Addus HomeCare Corp
Form 10-Q
November 04, 2011
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-Q

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

For the quarterly period ended September 30, 2011

OR

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

For the transition period from to

Commission file number 001-34504

ADDUS HOMECARE CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**20-5340172**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

2401 South Plum Grove Road

Palatine, Illinois 60067

(Address of principal executive offices) (Zip code)

(847) 303-5300

(Registrant s telephone number, including area code)

Not Applicable

(Former name, former address and former fiscal year, if changed since last report)

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes x No ¨.

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

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

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

Indicate the number of shares outstanding of each of the issuer s classes of common stock, as of the latest practicable date.

Common Stock $0.001 par value

Shares outstanding at November 3, 2011: 10,774,886

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FORM 10-Q

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PART I FINANCIAL INFORMATION

Item 1. Financial Statements

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

CONDENSED CONSOLIDATED BALANCE SHEETS

As of September 30, 2011 and December 31, 2010

(amounts and shares in thousands, except per share data)

(Unaudited)

	September 30, 2011	December 31, 2010
Assets		
Current assets		
Cash	$ 1,297	$ 816
Accounts receivable, net of allowances of $6,455 and $6,723 as of September 30, 2011 and December 31, 2010, respectively	69,918	70,954
Prepaid expenses and other current assets	10,753	7,704
Deferred tax assets	6,338	6,324
Total current assets	88,306	85,798
Property and equipment, net of accumulated depreciation and amortization	2,482	2,923
Other assets		
Goodwill	50,735	63,930
Intangibles, net of accumulated amortization	8,592	13,570
Deferred tax assets	5,666	
Other assets	560	703
Total other assets	65,553	78,203
Total assets	$ 156,341	$ 166,924
Liabilities and stockholders equity		
Current liabilities		
Accounts payable	$ 4,661	$ 3,304
Accrued expenses	33,241	26,529

Current maturities of long-term debt	6,250	5,158
Deferred revenue	2,318	2,141
Total current liabilities	46,470	37,132
Long-term debt, less current maturities	28,402	40,027
Deferred tax liabilities		562
Other long-term liabilities		1,112
Total liabilities	74,872	78,833
Commitments, contingencies and other matters		
Stockholders equity		
Preferred stock $.001 par value; 10,000 authorized and 0 shares issued and outstanding		
Common stock $.001 par value; 40,000 authorized; 10,774 and 10,751 shares issued and outstanding as of September 30, 2011 and December 31, 2010, respectively	11	11
Additional paid-in capital	82,347	82,106
Retained earnings (deficit)	(889)	5,974
Total stockholders equity	81,469	88,091
Total liabilities and stockholders equity	$ 156,341	$ 166,924

See accompanying Notes to Unaudited Condensed Consolidated Financial Statements.

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ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF INCOME

For the Three and Nine Months Ended September 30, 2011 and 2010

(amounts and shares in thousands, except per share data)

(Unaudited)

	For the Three Months Ended September 30,		For the Nine Months Ended September 30,	
	2011	2010	2011	2010
Net service revenues	$ 69,384	$ 69,842	$ 204,478	$ 201,612
Cost of service revenues	48,373	49,710	144,303	142,924
Gross profit	21,011	20,132	60,175	58,688
General and administrative expenses	16,955	16,277	49,567	46,972
Goodwill and intangible asset impairment charge	15,989		15,989	
Depreciation and amortization	927	1,058	2,783	2,955
Total operating expenses	33,871	17,335	68,339	49,927
Operating income (loss)	(12,860)	2,797	(8,164)	8,761
Interest expense, net	548	855	1,929	2,323
Income (loss) before income taxes	(13,408)	1,942	(10,093)	6,438
Income tax expense (benefit)	(4,359)	463	(3,230)	1,947
Net income (loss)	$ (9,049)	$ 1,479	$ (6,863)	$ 4,491
Income (loss) per common share:				
Basic	$ (0.84)	$ 0.14	$ (0.64)	$ 0.43
Diluted	$ (0.84)	$ 0.14	$ (0.64)	$ 0.43
Weighted average number of common shares and potential common shares outstanding:				
Basic	10,746	10,681	10,746	10,561
Diluted	10,746	10,681	10,746	10,561

See accompanying Notes to Unaudited Condensed Consolidated Financial Statements.

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ADDUS HOMECARE CORPORATION

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CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS EQUITY

For the Nine Months Ended September 30, 2011

(amounts and shares in thousands)

(Unaudited)

	Common Stock		Additional Paid-In Capital	Retained Earnings (Deficit)	Total Stockholders Equity
	Shares	Amount			
Balance at December 31, 2010	10,751	$ 11	$ 82,106	$ 5,974	$ 88,091
Issuance of shares of common stock under restricted stock award agreements	23				
Stock-based compensation			241		241
Net loss				(6,863)	(6,863)
Balance at September 30, 2011	10,774	$ 11	$ 82,347	$ (889)	$ 81,469

See accompanying Notes to Unaudited Condensed Consolidated Financial Statements

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ADDUS HOMECARE CORPORATION

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CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

For the Nine Months Ended September 30, 2011 and 2010

(amounts in thousands)

(Unaudited)

	For the Nine Months Ended September 30,	
	2011	2010
Cash flows from operating activities		
Net income (loss)	$ (6,863)	$ 4,491
Adjustments to reconcile net income (loss) to net cash provided by operating activities		
Depreciation and amortization	2,783	2,955
Deferred income taxes	(6,242)	
Change in fair value of financial instrument		(191)
Stock-based compensation	241	197
Amortization of debt issuance costs	167	118
Provision for doubtful accounts	3,154	3,158
Goodwill and intangible assets impairment charge	15,989	
Changes in operating assets and liabilities:		
Accounts receivable	(2,118)	(8,379)
Prepaid expenses and other current assets	(1,183)	(1,782)
Accounts payable	1,357	837
Accrued expenses	4,353	3,751
Deferred revenue	177	(81)
Net cash provided by operating activities	11,815	5,074
Cash flows from investing activities		
Acquisitions of businesses, net of cash received	(500)	(5,587)
Purchases of property and equipment	(277)	(524)
Net cash used in investing activities	(777)	(6,111)
Cash flows from financing activities		
Net (payments) borrowings on term loan	(1,667)	5,000
Net payments on credit facility	(6,750)	(2,500)
Payments on subordinated dividend notes	(1,750)	(750)
Net payments on other notes	(366)	(468)
Debt issuance costs	(24)	(151)
Net cash (used in) provided by financing activities	(10,557)	1,131

Net change in cash		481		94
Cash, at beginning of period		816		518
Cash, at end of period	$	1,297	$	612
Supplemental disclosures of cash flow information				
Cash paid for interest	$	1,811	$	2,359
Cash paid for income taxes		1,347		1,309
Supplemental disclosures of non-cash investing and financing activities				
Contingent and deferred consideration accrued for acquisitions	$		$	1,606
Tax benefit related to the amortization of tax goodwill in excess of book basis		119		309

See accompanying Notes to Unaudited Condensed Consolidated Financial Statements

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ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Condensed Consolidated Financial Statements

(amounts and shares in thousands)

(Unaudited)

1. Nature of Operations

Addus HomeCare Corporation (Holdings) and its subsidiaries (together with Holdings, the Company or we) provides home & community and home health services through a network of locations throughout the United States. These services are primarily performed in the homes of the consumers. The Company s home & community services include assistance to the elderly, chronically ill and disabled with bathing, grooming, dressing, personal hygiene and medication reminders, and other activities of daily living. Home & community services are primarily performed under agreements with state and local governmental agencies. The Company s home health services are operated through licensed and Medicare certified offices that provide physical, occupational and speech therapy, as well as skilled nursing services to pediatric, adult infirm and elderly patients. Home health services are reimbursed from Medicare, Medicaid and Medicaid-waiver programs, commercial insurance and private payors.

