Addus HomeCare Corp
Form 10-Q
August 04, 2011
Table of Contents

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 June 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 ¨ 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 July 29, 2011: 10,773,886

Table of Contents

ADDUS HOMECARE CORPORATION

FORM 10-Q

INDEX

Table of Contents

PART I FINANCIAL INFORMATION

Item 1. Financial Statements

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

CONDENSED CONSOLIDATED BALANCE SHEETS

As of June 30, 2011 and December 31, 2010

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

(Unaudited)

	2011	2010
Assets		
Current assets		
Cash	$ 24,105	$ 816
Accounts receivable, net of allowances of $6,251 and $6,723 as of June 30, 2011 and December 31, 2010, respectively	51,285	70,954
Prepaid expenses and other current assets	9,090	7,704
Deferred tax assets	6,338	6,324
Total current assets	90,818	85,798
Property and equipment, net of accumulated depreciation and amortization	2,576	2,923
Other assets		
Goodwill	63,851	63,930
Intangibles, net of accumulated amortization	12,193	13,570
Other assets	612	703
Total other assets	76,656	78,203
Total assets	$ 170,050	$ 166,924
Liabilities and stockholders equity		
Current liabilities		
Accounts payable	$ 5,246	$ 3,304
Accrued expenses	31,465	26,529
Current maturities of long-term debt	6,000	5,158
Deferred revenue	2,328	2,141

Total current liabilities	45,039	37,132
Long-term debt, less current maturities	34,027	40,027
Deferred tax liabilities	562	562
Other long-term liabilities		1,112
Total liabilities	79,628	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 June 30, 2011 and December 31, 2010, respectively	11	11
Additional paid-in capital	82,251	82,106
Retained earnings	8,160	5,974
Total stockholders equity	90,422	88,091
Total liabilities and stockholders equity	$ 170,050	$ 166,924

See accompanying Notes to Unaudited Condensed Consolidated Financial Statements.

Table of Contents

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF INCOME

For the Three and Six Months Ended June 30, 2011 and 2010

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

(Unaudited)

	For the Three Months Ended June 30,		For the Six Months Ended June 30,	
	2011	2010	2011	2010
Net service revenues	$ 68,252	$ 67,165	$ 135,094	$ 131,770
Cost of service revenues	48,142	47,429	95,930	93,214
Gross profit	20,110	19,736	39,164	38,556
General and administrative expenses	16,493	15,513	32,612	30,695
Depreciation and amortization	927	951	1,856	1,897
Total operating expenses	17,420	16,464	34,468	32,592
Operating income	2,690	3,272	4,696	5,964
Interest expense, net	668	750	1,381	1,468
Income before income taxes	2,022	2,522	3,315	4,496
Income tax expense	689	868	1,129	1,484
Net income	$ 1,333	$ 1,654	$ 2,186	$ 3,012
Income per common share:				
Basic	$ 0.12	$ 0.16	$ 0.20	$ 0.29
Diluted	$ 0.12	$ 0.16	$ 0.20	$ 0.29
Weighted average number of common shares and potential common shares outstanding:				
Basic	10,746	10,500	10,746	10,500
Diluted	10,770	10,500	10,762	10,500

See accompanying Notes to Unaudited Condensed Consolidated Financial Statements.

4

Table of Contents

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS EQUITY

For the Six Months Ended June 30, 2011

(amounts and shares in thousands)

(Unaudited)

	Common Stock		Additional Paid-In	Retained	Total Stockholders
	Shares	Amount	Capital	Earnings	Equity
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			145		145
Net income				2,186	2,186
Balance at June 30, 2011	10,774	$ 11	$ 82,251	$ 8,160	$ 90,422

See accompanying Notes to Unaudited Condensed Consolidated Financial Statements

Table of Contents

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

For the Six Months Ended June 30, 2011 and 2010

(amounts in thousands)

(Unaudited)

