state spending for the implementation of activities enhanced under the Medicaid HCBS in effect as of April 1, 2021.

HCBS spending plans for the additional matching funds vary by state, but common initiatives in which the Company is participating include those aimed at strengthening the provider workforce (e.g., efforts to recruit, retain, and train direct service providers). The Company is required to properly and fully document the use of such funds in reports to the state in which the funds originated. Funds may be subject to recoupment if not expended or if they are expended on non-approved uses.

The Company received state funding provided by the ARPA in an aggregate amount of $7.2 million and $15.7 million December 31, 2025 and 2024, respectively. The Company utilized $6.8 million and $10.2 million of these funds during the years ended December 31, 2025 and 2024, respectively, primarily for caregivers and adding support to recruiting and retention efforts. The deferred portion of ARPA funding was $11.7 million and $11.2 million as of December 31, 2025 and 2024, respectively, which is included within Government stimulus advances on the Company's Consolidated Balance Sheets.

17. Related Party Transactions

In December 2024, the Company completed the Gentiva Acquisition, which included an agreement with Gentiva's software provider, HHAeXchange. Darin Gordon, a member of the Company's board of directors, serves on the board of directors of HHAeXchange. For the year ended December 31, 2025, the Company paid $2.0 million to HHAeXchange for related services provided in the ordinary course of business. In addition, the Company received services from MetaSource. Mark First, a member of the Company's board of directors, serves on the board of directors of MetaSource. For the year ended December 31, 2025, the Company paid $0.4 million to MetaSource for related services provided in the ordinary course of business.

Exhibit 21.1

SUBSIDIARIES OF THE REGISTRANT

Name of Subsidiary	State of Incorporation	Doing Business As Name
A Plus Health Care, Inc.	Montana	A-Plus HealthCare
Addus HealthCare, Inc.	Illinois	Addus HomeCare; Arcadia Home Care & Staffing
Addus HealthCare (Delaware), Inc.	Delaware	Addus HomeCare Delaware
Addus HealthCare (Idaho), Inc.	Delaware	Addus HomeCare
Addus HealthCare (South Carolina), Inc.	Delaware	Addus HomeCare; Arcadia Home Care & Staffing
Addus Home Office, LLC	Delaware	N/A
Addus Hospice of Illinois, LLC	Delaware	JourneyCare - Barrington; JourneyCare - Deerfield; JourneyCare - Crystal Lake; JourneyCare - Palos Heights
Addus Nurse Care, Inc.	Delaware	Lifestyle Options; Arcadia Home Care & Staffing
Alamo Area Home Hospice, LP	Texas	Alamo Hospice
Alliance Home Health Care, LLC	New Mexico	Ambercare
Ambercare Corporation	New Mexico	N/A
Ambercare Home Health Care Corporation	New Mexico	Ambercare Home Health; Ambercare Personal Care Services
Ambercare Hospice, Inc.	New Mexico	Ambercare
Apple Home Healthcare, LTD	Illinois	JourneyCare Home Health - Chicago
Armada Hospice of New Mexico, LLC	Delaware	Armada Hospice of New Mexico, LLC
Armada Hospice of Santa Fe, LLC	Delaware	Armada Hospice of Santa Fe, LLC
Armada Skilled Home Care of New Mexico, LLC	Delaware	Ambercare Home Health
Coastal Nursecare of Florida, Inc.	Florida	Addus HomeCare
County Homemakers Inc.	Pennsylvania	Arcadia Home Care & Staffing
Cura Partners, LLC	Tennessee	Addus HomeCare
Girling Health Care, Inc.	Texas	Girling Personal Care
Girling Health Care Services of Knoxville, Inc.	Tennessee	The Home Option
Helping Hands Home Care Service, Inc.	Pennsylvania	Helping Hands Home Care Service; Helping Hands Health Network
Hospice Partners of America, LLC	Delaware	Hospice Partners of America
Hospice Partners of America Holding, LLC	Delaware	Alamo Hospice of Conroe; Alamo Hospice of Waco; Hospice of Virginia
Hospice Partners of Texas, LLC	Delaware	N/A
House Calls of New Mexico, LLC	New Mexico	House Calls of New Mexico
HPA Idaho, LLC	Idaho	Harrison's Hope Hospice; Harrison's Hope Hospice Twin Falls
HPA Medical Management, LLC	Delaware	Alamo Supportive Care; Serenity Supportive Care; JourneyCare Palliative Care, Hospice of Virginia Supportive Care
H&PC of America, LLC	Delaware	N/A
IntegraCare of Abilene, LLC	Texas	Arcadia Home Care & Staffing
Miracle City Hospice, LLC	Delaware	Miracle City Hospice
New Capital Partners II-HS, Inc.	Delaware	N/A
NP Plus, LLC	Delaware	Arcadia Home Care & Staffing
Options Service, Inc.	Colorado	Ambercare Personal Care Services
PHC Acquisition Corporation	California	Addus HomeCare
PRAC Holdings, Inc.	Delaware	Arcadia Home Care & Staffing
Priority Home Health Care, Inc.	Ohio	Addus HomeCare; Arcadia Home Care & Staffing
Professional Reliable Nursing Service, Inc.	California	Arcadia Home Care & Staffing
Queen City Hospice, LLC	Delaware	Queen City Hospice; Day City Hospice; Capital City Hospice, Queen City Hospice East
Serenity Palliative Care and Hospice, LLC	Delaware	Serenity Hospice
SLHC, Inc.	Arizona	Sunlife Home Care
South Shore Home Health Service, Inc.	New York	Addus HomeCare
Summit Home Health, LLC	Illinois	JourneyCare Home Health