2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying condensed consolidated financial statements are unaudited. These unaudited condensed consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States (GAAP) and applicable rules and regulations of the Securities and Exchange Commission (SEC) regarding interim financial reporting. Certain information and note disclosures normally included in the financial statements prepared in accordance with GAAP have been condensed or omitted pursuant to such rules and regulations. Accordingly these interim condensed consolidated financial statements should be read in conjunction with the Company s consolidated financial statements and related notes included in the Company s Annual Report on Form 10-K for the year ended December 31, 2010 as filed with the SEC on March 28, 2011 (the Form 10-K), which includes information and disclosures not included herein. The December 31, 2010 consolidated balance sheet included herein was derived from the audited financial statements as of that date, but does not include all disclosures including notes required by GAAP.

The unaudited condensed consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements and, in the opinion of management, the unaudited financial statements reflect all adjustments (all of which are of a normal and recurring nature), which are necessary to present fairly the financial position at September 30, 2011 and December 31, 2010, the Company s condensed consolidated statements of income for the three and nine months ended September 30, 2011 and 2010, the condensed consolidated statements of stockholders equity for the nine months ended September 30, 2011, and the condensed consolidated statements of cash flows for the nine months ended September 30, 2011 and 2010. The results for the three and nine months ended September 30, 2011 are not necessarily indicative of the results to be expected for the year ending December 31, 2011. All references to September 30, 2011 or to the three and nine months ended September 30, 2011 and 2010 in the notes to the condensed consolidated financial statements are unaudited.

Principles of Consolidation

All intercompany balances and transactions have been eliminated in consolidation.

Revenue Recognition

The Company generates net service revenues by providing home & community services and home health services directly to consumers. The Company receives payments for providing such services from federal, state and local governmental agencies, commercial insurers and private individuals.

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ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Condensed Consolidated Financial Statements (Continued)

(amounts and shares in thousands)

(Unaudited)

Home & Community

The home & community segment net service revenues are principally provided based on authorized hours, determined by the relevant agency, at an hourly rate specified in agreements or fixed by legislation and recognized as revenues at the time services are rendered. Home & community net service revenues are reimbursed by state, local and other governmental programs which are partially funded by Medicaid or Medicaid waiver programs, with the remainder reimbursed through private duty and insurance programs.

Home Health

The home health segment net service revenues are primarily generated on a per episode or per visit basis. Home health segment net service revenues consist of approximately 65% of Medicare services with the balance being non-Medicare services derived from Medicaid, commercial insurers and private duty. Home health net service revenues reimbursed by Medicare are based on episodes of care. Under the Medicare Prospective Payment System (PPS), an episode of care is defined as a length of care up to 60 days with multiple continuous episodes allowed per patient. Medicare billings under PPS vary based on the severity of the patient s condition and are subject to adjustment, both positive and negative, for changes in the patient s medical condition and certain other reasons. At the inception of each episode of care a request for anticipated payment (RAP) is submitted to Medicare for 50% to 60% of the estimated PPS reimbursement. The Company estimates the net PPS revenues to be earned during an episode of care based on the initial RAP billing, historical trends and other known factors. The net PPS revenues are initially recognized as deferred revenues and subsequently amortized as net service revenues ratably over the 60-day episodic period. At the end of each episode of care a final claim billing is submitted to Medicare and any changes between the initial RAP and final claim billings are recorded as an adjustment to net service revenues. No significant adjustments from initial estimates have been recorded as a result of the process. Other non-Medicare services are primarily provided on a per visit basis determinable and recognized as revenues at the time services are rendered.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates may change in the near term. The Company believes that it is in compliance in all material respects with all applicable laws and regulations.

Allowance for Doubtful Accounts

The Company establishes its allowance for doubtful accounts to the extent it is probable that a portion or all of a particular account will not be collected. The Company estimates its provision for doubtful accounts primarily by aging receivables utilizing eight aging categories, and applying its historical collection rates to each aging category, taking into consideration factors that might impact the use of historical collection rates or payor groups, with certain large payors analyzed separately from other payor groups. In the Company s evaluation of these estimates, it also considers delays in payment trends in individual states due to budget or funding issues, billing conversions related to acquisitions or internal systems, resubmission of bills with required documentation and disputes with specific payors. An allowance for doubtful accounts is maintained at a level management believes is sufficient to cover potential losses. However, actual collections could differ from our estimates.

Goodwill

The Company s carrying value of goodwill is the residual of the purchase price over the fair value of the net assets acquired from various acquisitions including the acquisition of Addus HealthCare, Inc. (Addus HealthCare). In accordance with Accounting Standards Codification

TM (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.

Goodwill is required to be tested for impairment at least annually using a two-step method. The first step in the evaluation of goodwill impairment involves comparing the current fair value of each reporting unit to the recorded value, including goodwill. The Company uses the combination of a discounted cash flow model (DCF model) and the market multiple analysis method to determine the current fair value of each reporting unit.

The DCF model was prepared using revenue and expense projections based on the Company s current operating plan. As such, a number of significant assumptions and estimates are involved in the application of the DCF model to forecast revenue growth, price changes, gross profits, operating expenses and operating cash flows. The cash flows were discounted using a weighted average cost of capital ranging from 13.5% to 15.5%, which was management s best estimate based on the capital structure of the Company and external industry data. As part of the second step of this evaluation, if the carrying value of goodwill exceeds its implied fair value an impairment loss would be recognized.

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ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Condensed Consolidated Financial Statements (Continued)

(amounts and shares in thousands)

(Unaudited)

Intangible Assets

The Company s identifiable intangible assets consist of customer and referral relationships, trade names, trademarks, state licenses and non-compete agreements. Amortization is computed using straight-line and accelerated methods based upon the estimated useful lives of the respective assets, which range from two to 25 years.

Long-Lived Assets

The Company reviews its long-lived assets and amortizable intangibles for impairment whenever changes in circumstances indicate that the carrying amount of an asset may not be recoverable. To determine if impairment exists, the Company compares the estimated future undiscounted cash flows from the related long-lived assets to the net carrying amount of such assets. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized for the amount by which the carrying amount of the asset exceeds the estimated fair value of the asset, generally determined by discounting the estimated future cash flows.

The Company also has indefinite-lived assets that are not subject to amortization expense such as certificates of need and licenses to conduct specific operations within geographic markets. The Company has concluded that certificates of need and licenses have indefinite lives, as management has determined that there are no legal, regulatory, contractual, economic or other factors that would limit the useful life of these intangible assets and the Company intends to renew and operate the certificates of need and licenses indefinitely. The certificates of need and licenses are tested annually for impairment using the cost approach. Under this method assumptions are made about the cost to replace the certificates of need.

Debt Issuance Costs

The Company amortizes debt issuance costs on a straight-line method over the term of the related debt.

Workers Compensation Program

The Company s workers compensation program has a $350 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 performed by an independent third party. The future claims payments related to the workers compensation program are secured by letters of credit. In August 2010, the FASB issued Accounting Standards Update No 2010-24, Health Care Entities (Topic 954), *Presentation of Insurance Claims and Related Insurance Recoveries* (ASU 2010-24), which clarifies that companies should not net insurance recoveries against a related claim liability. Additionally, the amount of the claim liability should be determined without consideration of insurance recoveries. As of September 30, 2011, the Company recorded $1,866 in workers compensation insurance recovery receivables and a corresponding increase in its workers compensation liability as of September 30, 2011. The Company will record this new presentation of its workers compensation insurance recovery receivable and corresponding obligation on a prospective basis. The workers compensation insurance recovery receivable is included in the Company s prepaid expenses and other current assets on the balance sheet.

Interest Expense, net

The Company s net interest expense consists of interest costs on its credit facility and other debt instruments and is recorded net of any interest income recorded by the Company. Legislation enacted in Illinois entitles designated service program providers to receive a prompt payment interest penalty based on qualifying services approved for payment that remain unpaid after a designated period of time. As the amount and timing of the receipt of these payments are not certain, the interest income is recognized when received and reported in the income statement caption, interest expense, net. The Company did not record any prompt payment interest income in the three and nine months ended September 30, 2011 and 2010. During October 2011, the Company received $2,257 in prompt payment interest which it will record in the fourth quarter of 2011. While additional prompt payment interest may be owed to the Company, the amount and timing of receipt of such payments remains uncertain and the Company has determined that it will continue to recognize interest income when received.