	For the Six Months Ended June 30, 2011	2010
Cash flows from operating activities		
Net income	$ 2,186	$ 3,012
Adjustments to reconcile net income to net cash provided by operating activities		
Depreciation and amortization	1,856	1,897
Change in fair value of financial instrument		(191)
Stock-based compensation	145	128
Amortization of debt issuance costs	110	74
Provision for doubtful accounts	2,110	1,950
Changes in operating assets and liabilities:		
Accounts receivable	17,559	(8,106)
Prepaid expenses and other current assets	2,722	(1,946)
Accounts payable	(93)	1,648
Accrued expenses	2,316	2,107
Deferred revenue	187	222
Net cash provided by operating activities	29,098	795
Cash flows from investing activities		
Acquisitions of businesses, net of cash received	(500)	(349)
Purchases of property and equipment	(132)	(346)
Net cash used in investing activities	(632)	(695)
Cash flows from financing activities		
Payments on term loan	(1,042)	
Net (payments) borrowings on credit facility	(2,750)	750
Payments on subordinated dividend notes	(1,000)	(500)
Net (payments) borrowings on other notes	(366)	67
Debt issuance costs	(19)	
Net cash (used in) provided by financing activities	(5,177)	317
Net change in cash	23,289	417

Cash, at beginning of period		816		518
Cash, at end of period	$	24,105	$	935
Supplemental disclosures of cash flow information				
Cash paid for interest	$	1,291	$	1,542
Cash paid for income taxes		1,139		933
Supplemental disclosures of non-cash investing and financing activities				
Contingent and deferred consideration accrued for acquisitions	$		$	97
Tax benefit related to the amortization of tax goodwill in excess of book basis		79		206

See accompanying Notes to Unaudited Condensed Consolidated Financial Statements

Table of Contents

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 June 30, 2011 and December 31, 2010, the Company s condensed consolidated statements of income for the three and six months ended June 30, 2011 and 2010, the condensed consolidated statements of stockholders equity for the six months ended June 30, 2011, and the condensed consolidated statements of cash flows for the six months ended June 30, 2011 and 2010. The results for the three and six months ended June 30, 2011 are not necessarily indicative of the results to be expected for the year ending December 31, 2011. All references to June 30, 2011 or to the three and six months ended June 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.

7

Table of Contents

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 it s 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 as of October 1, 2010. Although the Company believes that the financial projections used in the assessment are reasonable and appropriate for its two reporting units, there is uncertainty inherent in those projections. As of December 31, 2010 the Company determined that no events or circumstances from October 1, 2010 through December 31, 2010 indicated that a further assessment was necessary. However, the current Federal and state economic and reimbursement environments and state budgetary pressures to decrease or eliminate services provided by the Company could have a negative effect on future earnings and cash flows from operations, and are factors indicating the possibility of future impairment to the Company s goodwill.

The Company s total stockholders equity was $90,422 as of June 30, 2011 and the Company s market capitalization was approximately $58,502 based on 10,774 shares of common stock outstanding as of June 30, 2011. While the market capitalization of approximately $58,502 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.

The Company will continue to monitor market conditions and determine if any additional interim review of goodwill is warranted. Further deterioration in the market or actual results as compared with the Company s projections may ultimately result in a future impairment. In the event that the Company determines goodwill is impaired in the future, it would need to recognize a non-cash impairment charge, which could have a material adverse effect on its consolidated balance sheet and results of operations.

Table of Contents

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. No impairment charges were recorded in the three and six months ended June 30, 2011 and 2010.

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 June 30, 2011, the Company recorded $2,073 in workers compensation insurance recovery receivables and a corresponding increase in its workers compensation liability as of June 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 six months ended June 30, 2011 and 2010.

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.

Table of Contents

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Condensed Consolidated Financial Statements (Continued)

(amounts and shares in thousands)

(Unaudited)

Net Income 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 six months ended June 30, 2011 were 762 stock options of which 571 stock options and 597 stock options were out-of-the money for the three and six months ended June 30, 2011, respectively, and therefore anti-dilutive. Excluded from the Company s diluted weighted average common shares outstanding calculation for the three and six months ended June 30, 2010 were 607 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.

Reclassifications

Certain reclassifications have been made to prior periods financial statements in order to conform them to the current period s presentation.

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 $1,134 as of June 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.