Tennessee Valley Home Care, LLC	Tennessee	Tennessee Quality Care - Home Health Central; Tennessee Quality Care - Home Health; Tennessee Quality Care - Home Health West; Tennessee Quality Care - Home Health East
TR&B, LLC	Texas	TR&B
Tri County Home Health and Hospice, LLC	Tennessee	Tennessee Quality Care-Hospice

Pursuant to Item 601(b)(21)(ii) of Regulation S-K, certain subsidiaries have been omitted because, when considered in the aggregate, they do not constitute a significant subsidiary.

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-3 (No. 333-289894) and on Form S-8 (Nos. 333-272871, 333-219946, 333-190433, and 333-164413) of Addus HomeCare Corporation of our report dated February 24, 2026 relating to the financial statements and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP
Dallas, Texas
February 24, 2026

Exhibit 31.1

CERTIFICATION

I, R. Dirk Allison, Chief Executive Officer and Chairman of the Board of Addus HomeCare Corporation certify that:

1. I have reviewed this annual report on Form 10-K of Addus HomeCare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting, to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: February 24, 2026

/s/ R. Dirk Allison

R. Dirk Allison
Chief Executive Officer and Chairman of the Board

Exhibit 31.2

CERTIFICATION

I, Brian Poff, Chief Financial Officer of Addus HomeCare Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of Addus HomeCare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting, to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: February 24, 2026

/s/ Brian Poff

Brian Poff
Chief Financial Officer

Exhibit 32.1

CERTIFICATION OF CHIEF EXECUTIVE OFFICER
PURSUANT TO 18 U.S.C. SECTION 1350
(AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002)

In connection with the Annual Report on Form 10-K for the fiscal year ended December 31, 2025 of Addus HomeCare Corporation (the "Company") as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, R. Dirk Allison, Chief Executive Officer and Chairman of the Board of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 24, 2026

BY: /s/ R. Dirk Allison

R. Dirk Allison
Chief Executive Officer and Chairman of the Board

Exhibit 32.2

CERTIFICATION OF CHIEF FINANCIAL OFFICER
PURSUANT TO 18 U.S.C. SECTION 1350
(AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002)