Income Taxes

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 liabilities and assets 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 asset 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.

Stock-based Compensation

The Company has two stock incentive plans, the 2006 Stock Incentive Plan (the 2006 Plan) and the 2009 Stock Incentive Plan (the 2009 Plan) that provide for stock-based employee compensation. The Company accounts for stock-based compensation in accordance with ASC Topic 718, *Stock Compensation* . Compensation expense is recognized on a graded method under the 2006 Plan and on a straight-line basis under the 2009 Plan over the vesting period of the awards based on the fair value of the options. Under the 2006 Plan, the Company historically used the Black-Scholes option pricing model to estimate the fair value of its stock based payment awards, but beginning October 28, 2009 under its 2009 Plan it began using an enhanced Hull-White Trinomial model. The determination of the fair value of stock-based payments utilizing the Black-Scholes model and the Enhanced Hull-White Trinomial model is affected by Holdings stock price and a number of assumptions, including expected volatility, risk-free interest rate, expected term, expected dividends yield, expected forfeiture rate, expected turn-over rate, and the expected exercise multiple.

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ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Condensed Consolidated Financial Statements (Continued)

(amounts and shares in thousands)

(Unaudited)

Net Income (Loss) Per Common Share

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 for the three and nine months ended September 30, 2011 were 780 and 712 stock options of which all were anti-dilutive and excluded from the net loss per share calculation. Excluded from the Company s diluted weighted average common shares outstanding calculation for the three and nine months ended September 30, 2010 were 563 options which were out-of-the-money and therefore anti-dilutive.

Estimates

The financial statements are prepared by management in conformity with GAAP and include estimated amounts and certain disclosures based on assumptions about future events. Accordingly, actual results could differ from those estimates.

Fair Value of Financial Instruments

The Company s financial instruments consist of cash, accounts receivable, payables and debt. The carrying amounts reported in the 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 Company s long-term debt with variable interest rates approximates fair value based on instruments with similar terms.

New Accounting Principles

In September 2011, the FASB issued a GAAP update on goodwill to allow an entity the option of performing a qualitative assessment before calculating the fair value of the reporting unit when testing goodwill for impairment. If the qualitative assessment concludes that it is more likely than not that the fair value of a reporting unit is less than its carrying value, the entity shall perform the quantitative two-step goodwill impairment test. Otherwise, the two-step goodwill impairment test is not required. This revised GAAP will be effective for fiscal years beginning after December 15, 2011, with early adoption permitted. The Company does not expect the adoption of this revised GAAP to have a material effect on our financial position, results of operations or cash flows.

In July 2011, the FASB issued a GAAP update on revenue recognition for certain health care entities that recognize significant amounts of patient service revenue without assessing the patient s ability to pay. This revised GAAP requires such health care entities to present the provision for bad debt related to patient service revenue as a deduction from patient service revenue (net of contractual allowance and discounts) on their statement of income. It also requires additional disclosures of patient service revenue as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. This revised GAAP will be effective for annual and interim periods beginning after December 15, 2011. The Company is currently evaluating the potential impact on the Company s financial position and results of operations or cash flows.

3. Acquisitions

On July 26, 2010, the Company entered into an Asset Purchase Agreement (the Purchase Agreement), pursuant to which the Company acquired certain assets of Advantage Health Systems, Inc., a South Carolina corporation (Advantage). The total consideration payable pursuant to the Purchase Agreement was $8,380, comprised of $5,140 in cash, common stock consideration with a deemed value of $1,240 resulting in the issuance of 248 common shares, and a maximum of $2,000 in future cash consideration subject to the achievement of certain performance targets set forth in an earn-out agreement and the assumption of certain specified liabilities.

On July 26, 2010, the Company entered into an amendment (the Second Amendment) to its credit facility. The Second Amendment provided for a new term loan component of the credit facility in the aggregate principal amount of $5,000 with a maturity date of January 5, 2013. The requisite lenders also consented to the acquisition, effective July 25, 2010, of certain assets of Advantage, by the Company, pursuant to the Purchase Agreement. The new term loan will be repaid in 24 equal monthly installments which began in February 2011. Interest on the new term loan under the credit facility is payable either at a floating rate equal to the 30-day LIBOR, plus an applicable margin of 4.6% or the LIBOR rate for term periods of one, two, three or six months plus a margin of 4.6%. Interest will be paid monthly or at the end of the relevant interest period.

The Company s acquisition of Advantage has been accounted for in accordance with ASC Topic 805, *Business Combinations* and the resultant goodwill and other intangible assets will be accounted for under ASC Topic 350 *Goodwill and Other Intangible Assets* . Assets acquired and liabilities assumed were recorded at their fair values. The total purchase price was $7,980, comprised of:

	Total
Cash	$ 5,140
Issuance of 248 shares of common stock at $5.00 per share (valued at a price per share equal to the average closing price of the Company s stock for the three most recent trading days preceding the closing, subject to a floor of $5.00 per share)	1,240
Contingent earn-out obligation (net of $92 discount)	1,600
Total purchase price	$ 7,980

The contingent earn-out obligation has been recorded at its fair value of $1,600, which is the present value of the Company s obligation based on probability-weighted estimates of the achievement of certain performance targets, as defined in the Purchase Agreement. In April 2011, the Company paid the first earn-out payment of $500 to the sellers of Advantage. The second earn-out payment obligation is recorded at $1,143 as of September 30, 2011 and will be payable, if required, during the second quarter of 2012. The Company reclassified the second earn-out payment obligation from other long-term liabilities to accrued expenses as of June 30, 2011.

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Under business combination accounting, the total purchase price was allocated to Advantage s net tangible and identifiable intangible assets based on their estimated fair values. Based upon our management s valuation, the total purchase price has been allocated as follows:

	Total
Goodwill	$ 4,272
Identifiable intangible assets	3,631
Property and equipment	77
Total purchase price allocation	$ 7,980

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ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Condensed Consolidated Financial Statements (Continued)

(amounts and shares in thousands)

(Unaudited)

Goodwill represents the excess of the purchase price over the fair value of net tangible and identifiable intangible assets acquired. Goodwill amounts are not amortized, but rather are tested for impairment at least annually. In the event that the Company determines that the value of goodwill has become impaired, the Company will incur an impairment charge for the amount during the fiscal quarter in which such determination is made.

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ADDUS HOMECARE CORPORATION

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Notes to Condensed Consolidated Financial Statements (Continued)

(amounts and shares in thousands)

(Unaudited)

Identifiable intangible assets acquired consist of trade names and trademarks, certificates of need and state licenses, customer relationships, and non-compete agreements. The estimated fair value of identifiable intangible assets was determined by the Company s management.

The following table contains unaudited pro forma consolidated income statement information assuming the Advantage acquisition closed on January 1, 2010.

	Three Months Ended September 30, 2010	Nine Months Ended September 30, 2010
Net service revenues	$ 70,715	$ 209,013
Operating income	2,972	9,299
Net income	$ 1,594	$ 4,729
Basic earnings per share	$ 0.15	$ 0.44
Diluted earnings per share	$ 0.15	$ 0.44

The pro forma disclosures in the table above include adjustments for interest expense, amortization of intangible assets and tax expense to reflect results that are more representative of the combined results of the transactions as if they had occurred on January 1, 2010. This pro forma information is presented for illustrative purposes only and may not be indicative of the results of operation that would have actually occurred. In addition, future results may vary significantly from the results reflected in the pro forma information.

4. Goodwill and Intangible Assets

The Company s carrying value of goodwill is the residual of the purchase price over the fair value of the net assets acquired from various acquisitions including the acquisition of Addus HealthCare, Inc. (Addus HealthCare). In accordance with Accounting Standards Codification TM (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.

Goodwill is required to be tested for impairment at least annually using a two-step method. The first step in the evaluation of goodwill impairment involves comparing the current fair value of each reporting unit to the recorded value, including goodwill. The Company uses the combination of a discounted cash flow model (DCF model) and the market multiple analysis method to determine the current fair value of each reporting unit.