Under business combination accounting, the total purchase price will be 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

Table of Contents

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, we will incur an impairment charge for the amount during the fiscal quarter in which such determination is made.

Table of Contents

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

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 June 30, 2010	Six Months Ended June 30, 2010
Net service revenues	$ 70,450	$ 138,298
Operating income	3,442	6,369
Net income	$ 1,724	$ 3,191
Basic earnings per share	$ 0.16	$ 0.30
Diluted earnings per share	$ 0.16	$ 0.30

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. Details of Certain Balance Sheet Accounts

Prepaid expenses and other current assets consisted of the following:

	June 30, 2011	December 31, 2010
Prepaid health insurance	$ 3,013	$ 5,337
Prepaid workers compensation and liability insurance	2,404	1,386
Prepaid rent	201	198
Workers compensation insurance receivable	2,073	
Other	1,399	783
	$ 9,090	$ 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 June 30, 2011, the Company recorded $2,073 in workers compensation insurance recovery receivables and a corresponding increase in its workers compensation liability as of June 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 June 30, 2011.

Accrued expenses consisted of the following:

	June 30, 2011	December 31, 2010
Accrued payroll	$ 11,571	$ 10,453
Accrued workers compensation insurance	10,693	8,218
Accrued payroll taxes	2,217	1,579
Accrued health insurance	4,222	3,858
Accrued interest	129	144
Current portion of contingent earn-out obligation	1,134	502
Other	1,499	1,775
	$ 31,465	$ 26,529

Table of Contents

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Condensed Consolidated Financial Statements (Continued)

(amounts and shares in thousands)

(Unaudited)

5. Long-Term Debt

Long-term debt consisted of the following:

	June 30, 2011	December 31, 2010
Revolving credit loan	$ 30,500	$ 33,250
Term loan	3,958	5,000
Subordinated dividend notes bearing interest at 10.0%	5,569	6,569
Insurance note payable, due May 2011 and bearing interest at 2.9%		366
Total	40,027	45,185
Less current maturities	(6,000)	(5,158)
Long-term debt	$ 34,027	$ 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 June 30, 2011.

On May 24, 2011, the Company entered into a Joinder, Consent and Amendment No. 3 to the 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 (iii) 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 June 30, 2011 the interest rate on the revolving credit loan facility was 4.8% (30 day LIBOR rate was 0.2%) and total availability based on the Fourth Amendment was $14,143. Subsequent to June 30, 2011, the Company made a payment of approximately $25.5 million on its revolving credit loan resulting from a significant payment received from the State of Illinois at the end of June 2011.

Table of Contents

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Condensed Consolidated Financial Statements (Continued)

(amounts and shares in thousands)

(Unaudited)

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 amended 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.

Table of Contents

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Condensed Consolidated Financial Statements (Continued)

(amounts and shares in thousands)

(Unaudited)

6. 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 six months ended June 30, 2011 and 2010:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Net service revenue				
Home & Community	$ 55,009	$ 54,144	$ 109,152	$ 106,845
Home Health	13,243	13,021	25,942	24,925
	$ 68,252	$ 67,165	$ 135,094	$ 131,770
Operating income				
Home & Community	$ 6,020	$ 5,492	$ 11,345	$ 10,983
Home Health	840	1,688	1,538	2,694
General corporate expenses & corporate depreciation	(4,170)	(3,908)	(8,187)	(7,713)
	$ 2,690	$ 3,272	$ 4,696	$ 5,964
Depreciation and amortization				
Home & Community	$ 609	$ 621	$ 1,219	$ 1,235
Home Health	129	158	257	321
Corporate	189	172	380	341

$ 927	$ 951	$ 1,856	$ 1,897

15

Table of Contents

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Condensed Consolidated Financial Statements (Continued)

(amounts and shares in thousands)

(Unaudited)

7. 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 $1,500 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. We 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, we and the other named defendants entered into a stipulation of settlement with the plaintiffs with respect to the class action, pursuant to which we caused $3,000 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 effectiveness of the settlement is conditioned on the judgment of dismissal entered by the court becoming final (which will occur if no appeal is filed by August 25, 2011). There can be no assurance the settlement will become effective.