In connection with the Annual Report on Form 10-K for the fiscal year ended December 31, 2025 of Addus HomeCare Corporation (the "Company") as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Brian Poff, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 24, 2026

BY: /s/ Brian Poff

Brian Poff
Chief Financial Officer

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K/A
(Amendment No. 1)

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

For the fiscal year ended December 31, 2025

OR

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

For the transition period from to

Commission file number 001-34504

ADDUS HOMECARE CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**20-5340172**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
6303 Cowboys Way, Suite 600 Frisco, TX	**75034**
(Address of principal executive offices)	(Zip Code)

469-535-8200
(Registrant's telephone number, including area code)

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $0.001 par value	ADUS	The Nasdaq Stock Market LLC

Securities registered pursuant to Section 12(g) of the Act: None

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

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

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

Indicate by check mark whether the registrant has submitted electronically 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 ☒ No ☐

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

Large Accelerated Filer	☒	Accelerated Filer	☐
Non-Accelerated Filer	☐	Smaller Reporting Company	☐
		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 has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b). ☐

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

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the registrant, based on the last sale price on The Nasdaq Stock Market LLC on June 30, 2025 (the last business day of the registrant's most recently completed second fiscal quarter) was approximately $2,065,724,000.

As of March 11, 2026, there were 18,643,615 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Certain portions of the registrant's Definitive Proxy Statement for its 2026 Annual Meeting of Stockholders (which is expected to be filed with the Commission within 120 days after the end of the registrant's 2025 fiscal year) are incorporated by reference into Part III of this Annual Report on Form 10-K.

Auditor Firm PCAOB Id: 238 Auditor Name: PricewaterhouseCoopers LLP Auditor Location: Dallas, Texas

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EXPLANATORY NOTE

This Amendment No. 1 ("Amendment") on Form 10-K/A amends the Annual Report on Form 10-K of Addus HomeCare Corporation (the "Company") for the fiscal year ended December 31, 2025, as filed with the Securities and Exchange Commission (the "Commission") on February 24, 2026 (the "Original Filing"). We are filing this Amendment to the Original Filing solely for the purpose of updating the cover page of the Original Filing, incorporating by reference Exhibit 19.1, the Company's Insider Trading Policy, and Exhibit 97.1, the Company's Compensation Recoupment Policy, that were inadvertently omitted from the Original Filing, as well as making certain other ministerial changes to the Exhibit Index.

This Amendment hereby amends and restates the cover page to the Original Filing. Additionally, this Amendment hereby amends and restates Item 15 of Part IV of the Original Filing to incorporate by reference Exhibit 19.1 and Exhibit 97.1 and to reference the consolidated financial statements previously filed with the Original Filing. Pursuant to Rule 12b-15 of the Securities Exchange Act of 1934, as amended, this Amendment contains new certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002, as amended. Because no consolidated financial statements have been included in this Amendment and this Amendment does not contain or amend any disclosure with respect to Items 307 and 308 of Regulation S-K, paragraphs 3, 4 and 5 of the certifications have been omitted.

Except for the foregoing amended information or where otherwise noted, this Amendment does not reflect events that occurred after the filing of the Original Filing, or modify or update those disclosures that may be affected by subsequent events, and no other changes are being made to any other disclosure contained in the Original Filing.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) (1), (2) The Financial Statements filed as part of this report are indexed on page F-1 of the Original Filing and incorporated by reference to the Original Filing and are not included as part of this Amendment. All schedules are omitted, either because they are not applicable or because the required information is shown in the financial statements or the notes thereto.