The DCF model was prepared using revenue and expense projections based on the Company s current operating plan. As such, a number of significant assumptions and estimates are involved in the application of the DCF model to forecast revenue growth, price changes, gross profits, operating expenses and operating cash flows. The cash flows were discounted using a weighted average cost of capital ranging from 13.5% to 15.5%, which was management s best estimate based on the capital structure of the Company and external industry data. As part of the second step of this evaluation, if the carrying value of goodwill exceeds its implied fair value an impairment loss would be recognized.

The Company completed its annual impairment test of goodwill as of October 1, 2010 and determined that no goodwill impairment existed. The allocated goodwill for the Company s two reporting units, home & community and home health was $50,643 and $13,059, respectively. Home & community and home health had fair values in excess of carrying amounts of approximately $15,000, or 13% and $8,000, or 27%, respectively. Although the Company believes that the financial projections used in the assessment were reasonable and appropriate for its two reporting units at that time, there is uncertainty inherent in those projections.

In light of the current Federal and state economic and reimbursement environments and state budgetary pressures to decrease or eliminate services provided by the Company, the Company completed a preliminary assessment of the fair value of its two reporting units, home & community and home health and the potential for goodwill impairment as of June 30, 2011. The Company s total stockholders equity as of September 30, 2011 was significantly greater than the Company s market capitalization which was approximately $43,638 based on 10,774 shares of common stock outstanding as of September 30, 2011. While the market capitalization of approximately $43,638 is below the Company s stockholders equity, the market capitalization metric is only one indicator of fair value. In the Company s opinion, the market capitalization approach, by itself, is not a reliable indicator of the value for the Company.

Based on the above and updates to the Company s business projections and forecasts, and other factors, the Company determined that the estimated fair value of its home health reporting unit was less than the net book value indicating that its allocated goodwill was impaired. The preliminary assessment for the home & community reportable unit indicated that its fair value was greater than its net book value with no initial indication of goodwill impairment.

As permitted by ASC Topic 350, when an impairment indicator arises toward the end of an interim reporting period, the Company may recognize its best estimate of that impairment loss. Based on the Company s preliminary analysis prepared as of June 30, 2011, the Company determined that all of the $13,076 allocated to goodwill for the home health reportable unit as of September 30, 2011 was impaired and recorded a goodwill impairment loss for the three and nine months ended September 30, 2011. The goodwill impairment charge is noncash in nature and does not affect the Company s liquidity or cash flows from operating activities. Additionally, the goodwill impairment had no effect on the Company s borrowing availability or covenants under its credit facility agreement.

The analysis prepared as of June 30, 2011 is preliminary and subject to the completion of the Company s annual impairment test as of October 1, 2011. The completion of this analysis may result in an adjustment to the impairment loss recorded in the third quarter of 2011.

The following is a summary of the goodwill activity by segment for the nine months ended September 30, 2011.

	Home & Community	Home Health	Total
Goodwill, at December 31, 2010	$ 50,820	$ 13,110	$ 63,930
Adjustments to previously recorded goodwill	(85)	(34)	(119)
Impairment charge		(13,076)	(13,076)
Goodwill, at September 30, 2011	$ 50,735	$	$ 50,735

The Company s identifiable intangible assets consist of customer and referral relationships, trade names, trademarks, state licenses and non-compete agreements. Amortization is computed using straight-line and accelerated methods based upon the estimated useful lives of the respective assets, which range from two to 25 years.

In connection with the Company s preliminary assessment of its fair value discussed above, it determined that all of its $2,273 allocated to identifiable intangible assets for the home health reportable unit as of September 30, 2011 was impaired and recorded an impairment loss for the three and nine months ended September 30, 2011. The impairment charge is noncash in nature and does not affect the Company s liquidity or cash flows from operating activities.

The Company also has indefinite-lived assets that are not subject to amortization expense such as certificates of need and licenses to conduct specific operations within geographic markets. The Company has concluded that certificates of need and licenses have indefinite lives, as management has determined that there are no legal, regulatory, contractual, economic or other factors that would limit the useful life of these intangible assets and the Company intends to renew and operate the certificates of need and licenses indefinitely. The certificates of need and licenses are tested annually for impairment using the cost approach. Under this method assumptions are made about the cost to replace the certificates of need. In connection with the Company s preliminary assessment of its fair value discussed above, it determined that all of the $640 allocated to home health certificates of need and licenses were impaired and recorded an impairment loss for the three and nine months ended September 30, 2011. The completion of this analysis may result in an adjustment to the impairment loss recorded in the third quarter of 2011.

No impairment charges were recorded in the three and nine months ended September 30, 2010.

The following is a summary of the intangible assets and indefinite-lived asset activity as of September 30, 2011.

September 30, 2011	Gross Carrying Amount	Accumulated Amortization	Impairment Charge	Net Carrying Amount
Customer and referral relationships	$ 26,675	$ 18,218	$ 1,754	$ 6,703
Trade names and trademarks	4,587	2,459	506	1,622
State Licenses	790		640	150
Non-competition agreements	408	278	13	117
	$ 32,460	$ 20,955	$ 2,913	$ 8,592

5. Details of Certain Balance Sheet Accounts

Prepaid expenses and other current assets consisted of the following:

	September 30, 2011	December 31, 2010
Prepaid health insurance	$ 5,508	$ 5,337
Prepaid workers compensation and liability insurance	1,732	1,386
Prepaid rent	206	198
Workers compensation insurance receivable	1,866	
Other	1,441	783
	$ 10,753	$ 7,704

In August 2010, the FASB issued Accounting Standards Update No 2010-24, Health Care Entities (Topic 954), *Presentation of Insurance Claims and Related Insurance Recoveries* (ASU 2010-24), which clarifies that companies should not net insurance recoveries against a related claim liability. Additionally, the amount of the claim liability should be determined without consideration of insurance recoveries. As of September 30, 2011, the Company recorded $1,866 in workers compensation insurance recovery receivables and a corresponding increase in its workers compensation liability as of September 30, 2011. The Company will record this new presentation of its workers compensation insurance recovery receivable and corresponding obligation on a prospective basis. The workers compensation insurance recovery receivable is included in the Company s prepaid expenses and other current assets on the balance sheet as of September 30, 2011.

Accrued expenses consisted of the following:

	September 30, 2011	December 31, 2010
Accrued payroll	$ 11,210	$ 10,453
Accrued workers compensation insurance	10,745	8,218
Accrued payroll taxes	2,022	1,579
Accrued health insurance	4,548	3,858
Accrued interest	90	144
Current portion of contingent earn-out obligation	1,143	502
Other	3,483	1,775
	$ 33,241	$ 26,529

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(amounts and shares in thousands)

(Unaudited)

6. Long-Term Debt

Long-term debt consisted of the following:

	September 30, 2011	December 31, 2010
Revolving credit loan	$ 26,500	$ 33,250
Term loan	3,333	5,000
Subordinated dividend notes bearing interest at 10.0%	4,819	6,569
Insurance note payable, due May 2011 and bearing interest at 2.9%		366
Total	34,652	45,185
Less current maturities	(6,250)	(5,158)
Long-term debt	$ 28,402	$ 40,027

Senior Secured Credit Facility

On March 18, 2010, the Company entered into an amendment (the First Amendment) to its credit facility. The First Amendment (i) increased the maximum aggregate amount of revolving loans available to the Company by $5,000 to $55,000, (ii) modified the Company s maximum senior leverage ratio from 2.75 to 1.0 to 3.00 to 1.0 for each twelve month period ending on the last of day of each fiscal quarter after March 31, 2010 and (iii) increased the advance multiple used to determine the amount of the borrowing base from 2.75 to 1.0 to 3.0 to 1.0.