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, we and the other defendants entered into a stipulation of settlement with the plaintiff with respect to the shareholder derivative action, pursuant to which we have caused the plaintiff s counsel s fees and expenses in an amount up to and including $200 to be paid. In addition, we have 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 effectiveness of the settlement is conditioned upon the judgment of dismissal entered in the class action described above becoming final. There can be no assurance that the settlement will become effective.

Illinois Attorney General s Investigation

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. While the CID primarily sought general information regarding our administration of the program, there were specific details sought concerning certain individuals.

The Company submitted its response to the CID on January 7, 2011. On February 15, 2011, the Assistant Attorney General issued a Supplemental CID, which contained a written complaint from an individual in the program. The Supplemental CID sought additional information concerning the administration of the program and many of the questions appear to be tailored to respond to specific complaints received by the Illinois Attorney General s office. The Company submitted its response to the Supplemental CID on April 15, 2011. In March and April of 2011, the Company received requests for information related to specific individuals and it has responded to the first of such requests. The Company is cooperating with the investigation and submitted responses to the requests for information related to specific individuals. Given the preliminary stage of this investigation and the uncertainty regarding its direction, we are unable at this time to offer an assessment as to whether the investigation will have any impact on the Company s financial position or operations.

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.

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

Table of Contents

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Condensed Consolidated Financial Statements (Continued)

(amounts and shares in thousands)

(Unaudited)

include non-compete and nondisclosure provisions, as well as provide for defined severance payments in the event of termination.

8. 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 12.9% and 42.2% of the Company s net service revenues for the three months ended June 30, 2011, respectively, and 12.7% and 36.8% of the Company s net service revenues for the three months ended June 30, 2010, respectively. Medicare and one state governmental agency accounted for 12.7% and 41.8% of the Company s net service revenues for the six months ended June 30, 2011, respectively, and 12.1% and 36.5% of the Company s net service revenues for the six months ended June 30, 2010, respectively.

The related receivables due from Medicare and the state agency represented 13.4% and 39.8%, respectively, of the Company s accounts receivable at June 30, 2011, and 9% and 58%, respectively, of the Company s accounts receivable at December 31, 2010.

9. Subsequent Events

On July 26, 2011, the Company entered into the Fourth Amendment. The Fourth Amendment (i) 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 (ii) 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.

Subsequent to June 30, 2011, the Company made a payment of approximately $25.5 million on its revolving credit loan resulting from a significant payment received from the State of Illinois at the end of June 2011.

Table of Contents

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 over 125 locations across 19 states to over 27,000 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). There is 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.

Table of Contents

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 proposes 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 proposes four payment changes. First, CMS proposes to reduce the home health base episode payment to account for its perceived nominal case-mix growth from the inception of the home health PPS through 2009 by implementing a 5.06% payment reduction to the national standardized 60-day episode rates. Second, CMS proposes removing two codes for hypertension from the home health PPS case-mix model s hypertension group. Third, CMS proposes to revise payment weights to provide what it believes will be more accurate case-mix payments. CMS proposes 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 proposes 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 -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 proposes 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 April 7, 2011 CMS published proposed regulations for the Medicare Shared Savings Program, which will be in place no later than January 1, 2012. 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, to a certain extent, bear the risk of losses. CMS requested comments on a number of issues including the range of providers and suppliers that could participate in an ACO. The reaction to the proposed regulations has been 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. It is not known when final regulations will be published. Although provider and supplier participation in an ACO is voluntary, participation by our competitors in some markets may force us to participate as well. Even where we do not participate we will need to be mindful of quality measure criteria and 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.

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. 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.

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 June 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	(2)	(2)	(4)
Total at June 30, 2011	94	31	125

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.