(b) Exhibits

EXHIBIT INDEX

Exhibit Number	Description of Document	Incorporated by Reference			
		Form	File No.	Date Filing	Exhibit Number
3.1	Amended and Restated Certificate of Incorporation of Addus HomeCare Corporation dated as of October 27, 2009.	10-Q	001-34504	11/20/2009	3.1
3.2	Amended and Restated Bylaws of Addus HomeCare Corporation, as amended by the First Amendment to Amended and Restated Bylaws.	10-Q	001-34504	05/9/2013	3.2
4.1	Form of Common Stock Certificate.	S-1/A	333-160634	10/2/2009	4.1
4.2	Description of Securities of Addus HomeCare Corporation Registered under Section 12 of the Exchange Act.	10-K	001-34504	8/10/2020	4.2
10.1*	Addus Holding Corporation 2006 Stock Incentive Plan.	S-1	333-160634	7/17/2009	10.12
10.2*	Director Form of Non-Qualified Stock Option Certificate under the 2006 Stock Incentive Plan.	S-1	333-160634	7/17/2009	10.13
10.3*	Executive Form of Non-Qualified Stock Option Certificate under the 2006 Stock Incentive Plan.	S-1	333-160634	7/17/2009	10.14
10.4	2009 Form of Indemnification Agreement.	S-1	333-160634	7/17/2009	10.16
10.5*	Form of Addus HomeCare Corporation 2009 Stock Incentive Plan.	S-1/A	333-160634	9/21/2009	10.20
10.6*	Form of Nonqualified Stock Option Award Agreement pursuant to the 2009 Stock Incentive Plan.	S-1/A	333-160634	9/21/2009	10.20(a)
10.7*	Form of Restricted Stock Award Agreement pursuant to the 2009 Stock Incentive Plan.	S-1/A	333-160634	9/21/2009	10.20(b)
10.8	Securities Purchase Agreement, dated as of April 24, 2015, by and among Addus HealthCare, Inc., Margaret Coffey, Carol Kolar, South Shore Home Health Service, Inc. and Acaring Home Care, LLC.	10-Q	001-34504	5/8/2015	10.1

10.9	Credit Agreement, dated as of May 8, 2017, by and among Addus Healthcare, Inc., as the Borrower, the other parties from time to time a party thereto, and Capital One, National Association, as a Lender and Swing Lender and as Agent for all Lenders, Suntrust Bank, as Documentation Agent, Bank of the West, Compass Bank, Fifth Third Bank and JPMorgan Chase Bank, N.A., as Co-Syndication Agents, the other financial institutions party thereto, as Lenders, Capital One, National Association, Bank of the West, Compass Bank, Fifth Third Bank and JPMorgan Chase Bank, N.A. and Suntrust Robinson Humphrey as Joint Lead Arrangers and Capital One, National Association, as Sole Bookrunner.	10-Q	001-34504	5/9/2017	10.3
10.10*	Addus HomeCare Corporation's 2017 Omnibus Incentive Plan, effective as of April 27, 2017.	8-K	001-34504	6/16/2017	10.1
10.11*	Form of Nonqualified Stock Option Award Agreement pursuant to the 2017 Omnibus Incentive Plan.	10-K	001-34504	3/14/2018	10.28
10.12*	Form of Restricted Stock Award Agreement pursuant to the 2017 Omnibus Incentive Plan.	10-K	001-34504	3/14/2018	10.29
10.13	Stock Purchase Agreement, dated February 27, 2018, by and among Addus Healthcare, Inc., Michael J. Merrell and Mary E. Merrell, individually, Michael J. Merrell and Mary E. Merrell, as Trustees of the Merrell Revocable Trust UTA dated June 3, 2012, and Michael J. Merrell and Mary E. Merrell, as Trustees of the Ambercare Corporation Employee Stock Ownership Plan Trust.	8-K	001-34504	3/5/2018	10.1
10.14	Amended and Restated Credit Agreement, dated October 31, 2018, by and among Addus HealthCare, Inc., as borrower, the Company, the other Credit Parties party thereto, the Lenders and L/C Issuers party thereto, and Capital One, National Association, as administrative agent.	10-Q	001-34504	11/8/2018	10.2
10.15*	Second Amended and Restated Employment and Non-Competition Agreement, dated November 5, 2018, by and between Addus HealthCare, Inc. and R. Dirk Allison.	10-Q	001-34504	11/8/2018	10.3
10.16*	Second Amended and Restated Employment and Non-Competition Agreement, dated November 5, 2018, by and between Addus HealthCare, Inc. and Brian Poff.	10-Q	001-34504	11/8/2018	10.4
10.17*	Second Amended and Restated Employment and Non-Competition Agreement, dated November 5, 2018, by and between Addus HealthCare, Inc. and Darby Anderson.	10-Q	001-34504	11/8/2018	10.6
10.18*	Second Amended and Restated Employment and Non-Competition Agreement, dated November 5, 2018, by and between Addus HealthCare, Inc. and W. Bradley Bickham.	10-Q	001-34504	11/8/2018	10.7
10.19*	Employment and Non-Competition Agreement, effective April 29, 2019, by and between Addus HealthCare, Inc. and Sean Gaffney.	8-K	001-34504	4/8/2019	99.2
10.20*	Amended and Restated Employment and Non-Competition Agreement, effective November 7, 2019, by and between Addus HealthCare, Inc. and David Tucker.	10-K	001-34504	8/10/2020	10.40