On July 26, 2010, the Company entered into the Second Amendment to its credit facility. The Second Amendment provided for a new term loan component of the credit facility in the aggregate principal amount of $5,000 with a maturity date of January 5, 2013. The requisite lenders also consented to the acquisition, effective July 25, 2010, of certain assets of Advantage by the Company, pursuant to the Purchase Agreement. The term loan will be repaid in 24 equal monthly installments, which commenced February 2011. Interest on the term loan under the credit facility is payable either at a floating rate equal to the 30-day LIBOR, plus an applicable margin of 4.6% or the LIBOR rate for term periods of one, two, three or six months plus a margin of 4.6%. Interest will be paid monthly or at the end of the relevant interest period. The credit facility contains customary affirmative, negative, and financial covenants with which the Company was in compliance at September 30, 2011.

On May 24, 2011, the Company entered into a Joinder, Consent and Amendment No. 3 to its credit facility to include Addus HealthCare (Delaware) Inc., a newly-formed, wholly-owned subsidiary of Addus HealthCare, as an additional borrower under the credit facility.

On July 26, 2011, the Company entered into a fourth amendment (the Fourth Amendment) to its credit facility. The Fourth Amendment modified the Company s maximum senior leverage ratio from 3.00 to 1.00 to 3.25 to 1.00 for each twelve month period ending on the last of day

of each fiscal quarter beginning with the twelve month period ended June 30, 2011 and increased the advance multiple used to determine the amount of the borrowing base from 3.0 to 1.0 to 3.25 to 1.0. The Fourth Amendment resulted in an increase in the Company s available borrowings under the credit facility.

The availability of funds under the revolving credit portion of the credit facility, as amended, is based on the lesser of (i) the product of adjusted EBITDA, as defined in the credit facility agreement, for the most recent 12-month period for which financial statements have been delivered under the credit facility agreement multiplied by the specified advance multiple, up to 3.25, less the outstanding senior indebtedness and letters of credit, and (ii) $55,000 less the outstanding revolving loans and letters of credit. Interest on the amounts outstanding under the revolving credit portion of the credit facility is payable either at a floating rate equal to the 30-day LIBOR, plus an applicable margin of 4.6% or the LIBOR rate for term periods of one, two, three or six months plus a margin of 4.6%. Interest will be paid monthly or at the end of the relevant interest period, as determined in accordance with the credit facility agreement. The borrowers will pay a fee equal to 0.5% per annum of the unused portion of the revolving portion of the credit facility. Issued stand-by letters of credit will be charged at a rate of 2.0% per annum payable monthly. On September 30, 2011 the interest rate on the revolving credit loan facility was 4.8% (30 day LIBOR rate was 0.2%). The total availability under the revolving credit loan facility was $17,986 at September 30, 2011 compared to $13,478 at December 31, 2010.

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Subordinated Dividend Notes

On March 18, 2010, the Company amended its subordinated dividend notes that were issued in respect of certain unpaid dividends on the Company s preferred stock that converted into shares of common stock in conjunction with the Company s initial public offering (the IPO). Pursuant to the amendments, the dividend notes were amended to (i) extend the maturity date of the dividend notes from September 30, 2011 to December 31, 2012, (ii) modify the amortization schedule of the dividend notes to reduce the annual principal payment amounts from $4,468 to $1,250 in 2010; from $3,351 to $2,500 in 2011; and provided for total payments in 2012 to $4,069, and (iii) permit, based on the Company s leverage ratio, the prepayment of all or a portion of the principal amount of the dividend notes, together with interest on the principal amount.

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7. Segment Data

The Company provides home & community and home health services primarily in the home of the consumer. The Company s locations and operations are organized principally along these lines of service. The home & community and home health services lines have been identified as reportable segments applying the criteria in ASC Topic 280, *Disclosure about Segments of an Enterprise and Related Information.* The accounting policies of the segments are the same as those described in the Summary of Significant Accounting Policies. Intersegment net service revenues are not significant. All services are provided in the United States.

The Company evaluates the performance of its segments through operating income which excludes corporate depreciation and general corporate expenses. General corporate expenses consist principally of accounting and finance, information systems, billing and collections, human resources and national sales and marketing administration.

The following is a summary of segment information for the three and nine months ended September 30, 2011 and 2010:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2011	2010	2011	2010
Net service revenue				
Home & Community	$ 56,157	$ 57,311	$ 165,309	$ 164,156
Home Health	13,227	12,531	39,169	37,456
	$ 69,384	$ 69,842	$ 204,478	$ 201,612
Operating income (loss)				
Home & Community	$ 6,798	$ 5,916	$ 18,143	$ 16,899
Home Health	(15,809)	1,060	(14,271)	3,754
General corporate expenses & corporate depreciation	(3,849)	(4,179)	(12,036)	(11,892)
	$ (12,860)	$ 2,797	$ (8,164)	$ 8,761
Depreciation and amortization				
Home & Community	$ 609	$ 712	$ 1,828	$ 1,947
Home Health	128	158	385	479
Corporate	190	188	570	529

$ 927	$ 1,058	$ 2,783	$ 2,955

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8. Commitments and Contingencies

Legal Proceedings

Class Action Lawsuit

As previously disclosed, on March 26, 2010, a class action lawsuit was filed in the United States District Court for the Northern District of Illinois on behalf of a class consisting of all persons or entities who purchased or otherwise acquired the Company s common stock between October 27, 2009 and March 18, 2010, in connection with the Company s IPO. The complaint, which was amended on August 10, 2010, asserted claims against the Company and individual officers and directors pursuant to Sections 11 and 15 of the Securities Act of 1933 and alleged, inter alia, that the Company s registration statement was materially false and/or omitted the following: (1) that the Company s accounts receivable included at least $1.5 million in aging receivables that should have been reserved for; and (2) that the Company s home health segment s revenues were falling short of internal forecasts due to a slowdown in admissions from the Company s integrated services program due to the State of Illinois effort to develop new procedures for integrating care. A motion to dismiss the complaint was filed on behalf of the defendants on September 20, 2010. The Company and the other defendants have denied and continue to deny all charges of wrongdoing or liability arising out of any conduct, statements, acts or omissions alleged in the complaint. In addition, on April 16, 2010, Robert W. Baird & Company, on behalf of the underwriters of the IPO, notified the Company that the underwriters were seeking indemnification in respect of the above-referenced action pursuant to the underwriting agreement entered into in connection with the IPO.

As previously reported, on March 21, 2011, the Company and the other named defendants entered into a stipulation of settlement with the plaintiffs with respect to the class action, pursuant to which the Company caused $3.0 million to be paid into a settlement fund. The monetary amount of this settlement is covered by insurance.

On July 21, 2011, the United States District Court for the Northern District of Illinois approved the settlement and dismissed the class action with prejudice.

The settlement became effective when the judgment of dismissal entered by the court became final on August 25, 2011.

Derivative Action Lawsuit

As previously disclosed, on November 1, 2010, a shareholder derivative action was filed on behalf of the Company in the Circuit Court of Cook County, Illinois by Paul Wes Bockley, an alleged shareholder of the Company. The complaint asserted claims against certain individual officers and directors of the Company, and against the Company as a nominal defendant, for breach of fiduciary duty, corporate waste and unjust enrichment based, inter alia, on alleged material misstatements and omissions in the registration statement relating to the Company s IPO. The alleged misstatements and omissions were essentially the same as those asserted in the class action litigation, discussed above.

As previously reported, on March 21, 2011, the Company and the other defendants entered into a stipulation of settlement with the plaintiff with respect to the shareholder derivative action, pursuant to which the Company caused the plaintiff s counsel s fees and expenses in an amount up to and including $0.2 million to be paid. In addition, the Company has agreed to adopt certain corporate governance measures. The monetary amount of this settlement is covered by insurance.

On June 6, 2011 the Company received approval of the derivative action settlement and the derivative action was dismissed with prejudice. The settlement became effective when the judgment of dismissal entered in the class action described above became final on August 25, 2011.

Illinois Attorney General s Investigation

As previously disclosed, the Illinois Attorney General s Health Care Bureau and Military & Veterans Rights Bureau served a Civil Investigative Demand (CID) on Addus HealthCare in early November 2010. The CID sought information concerning Addus HealthCare s Veterans Deserve program. The Company cooperated with the investigation and it was informed on September 13, 2011 that the Illinois Attorney General s Office has concluded this investigation and that it requires no additional information or actions from the Company.