Table of Contents

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

	Home & Community			
	For the Three Months Ended June 30,		For the Six Months Ended June 30,	
	2011	2010	2011	2010
State, local and other governmental programs	94.5%	94.0%	94.5%	94.3%
Commercial	0.9	0.9	0.8	0.8
Private duty	4.6	5.1	4.7	4.9
	100.0%	100.0%	100.0%	100.0%

	Home Health			
	For the Three Months Ended June 30,		For the Six Months Ended June 30,	
	2011	2010	2011	2010
Medicare	66.3%	65.7%	65.9%	64.0%
State, local and other governmental programs	18.2	18.9	18.4	20.0
Commercial	9.9	9.2	10.0	9.6
Private duty	5.6	6.2	5.7	6.4
	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 55.3% and 10.5%; and 51.9% and 13.6%, of our total net service revenues for the three months ended June 30, 2011 and 2010, respectively. Net service revenues from our operations in Illinois and California represented 54.9% and 10.6%; and 51.4% and 13.8%, of our total net service revenues for the six months ended June 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 42.2% and 12.9%; and 36.8% and 12.7% of our total net service revenues for the three months ended June 30, 2011 and 2010, respectively. The Illinois Department on Aging and Medicare accounted for 41.8% and 12.7%; and 36.5% and 12.1% of our total net service revenues for the six months ended June 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.

Our general and administrative expenses for home & community and home health services consist principally of supervisory personnel, care coordination and

Table of Contents

office administration costs. Our general and administrative expenses for home health also include additional staffing for clinical and admissions processing. These expenses consist principally of wages, payroll taxes and benefit-related costs; facility rent; operating costs such as utilities, postage, telephone and office expenses; and bad debt expense.

Our corporate general and administrative expenses cover the centralized administrative departments of accounting, information systems, human resources, billing and collections and contract administration, as well as national program coordination efforts for marketing and private duty. These expenses primarily consist of compensation, including stock-based compensation, payroll taxes, and related benefits; legal, accounting and other professional fees; rents and related facility costs; and other operating costs such as software application costs, software implementation costs, travel, general insurance and bank account maintenance fees.

Depreciation and Amortization Expenses

We amortize our intangible assets with finite lives, consisting of customer and referral relationships, trade names, trademarks, state licenses and non-compete agreements, principally on accelerated methods based upon their estimated useful lives. Depreciable assets at the segment level consist principally of furniture and equipment, and for the home & community segment, also include vehicles for our adult day centers.

A substantial portion of our capital expenditures is infrastructure-related or for our corporate office. Corporate asset purchases consist primarily of network administration and telephone equipment, operating system software, furniture and equipment. 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.

Interest Expense, net

Our net interest expense consists of interest costs on our credit facility and other debt instruments and is recorded net of any interest income recorded by us. 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. We did not record any prompt payment interest income for the three and six months ended June 30, 2011 and 2010.

Income Tax Expense

All of our income is from domestic sources. We incur state and local taxes in states in which we operate. The differences from the federal statutory rate of 34% are principally due to state taxes and the use of federal employment tax credits.

Table of Contents

Results of Operations

Three Months Ended June 30, 2011 Compared to Three Months Ended June 30, 2010

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

	Three Months Ended June 30, 2011		Three Months Ended June 30, 2010		Change	
	Amount	% of Net Service Revenues	Amount	% of Net Service Revenues	Amount	%
	(in thousands, except percentages)					
Net service revenues:						
Home & Community	$ 55,009	80.6%	$ 54,144	80.6%	$ 865	1.6%
Home Health	13,243	19.4	13,021	19.4	222	1.7
Total	68,252	100.0	67,165	100.0	1,087	1.6
Operating income before corporate expenses:						
Home & Community	6,020	10.9	5,492	10.1	528	9.6
Home Health	840	6.3	1,688	13.0	(848)	(50.2)
Total	6,860	10.1	7,180	10.7	(320)	(4.5)
Corporate general and administrative expenses	3,981	5.8	3,736	5.6	245	6.6
Corporate depreciation and amortization	189	0.3	172	0.3	17	9.9
Total operating income	2,690	4.0	3,272	4.9	(582)	(17.8)
Interest expense, net	668	1.0	750	1.1	(82)	(10.9)
Income from operations before taxes	2,022	3.0	2,522	3.8	(500)	(19.8)
Income tax expense	689	1.0	868	1.3	(179)	(20.6)
Net income	$ 1,333	2.0%	$ 1,654	2.5%	$ (321)	(19.4)%