10.21*	Amended and Restated Employment and Non-Competition Agreement, effective November 7, 2019, by and between Addus HealthCare, Inc. and Mike Wattenbarger.	10-K	001-34504	8/10/2020	10.41
10.22	Equity Purchase Agreement, dated August 25, 2019, by and among Addus Healthcare, Inc., Hospice Partners of America, LLC, New Capital Partners II – HS, Inc., Senior Care Services, LLC, Eastside Partners II, L.P., and New Capital Partners II, LLC.	S-3ASR	333-233600	9/3/2019	2.1
10.23	First Amendment to Amended and Restated Credit Agreement, dated as of September 12, 2019, by and among Addus HealthCare, Inc., as the Borrower, Addus HomeCare Corporation, other Credit Parties party thereto, Capital One, National Association, as administrative agent and as a Lender, and the other Lenders party thereto.	8-K	001-34504	9/13/2019	10.1
10.24	Unit Purchase Agreement, dated November 10, 2020, by and among Addus Healthcare, Inc., Queen City Hospice, LLC, Miracle City Hospice, LLC, and QCH Holdings LLC.	10-K	001-34504	3/1/2021	10.45
10.25	Amendment to Unit Purchase Agreement, dated December 3, 2020, by and among Addus Healthcare, Inc., Queen City Hospice, LLC, Miracle City Hospice, LLC, and QCH Holdings LLC.	10-K	001-34504	3/1/2021	10.46
10.26*	Employment and Non-Competition Agreement, effective June 14, 2021, by and between Addus HealthCare, Inc. and Roberton James Stevenson.	10-Q	001-34504	8/4/2021	10.2
10.27**	Second Amendment to Amended and Restated Credit Agreement, dated as of July 30, 2021, by and among Addus HealthCare, Inc., as the Borrower, Addus HomeCare Corporation, the other Credit Parties party thereto, Capital One, National Association, as administrative agent and as a Lender, and the other Lenders party thereto.	8-K	001-34504	8/4/2021	10.1
10.28*	2022 Form of Indemnification Agreement.	10-K	001-34504	2/25/2022	10.50
10.29*	Amended and Restated Employment and Non-Competition Agreement, effective March 1, 2022, by and between Addus HealthCare, Inc. and Monica Raines.	10-Q	001-34504	5/3/2022	10.1
10.30*	Employment and Non-Competition Agreement, effective April 20, 2022, by and between Addus HealthCare, Inc. and Cliff Blessing.	10-Q	001-34504	8/2/2022	10.1
10.31	Third Amendment to Amended and Restated Credit Agreement, dated as of April 26, 2023, by and among Addus HealthCare, Inc., as the Borrower, Addus HomeCare Corporation, the other Credit Parties party thereto, Capital One, National Association, as administrative agent and as a Lender, and the other Lenders party thereto.	10-Q	001-34504	5/2/2023	10.1
10.32*	Addus HomeCare Corporation Amended and Restated 2017 Omnibus Incentive Plan.	8-K	001-34504	6/15/2023	10.1
10.33**	Membership Interests Purchase Agreement, dated June 28, 2023, by and among Addus HealthCare, Inc., HHH Newco Holdings, LLC, American Health Companies, LLC, American Home Care, LLC, Homecare, LLC, Tennessee Valley Home Care, LLC, and Tri-County Home Health and Hospice, LLC.	10-Q	001-34504	8/1/2023	10.2