Other

The Company is a party to other legal and/or administrative proceedings arising in the ordinary course of its business. It is the opinion of management that the outcome of such proceedings will not have a material effect on the Company s financial position and results of operations.

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Employment Agreements

The Company has entered into employment agreements with certain members of senior management. The terms of these agreements are up to four years and include non-compete and nondisclosure provisions, as well as provide for defined severance payments in the event of termination.

9. Significant Payors

A substantial portion of the Company s net service revenues and accounts receivables are derived from services performed for federal, state and local governmental agencies. Medicare and one state governmental agency accounted for 12.4% and 43.5% of the Company s net service revenues for the three months ended September 30, 2011, respectively, and 11.4% and 38.9% of the Company s net service revenues for the three months ended September 30, 2010, respectively. Medicare and one state governmental agency accounted for 12.6% and 42.2% of the Company s net service revenues for the nine months ended September 30, 2011, respectively, and 11.8% and 37.3% of the Company s net service revenues for the nine months ended September 30, 2010, respectively.

The related receivables due from Medicare and the state agency represented 9.1% and 59.0%, respectively, of the Company s accounts receivable at September 30, 2011, and 7.5% and 58.5%, respectively, of the Company s accounts receivable at December 31, 2010.

10. Subsequent Events

During October 2011, the Company received a payment of $2,257 from the State of Illinois related to legislation enacted in Illinois which entitles designated service program providers to receive a prompt payment interest penalty based on qualifying services approved for payment that remain unpaid after a designated period of time. As the amount and timing of the receipt of these payments are not certain, the interest income is recognized when received and reported in the income statement caption, interest expense, net. The Company will record this interest income in the fourth quarter of 2011.

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ITEM 2. MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

You should read the following discussion together with our unaudited condensed consolidated financial statements and the related notes. This discussion contains forward-looking statements about our business and operations. Our actual results may differ materially from those we currently anticipate.

Overview

We are a comprehensive provider of a broad range of social and medical services in the home. Our services include personal care and assistance with activities of daily living, skilled nursing and rehabilitative therapies, and adult day care. Our consumers are individuals with special needs who are at risk of hospitalization or institutionalization, such as the elderly, chronically ill and disabled. Our payor clients include federal, state and local governmental agencies, commercial insurers, and private individuals. We provide our services through 120 locations across 19 states to over 26,000 consumers.

We operate our business through two segments, home & community services and home health services. Our home & community services are social, or non-medical, in nature and include assistance with bathing, grooming, dressing, personal hygiene and medication reminders, and other activities of daily living. We provide home & community services on a long-term, continuous basis, with an average duration of approximately 20 months per consumer. Our home health services are primarily medical in nature and include physical, occupational and speech therapy, as well as skilled nursing. We generally provide home health services on a short-term, intermittent or episodic basis to individuals recovering from an acute medical condition, with an average length of care of approximately 80 days.

The comprehensive nature of our social and medical services enables us to maintain a long-term relationship with our consumers as their needs change over time and provides us with diversified sources of revenue. To meet our consumers changing needs, we utilize an integrated service delivery model approach that allows our consumers to access social and medical services from one homecare provider and appeals to referral sources who are seeking a provider with a breadth of services, scale and systems to meet consumers needs effectively. Our integrated service delivery model enables our consumers to access services from both our home & community services and home health services divisions, thereby receiving the full spectrum of their social and medical homecare service needs from a single provider. Our integrated service model is designed to reduce service duplication, which lowers health care costs, enhances consumer outcomes and satisfaction and lowers our operating costs, as well as drives our internal growth strategy. In our target markets, our care and service coordinators work with our caregivers, consumers and their providers to review our consumers current and anticipated service needs and, based on this continuous review, identify areas of service duplication or new service opportunities.

Our ability to grow our net service revenues is closely correlated with the number of consumers to whom we provide our services. Our continued growth depends on our ability to maintain our existing payor client relationships, establish relationships with new payors, enter into new contracts and increase our referral sources. Our continued growth is also dependent upon the authorization by state agencies of new consumers to receive our services. We believe there are several market opportunities for growth. The U.S. population of persons aged 65 and older is growing, and the U.S. Census Bureau estimates that this population will more than double by 2050. Additionally, we believe the overwhelming majority of individuals in need of care generally prefer to receive care in their homes or community-based settings. Finally, we believe the provision of home & community services is more cost-effective than the provision of similar services in an institutional setting for long-term care.

We have historically grown our business primarily through organic growth, complemented with selective acquisitions. Our home & community segment acquisitions have been focused on facilitating entry into new states, whereas our home health segment acquisitions have been focused on complementing our existing home & community business, enabling us to provide a more comprehensive range of services in those locations. Acquisitions in the home health segment, while not significant, reflect our goal of being a comprehensive provider of both home & community and home health services in the markets in which we operate.

On July 26, 2010, we entered into an Asset Purchase Agreement (the Purchase Agreement), pursuant to which we acquired the operations and certain assets of Advantage Health Systems, Inc., a South Carolina corporation (Advantage). Advantage is a provider of home & community, home health and hospice services in South Carolina and Georgia, which expanded our services across 19 states. The total consideration payable pursuant to the Purchase Agreement was $8.3 million, comprised of $5.1 million in cash, common stock consideration with a deemed value of $1.2 million resulting in the issuance of 248,000 common shares, a maximum of $2.0 million in future cash consideration subject to the achievement of certain performance targets set forth in an earn-out agreement and the assumption of certain specified liabilities. In April 2011,

we paid the first earn-out payment of $0.5 million to the sellers of Advantage.

In March 2010, the President signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, both laws are referred to herein as the Health Reform Act). The Health Reform Act includes several provisions that may affect reimbursement for home health agencies. The Health Reform Act is broad, sweeping reform, and is subject to change, including through the adoption of related regulations, the way in which its provisions are interpreted and the manner in which it is enforced. We cannot assure you that the provisions of the Health Reform Act will not adversely impact our business, results of operations or financial position. We may be unable to mitigate any adverse effects resulting from the Health Reform Act.

On July 14, 2010, the Office for Civil Rights of the U.S. Department of Health and Human Services (OCR) published proposed regulations to implement the Health Information Technology for Economic and Clinical Health Act. Failure to comply with Health Insurance Portability and Accountability Act, or HIPAA, could result in fines and penalties that could have a material adverse effect on the Company. Recently, the OCR has imposed substantial financial and other penalties on covered entities that improperly disclosed individuals health information.

On July 23, 2010, Centers for Medicare & Medicaid Services (CMS) published its proposed Home Health Prospective Payment System Update for Calendar Year 2011 (Proposed 2011 Home Health PPS Update). A proposed overall reduction in the home health payment base rate of 4.9% included a reduction for each 60-day episode and the conversion factor for non-routine medical supplies (NRS) of 3.8%. The 3.8% decrease, which also will be imposed in 2012, is a result of the CMS determination that there has been a general increase in case mix that CMS believes is unwarranted. CMS believes that this case-mix creep is due to improved coding, coding practice changes, and other behavioral responses to the change in reimbursement that went in to effect in 2009, including greater use of high therapy treatment plans above what CMS believes is related to an increase in patient acuity. CMS warned that it will continue to monitor changes in case-mix. If new data identifies additional increases in case-mix, CMS will immediately impose further reductions. The Health Reform Act requires a physician certifying a patient for home health services to document that the physician or a non-physician practitioner under the direction of the physician has had a face-to-face encounter with the patient. In CMS s proposed Home Health Update for 2011 (the 2011 Proposed Home Health Rule), CMS proposed regulations that would require the face-to-face encounter to take place within thirty days of the home health start date. An additional face-to-face encounter within two weeks of the start date would be required if the original face-to-face encounter did not primarily relate to the reason for the home health services.