Our net service revenues increased by $1.1 million, or 1.6%, to $68.3 million for the three months ended June 30, 2011 compared to $67.2 million for the three months ended June 30, 2010. This increase represents 1.6% growth in home & community net service revenues and 1.7% growth in home health net service revenues. Home & community revenue growth was primarily driven by revenues attributable to the acquisition of Advantage on July 26, 2010 partially offset by a reduction in services revenues from the loss of certain programs during the second half of 2010. Our home health growth in revenue for the three months ended June 30, 2011 was due to the revenue contribution from the acquisition of Advantage partially offset by a decrease in Medicare revenue due to a 2011 Medicare reduction in payment base rates, a decrease in Medicare admissions, and due to a decline in non-Medicare service revenues.

Total operating income, expressed as a percentage of net service revenues, for the three months ended June 30, 2011 and 2010, was 4.0% and 4.9%, respectively. Corporate general and administrative expenses increased by 0.2% to 5.8% of net service revenues for the three months ended June 30, 2011. The decrease of $0.6 million in operating income for the three months ended June 30, 2011 was primarily due to an increase in general and administrative expenses in our home health division relating to an increase in administrative wages, an increase in consulting costs related to interim home health management services provided until the search for a permanent vice president position was completed, and an increase in data processing costs. In addition, the decrease was due to an increase in corporate wage related costs as a result of an increase in our corporate infrastructure and an increase in other corporate administrative expenses.

22

Table of Contents

Home & Community Segment

The following table sets forth, for the periods indicated, a summary of our home & community segment s unaudited results of operations through operating income, before corporate expenses:

	Three Months Ended June 30, 2011		Three Months Ended June 30, 2010		Change	
	Amount	% of Net Service Revenues	Amount	% of Net Service Revenues	Amount	%
	(in thousands, except percentages)					
Net service revenues	$ 55,009	100.0%	$ 54,144	100.0%	$ 865	1.6%
Cost of service revenues	41,076	74.7	40,450	74.7	626	1.5
Gross profit	13,933	25.3	13,694	25.3	239	1.7
General and administrative expenses	7,304	13.3	7,581	14.0	(277)	(3.7)
Depreciation and amortization	609	1.1	621	1.1	(12)	(1.9)
Operating income	$ 6,020	10.9%	$ 5,492	10.1%	$ 528	9.6%
Segment Data:						
Billable hours (in thousands)	3,229		3,252		(23)	(0.7)%
Billable hours per business day	50,456		50,819		(363)	(0.7)%
Revenues per billable hour	$ 17.03		$ 16.65		$ 0.38	2.3%
Average weekly census	21,036		20,648		388	1.9%

Net service revenues from state, local and other governmental programs accounted for 94.5% and 94.0% of home & community net service revenues for the three months ended June 30, 2011 and 2010, respectively. Private duty and, to a lesser extent, commercial payors accounted for the remainder of net service revenues.

Net service revenues increased $0.9 million, or 1.6%, to $55.0 million for the three months ended June 30, 2011 compared to $54.1 million for the three months ended June 30, 2010. Net service revenue growth in the home & community segment included the Advantage acquisition, which contributed $2.4 million in service revenues for the three months ended June 30, 2011. Excluding $1.8 million in revenue from the loss of certain programs and locations closed during the second half of 2010, organic revenue increased by $0.2 million, or 0.4%, which is primarily due to a 2.6% increase in revenues per billable hour.

Gross profit, expressed as a percentage of net service revenues was 25.3% for the three months ended June 30, 2011 and 2010. Excluding the gross profit contribution attributable to Advantage, gross profit, expressed as a percentage of net service revenues, decreased by 0.2% to 25.1% for three months ended June 30, 2011 compared to 25.3% for the three months ended June 30, 2010. The decrease of 0.2% was principally due to contractual field wage increases that became effective during the third quarter of 2010 and increases in unemployment payroll taxes.