10.34	Stock and Asset Purchase Agreement, dated June 8, 2024, by and between Addus HealthCare, Inc. and Curo Health Services, LLC.	8-K/A	001-34504	6/26/2024	10.1
10.35**	Fourth Amendment to Amended and Restated Credit Agreement, dated as of October 22, 2024, by and among Addus HealthCare, Inc., as the Borrower, Addus HomeCare Corporation, the other Credit Parties party thereto, Capital One, National Association, as administrative agent and as a Lender, and the other Lenders party thereto.	8-K	001-34504	10/23/2024	10.1
10.36*	Retention and Transition Agreement, dated March 10, 2025, by and between Addus Healthcare, Inc. and W. Bradley Bickham.	8-K	001-34504	3/11/2025	10.1
10.37*	Third Amended and Restated Employment and Non-Competition Agreement, dated March 10, 2025, by and between Addus Healthcare, Inc. and R. Dirk Allison.	8-K	001-34504	3/11/2025	10.2
10.38*	Employment and Non-Competition Agreement, dated August 4, 2025, by and between Addus Healthcare, Inc. and Heather Dixon.	8-K	001-34504	8/7/2025	10.1
10.39*	Amended and Restated Retention and Transition Agreement, dated August 4, 2025, by and between Addus Healthcare, Inc. and W. Bradley Bickham.	8-K	001-34504	8/7/2025	10.2
19.1	Addus Homecare Corporation Insider Trading Policy.	10-K	001-34504	2/25/2025	19.1
21.1	Subsidiaries of Addus HomeCare Corporation.	10-K	001-34504	2/24/2026	21.1
23.1	Consent of PricewaterhouseCoopers LLP, Independent Registered Public Accounting Firm.	10-K	001-34504	2/24/2026	23.1
31.1	Certification of Chief Executive Officer Pursuant to Rule 13-14(a) of the Securities Exchange Act of 1934 as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.	10-K	001-34504	2/24/2026	31.1
31.2	Certification of Chief Financial Officer Pursuant to Rule 13-14(a) of the Securities Exchange Act of 1934 as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.	10-K	001-34504	2/24/2026	31.2
31.3	Certification of Chief Executive Officer Pursuant to Rule 13-14(a) of the Securities Exchange Act of 1934 as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002, as amended.				
31.4	Certification of Chief Financial Officer Pursuant to Rule 13-14(a) of the Securities Exchange Act of 1934 as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002, as amended.				
32.1	Certification of Chief Executive Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	10-K	001-34504	2/24/2026	32.1
32.2	Certification of Chief Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.	10-K	001-34504	2/24/2026	32.2
97.1	Addus Homecare Corporation Compensation Recoupment Policy.	10-K	001-34504	2/27/2024	97.1

101.INS	Inline XBRL Instance Document (the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document).
101.SCH	Inline XBRL Taxonomy Extension Schema Document.
101.CAL	Inline XBRL Taxonomy Calculation Linkbase Document.
101.LAB	Inline XBRL Taxonomy Label Linkbase Document.
101.PRE	Inline XBRL Presentation Linkbase Document.
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document.
104	Cover Page Interactive Data File (embedded within the Inline XBRL document and contained in Exhibit 101).