On November 3, 2010, CMS released its Home Health Prospective Payment System Update for Calendar Year 2011 (the Final 2011 Home Health PPS Update), which included a 1.1% market basket increase for 2011 (after application of the mandated 1.0% reduction) and a mandated 3.8% rate reduction. The final 2011 payment base rate reflects a 0.3% decrease from the proposed market basket rate in July 2010. CMS announced that it is postponing its proposed 3.8% reduction in home health rates for calendar year 2012 pending its further monitoring of case-mix changes. Home health agencies that do not submit required quality data will be subject to a 2.0% reduction in the market basket update.

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CMS made some revisions to its proposed regulations regarding face-to-face-encounters. The physician or non-physician practitioner must have a face-to-face encounter with the patient within 90 days of the home health start date as a condition for payment. If there is no face-to-face encounter within the 90 day period or if the encounter did not relate to the reason for home health, a face-to-face encounter must occur within 30 days after the home health start date. CMS emphasized that the certification must be dated by the physician (not the home health agency) and the patient must be under the care of a physician while receiving home health services. But, the face-to-face encounter is only required for the initial certification. The certifying physician may not be the home health agency medical director and the physician or non-physician practitioner may not have a financial relationship with the home health agency. The Final 2011 Home Health PPS Update provided that the face-to-face-encounter requirement would be effective January 1, 2011. In December 2010, in response to requests from home health and hospice provider associations, physician groups and others, CMS announced a suspension of the requirement until April 1, 2011. Although these groups requested another suspension until July 1, 2011, that was not granted and the face-to-face requirement went into effect on April 1, 2011.

CMS also requires that for therapy services, a qualified therapist (not a therapy assistant) must assess the patient, measure progress, and document progress toward therapy goals at least once every 30 days as a condition for payment. For patients requiring 13 or 19 therapy visits, the qualified therapist must perform this evaluation at the 13th and 19th therapy visit. The requirement is relaxed for patients in rural areas, requiring the qualified therapist evaluation any time after the 10th visit and not later than the 13th visit, and after the 16th therapy visit but not later than the 19th visit. If more than one therapy is furnished, an evaluation must be made by a qualified therapist for each therapy.

CMS also announced that it is going to assess a variety of home health issues, including the current therapy threshold reimbursement. CMS also clarified its rules regarding change of ownership of home health agencies and the 36-month rule. If there is a change of ownership within 36 months of enrollment in Medicare or within 36 months of a prior change of ownership, the home health agency must undergo a new survey. CMS clarified that indirect ownership changes are not subject to the 36-month rule. There are also several exceptions to the 36-month rule but in order to qualify, the home health agency must have submitted two or more consecutive cost reports (excluding low utilization cost reports or no cost report). Exceptions to the 36-month rule include death of an owner and changes in business structure as long as ownership remains the same.

On July 12, 2011, CMS published proposed regulations regarding the face-to-face requirement for Medicaid. CMS adopted the same requirements imposed for Medicare. The physician or non-physician practitioner must have a face-to-face encounter with the patient within 90 days of the home health start date as a condition for payment. If there is no face-to-face encounter within the 90 day period or if the encounter did not relate to the reason for home health, a face-to-face encounter must occur within 30 days after the home health start date. Documentation of the face-to-face encounter (including the date) must be entered on the written order for home health services or on a clearly marked addendum to the order. The documentation must describe how the patient s health status at the time of the face-to-face encounter related to the primary reason the patient needs home health services. In the same publication, CMS clarified that Medicaid home health cannot be limited to services and proposed to modify its policy and remove the requirement that Medicaid beneficiaries must be home-bound to receive Medicaid home health benefits. CMS clarified that Medicaid home health services may not be limited to individuals that are homebound. In addition, CMS proposed to amend regulations to provide that home health services may be provided in any non-institutional setting in which normal life activities take place; they do not have to be performed in the individual s home.

Also on July 12, 2011, CMS published its proposed Medicare Home Health Prospective Payment System Update for Calendar Year 2012 (the 2012 Proposed Home Health Rule). CMS proposed four payment changes. First, CMS proposed to reduce the home health base episode payment to account for its perceived nominal case-mix growth from the inception of the home health Prospective Payment System (PPS) through 2009 by implementing a 5.06% payment reduction to the national standardized 60-day episode rates. Second, CMS proposed removing two codes for hypertension from the home health PPS case-mix model s hypertension group. Third, CMS proposed to revise payment weights to provide what it believes will be more accurate case-mix payments. CMS proposed to lower the relative weights for home health episodes with a high number of therapy visits and increase the weights for episodes with little or no therapy. The effect will be to lower payments for home health episodes with high numbers of therapy visits and increase payments to episodes with little or no therapy. Fourth, CMS proposed to increase payments for episodes of care with three to five therapy visits so that these episodes would have higher payment to cost ratios and reduce payments for episodes with 20 or just higher than 20 therapy visits so that episodes with around 20 therapy visits would have more reasonable payment to cost ratio. Under the proposed changes in payment weights, episodes with three to five therapy visits would have a higher payment to cost ratio and would receive higher payments and episodes of 20 or just over 20 visits would have lower cost ratios. All changes are expected to be made in a budget neutral way. The proposed effective home health market basket update is 1.5% (2.5% less a required reduction of 1%). Home health agencies that do not meet quality data reporting requirements will be subject to a 2% reduction in the home health market basket increase, which would yield a negative market basket update of -0.5%.

CMS also made two clarifications in the 2012 Proposed Home Health Rule. Regarding the face-to-face requirement, beginning January 1, 2012, for beneficiaries who receive home health services directly following discharge from a hospital or post acute care facility, if the physician who will certify the beneficiary s need for home health services is not the physician who attended the beneficiary during the hospital or post acute care stay the physician who provided care to the beneficiary at the hospital or post acute care facility may provide information to the certifying

physician for purposes of the face-to-face encounter and that may form the basis for certification. CMS also proposed to clarify the definition of confined to the home (homebound status) for purposes of qualification for home health services.

On August 2, 2011 the President signed into law the Budget Control Act of 2011, which raised the debt ceiling and put into effect a series of actions for deficit reduction. The Budget Control Act creates a Congressional Joint Select Committee on Deficit Reduction that is tasked with proposing additional deficit reduction of at least $1.5 trillion. Payments for Medicare and Medicaid are not specifically exempted from those reductions. If the committee is unable to achieve savings of at least $1.5 trillion over 10 years that will trigger automatic across the board reductions in spending of $1.2 trillion. Medicare is subject to these reductions but Medicare reductions are capped at 2%. The Budget Control Act also requires Congress to vote on an amendment to the Constitution that would require a balanced budget.

As mandated by the Health Reform Act, on October 20, 2011, CMS released final regulations for the Medicare Shared Savings Program. Although the Health Reform Act mandates that the program be established no later than January 1, 2012, CMS has set start dates of April 1, 2011 and July 1, 2011. The Medicare Shared Savings Program is designed to give financial incentives to healthcare providers and suppliers that meet criteria established by the US Department of Health and Human Services (HHS) that work together to manage and coordinate care through Accountable Care Organizations (ACOs) for fee-for-service Medicare beneficiaries assigned to the ACO by CMS to increase quality of care and reduce costs. Participating providers and suppliers would share in the savings generated and in one of two plans, bear the risk of losses. In proposed regulations published April 7, 2011, CMS requested comments on a number of issues including the range of providers and suppliers that could participate in an ACO. Reaction to the proposed regulations issued on April 7, 2011 was generally negative especially with regard to start up costs, retroactive assignment of beneficiaries, antitrust issues, the proposed quality measures (both the number and complexity), and the lack of a model that only includes shared savings. The final regulations addressed several but not all of these concerns. The final regulations set a savings-only model where providers share any savings over a threshold amount but do not share any losses, as well as a two sided model where the ACO shares in the savings but is also at risk for losses. The number of quality measures is reduced by almost one half, and beneficiaries are assigned prospectively. In connection with the ACO rules, also on October 20, 2011, the FTC and the DOJ released a joint antitrust policy statement, the IRS released a fact sheet, and the OIG released an interim final rule with five fraud waivers (waiving prosecution under the federal anti-kickback statute applicable to federal and state healthcare programs (the Anti-Kickback Statute), the federal Ethics in Patient Referral Act or physician referral law (the Stark Law) and the Civil Monetary Penalty Law (the CMPL) and laws regarding gain sharing arrangements. The FTC and the DOJ antitrust policy statement addressed some but not all antitrust concerns. The OIG waivers set forth who would be protected by the waivers and under what circumstances. A home health agency cannot qualify for a waiver for activities during ACO pre-participation, which would include activities in the start-up period until an application is accepted but which CMS states could also occur during the participation period. Post-acute care facilities, such as skilled nursing facilities (SNFs) and rehabilitation facilities (IRFs), can qualify for pre-participation waivers. Without a pre-participation waiver, it may be difficult for home health agencies, such as ours, to participate in the planning process for formation of an ACO and this may put us at a disadvantage in negotiating sharing of savings if we were to participate in an ACO. In addition, because other post-acute care providers, such as SNFs and IRFs, can participate in the planning process they may more readily participate in ACOs and may attract referrals that otherwise would have been made to us. Although provider and supplier participation in an ACO is voluntary, participation by our competitors in some markets may force us to participate as well, or if we do not participate, result in loss of business. Also, where we do not participate we will need to be mindful of quality measure criteria and

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if we are unable to meet those criteria we could be at risk for losing Medicare referrals. In addition, other savings programs similar to ACOs may be adopted by government and commercial payors to control costs and reduce hospital readmissions in which we could be financially at risk. We cannot predict what affect, if any, ACOs will have on our company.

On July 15, 2011, HHS published two sets of proposed regulations relating to health insurance exchanges established under the Health Reform Act providing guidance and options to states on how to structure their exchanges. On September 30, 2011, HHS extended the date for public comment from September 28 to October 31, 2011. At this point it is uncertain what services will be mandated for coverage by exchanges or at what level services will be paid or what impact the exchanges will have on other payors.

On October 31, 2011 CMS released the Final 2011 Home Health PPS Update. CMS finalized the 5.06% reduction to the national standardized 60-day episode rates to account for its perceived nominal case-mix growth since the inception of the home health PPS through 2009, phasing in the reduction over 2 years. The reduction in calendar year 2012 will be 3.79% and the remaining 1.32% will be applied for calendar year 2013. The effective market basket update for calendar year 2012 is 1.4% rather than the proposed 1.5% (resulting from a market basket update of 2.4% less the required reduction of 1.0%). Home health agencies that do not meet quality data reporting requirements will have a market basket update of -0.6%. After applying the 3.79% reduction, the 60-day episode rate for calendar year 2012 will be lower than the rate for calendar year 2011. CMS finalized all of the other proposals from the Proposed 2012 Home Health PPS Update outlined above: eliminating two hypertension codes from the case-mix model, revising payment rates for therapy visits, clarifying the definition of confined to the home (homebound status) for qualification for home health services and relaxing the requirement for initial physician certification for home health services permitting the patient s attending physician at a hospital or post acute care facility to conduct the face-to-face encounter and inform the certifying physician of his or her findings. CMS also reported that for future rulemaking it plans to do further analysis of the costs for providing therapy visits and the use of therapy assistants and plans to make further rate adjustments in accordance with its findings.

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Segments

We operate our business through two segments, home & community services and home health services. We have organized our internal management reports to align with these segment designations. As such, we have identified two reportable segments, home & community and home health, applying the criteria in ASC 280, Disclosure about Segments of an Enterprise and Related Information . The following table presents our locations by segment, setting forth acquisitions, start-ups and closures for the period January 1, 2010 to September 30, 2011:

	Home & Community	Home Health	Total
Total at December 31, 2009	92	30	122
Acquired	8	3	11
Start-up	3		3
Closed/Merged	(7)		(7)
Total at December 31, 2010	96	33	129
Closed/Merged	(6)	(3)	(9)
Total at September 30, 2011	90	30	120

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

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For the three and nine months ended September 30, 2011 and 2010, our payor revenue mix by segment was as follows:

	Home & Community			
	For the Three Months Ended September 30,		For the Nine Months Ended September 30,	
	2011	2010	2011	2010
State, local and other governmental programs	94.4%	94.2%	94.4%	94.3%
Commercial	1.4	0.8	1.0	0.8
Private duty	4.2	5.0	4.6	4.9
	100.0%	100.0%	100.0%	100.0%

	Home Health			
	For the Three Months Ended September 30,		For the Nine Months Ended September 30,	
	2011	2010	2011	2010
Medicare	64.8%	63.3%	65.5%	63.8%
State, local and other governmental programs	18.6	19.2	18.5	19.7
Commercial	11.7	10.2	10.6	9.8
Private duty	4.9	7.3	5.4	6.7
	100.0%	100.0%	100.0%	100.0%

We also measure the performance of each segment using a number of different metrics. For our home & community segment, we consider billable hours, billable hours per business day, revenues per billable hour and the number of consumers, or census. For our home health segment, we consider Medicare census, non-Medicare census, Medicare admissions and Medicare revenues per episode completed.

We derive a significant amount of our net service revenues from our operations in Illinois and California, which represented 56.7% and 10.0%; and 51.6% and 12.3%, of our total net service revenues for the three months ended September 30, 2011 and 2010, respectively. Net service revenues from our operations in Illinois and California represented 55.5% and 10.4%; and 51.5% and 13.3%, of our total net service revenues for the nine months ended September 30, 2011 and 2010, respectively.

A significant amount of our net service revenues are derived from two specific payor clients. The Illinois Department on Aging, in the home & community segment, and Medicare, in the home health segment, which accounted for 43.5% and 12.4%; and 38.9% and 11.4% of our total net service revenues for the three months ended September 30, 2011 and 2010, respectively. The Illinois Department on Aging and Medicare accounted for 42.2% and 12.6%; and 37.3% and 11.8% of our total net service revenues for the nine months ended September 30, 2011 and 2010, respectively.

Components of our Statements of Income

Net Service Revenues

We generate net service revenues by providing our home & community services and home health services directly to consumers. We receive payment for providing such services from our payor clients, including federal, state and local governmental agencies, commercial insurers and private individuals.

Home & community segment revenues are typically generated on an hourly basis. Our home & community segment revenues were generated principally through reimbursements by state, local and other governmental programs which are partially funded by Medicaid or Medicaid waiver programs, and to a lesser extent from private duty and insurance programs. Net service revenues for our home & community segment 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 recognized as net service revenues at the time services are rendered.

Home health segment revenues are primarily generated on a per episode or visit basis rather than on a flat fee or an hourly basis. Our home health segment revenues are generated principally through reimbursements by the Medicare program, and to a lesser extent from Medicaid and Medicaid waiver programs, commercial insurers and private duty. Net service revenues from home health payors, other than Medicare, are readily determinable and recognized as net service revenues at the time the services are rendered. Medicare reimbursements are based on 60-day episodes of care. The anticipated net service revenues from an episode are initially recognized as accounts receivable and deferred revenues and subsequently amortized as net service revenues ratably over the 60-day episodic period. At the end of each episode of care, a final claim billing is submitted to Medicare and any changes between the initial anticipated net service revenues and final claim billings are recorded as an adjustment to net service revenues. For open episodes, we estimate net service revenues based on historical data and adjust for the difference between the initial anticipated net service revenues and the ultimate final claim amount.

Cost of Service Revenues

We incur direct care wages, payroll taxes and benefit-related costs in connection with our employees providing our home & community and home health services. We also provide workers compensation and general liability coverage for these employees.

Employees are also reimbursed for their travel time and related travel costs. For home health services, we provide medical supplies and occasionally hire contract labor services to supplement existing staffing in order to meet our consumers needs.

General and Administrative Expenses

Our general and administrative expenses consist of expenses incurred in connection with our segments activities and as part of our central administrative functions.

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Our general and administrative expenses for home & community and home health services consist principally of supervisory personnel, care coordination and office administration costs. Our general a