* Management compensatory plan or arrangement

** Schedules and exhibits have been omitted pursuant to Item 601 of Regulation S-K. The Company hereby undertakes to furnish supplementally a copy of any of the omitted schedules and exhibits upon request by the Securities and Exchange Commission.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Addus HomeCare Corporation

By: /s/ R. DIRK ALLISON

R. Dirk Allison,
Chief Executive Officer and
Chairman of the Board

Date: March 12, 2026

Exhibit 31.3

CERTIFICATION

I, R. Dirk Allison, Chief Executive Officer and Chairman of the Board of Addus HomeCare Corporation certify that:

1. I have reviewed this Amendment No. 1 to the annual report on Form 10-K of Addus HomeCare Corporation (the "Registrant"); and

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report.

Date: March 12, 2026

/s/ R. Dirk Allison

R. Dirk Allison
Chief Executive Officer and Chairman of the Board

Exhibit 31.4

CERTIFICATION

I, Brian Poff, Chief Financial Officer of Addus HomeCare Corporation, certify that:

1. I have reviewed this Amendment No. 1 to the annual report on Form 10-K of Addus HomeCare Corporation (the "Registrant"); and

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report.

Date: March 12, 2026

/s/ Brian Poff

Brian Poff
Chief Financial Officer

Company Information

Executive Officers

R. Dirk Allison
Chairman of the Board and
Chief Executive Officer

Heather Dixon
President and
Chief Operating Officer

Darby Anderson
Executive Vice President and
Chief Government Relations
Officer

Cliff Blessing
Executive Vice President and
Chief Development Officer

Sean Gaffney
Executive Vice President and
Chief Legal Officer

Brian Poff
Executive Vice President and
Chief Financial Officer,
Treasurer and Secretary

Monica Raines
Executive Vice President and
Chief Compliance and
Quality Officer

Robby Stevenson
Executive Vice President and
Chief Human Resource Officer

David Tucker
Executive Vice President and
Chief Strategy Officer

Mike Wattenbarger
Executive Vice President and
Chief Information Officer

Board of Directors

R. Dirk Allison [4]
Chairman of the Board and
Chief Executive Officer

Michael Earley [1][3]
Former Chairman and
Chief Executive Officer,
Metropolitan Health Networks, Inc.
(a healthcare services company)

Mark L. First [2]
Lead Director
Managing Director,
Eos Management, L.P.
(a private investment firm)

Darin J. Gordon [1][4]
President and
Chief Executive Officer,
Gordon & Associates, LLC
(a healthcare consulting firm)

Veronica Hill-Milbourne [4]
President and Chief Executive
Officer of Spectrum Health
Services, Inc.
(a healthcare services company)

Esteban López, M.D. [3]
Partner,
West Monroe Healthcare
Consulting
(a healthcare consulting company)

Jean Rush [1][2]
Former Executive Vice Presdent–
Government Markets,
Highmark Inc.
(a health insurance company)

Susan T. Weaver, M.D., FACP [2][3]
Former President and
Chief Executive Officer,
KEPRO
(a healthcare information company)

[1] Audit Committee
[2] Compensation Committee
[3] Nominating and Corporate Governance Committee
[4] Government Affairs Committee

Corporate Headquarters
6303 Cowboys Way, Suite 600
Frisco, TX 75034
(469) 535-8200

Annual Meeting
The annual meeting of share-
holders will be held on June 10,
2026, at 10:00 A.M. (central).

Form 10-K
The Company has filed an
annual report on Form 10-K and
related amendment for the year
ended December 31, 2025, with
the Securities and Exchange
Commission (SEC). Shareholders
may obtain a copy of this report,
free of charge, by writing to the
Investor Relations department
at the Company's address or
online at the Investors section
of the Company's website,
www.addus.com.

Transfer Agent and Registrar
Computershare Investor
Services, LLC
2 North LaSalle Street
Chicago, IL 60602

Stock Exchange Listing
Nasdaq: ADUS

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