General and administrative expenses, expressed as a percentage of net service revenues, decreased 0.7% to 13.3% for the three months ended June 30, 2011, from 14.0% for the three months ended June 30, 2010. Excluding the $0.4 million of general and administrative expenses attributable to Advantage, general and administrative expenses decreased by $0.7 million, or 8.9%, to $6.9 million for the three months ended June 30, 2011 compared to $7.6 million for the three months ended June 30, 2010. The decrease was primarily due to a reduction in wage related costs and a decrease in other administrative costs due to our focus on administrative staffing requirements and on general cost controls.

Depreciation and amortization, expressed as a percentage of net service revenues was 1.1% for the three months ended June 30, 2011 and 2010. Amortization of intangibles, which are principally amortized using accelerated methods, totaled $0.6 million for the three months ended June 30, 2011 and 2010.

Table of Contents

Home Health Segment

The following table sets forth, for the periods indicated, a summary of our home health segment s unaudited results of operations through operating income, before corporate expenses:

	Three Months Ended June 30, 2011		Three Months Ended June 30, 2010		Change	
	Amount	% of Net Service Revenues	Amount	% of Net Service Revenues	Amount	%
	(in thousands, except percentages)					
Net service revenues	$ 13,243	100.0%	$ 13,021	100.0%	$ 222	1.7%
Cost of service revenues	7,066	53.4	6,979	53.6	87	1.2
Gross profit	6,177	46.6	6,042	46.4	135	2.2
General and administrative expenses	5,208	39.3	4,196	32.2	1,012	24.1
Depreciation and amortization	129	1.0	158	1.2	(29)	(18.4)
Operating income	$ 840	6.3%	$ 1,688	13.0%	$ (848)	(50.2)%
Segment Data:						
Average weekly census:						
Medicare	1,475		1,602		(127)	(7.9)%
Non-Medicare	1,528		1,493		35	2.3%
Medicare admissions	2,274		2,179		95	4.4%
Medicare revenues per episode completed	$ 2,581		$ 2,633		$ (52)	(2.0)%

Net service revenues from Medicare accounted for 66.3% and 65.7% of home health net service revenues for the three months ended June 30, 2011 and 2010, respectively. Non-Medicare net service revenues, in order of significance, include Medicaid and other governmental programs, commercial insurers and private duty payors.

Net service revenues increased $0.2 million, or 1.7%, to $13.2 million for the three months ended June 30, 2011 compared to $13.0 million for the three months ended June 30, 2010. Revenue from the Advantage acquisition contributed $0.9 million to net service revenues for the three months ended June 30, 2011. Excluding the acquisition of Advantage, net service revenues decreased $0.7 million, or 5.5%, to $12.3 million for the three months ended June 30, 2011 compared to $13.0 million for the three months ended June 30, 2010. This decline in net service revenue is primarily attributable to the 2011 Medicare reduction in payment base rates and a decline in non-Medicare service revenues.

Gross profit, expressed as a percentage of net service revenues, increased by 0.2% to 46.6% for the three months ended June 30, 2011, from 46.4% for the three months ended June 30, 2010. Excluding the gross profit contribution attributable to Advantage, gross profit, expressed as a percentage of net service revenues, decreased by 0.2% to 46.2% for the three months ended June 30, 2011 compared to 46.4% for the three months ended June 30, 2010. The decrease in gross margin of 0.2% is primarily due to the reduction in 2011 Medicare payment base rates partially offset by an increase in our revenue mix from our higher margin Medicare business in the second quarter of 2011 and due to an increase in revenue relating to higher than normal favorable final claim adjustments.

General and administrative expenses, expressed as a percentage of net service revenues, increased 7.1% to 39.3% for the three months ended June 30, 2011, from 32.2% for the three months ending June 30, 2010. Excluding the acquisition of Advantage, general and administrative expenses, expressed as a percentage of net service revenues, increased 6.9% to 39.1% for the three months ended June 30, 2011, from 32.2% for

the three months ended June 30, 2010. General and administrative expenses, when excluding $0.4 million attributable to Advantage, increased $0.6 million, or 14.7%, to $4.8 million for the three months ended June 30, 2011 compared to $4.2 million for the three months ended June 30, 2010. This increase was due to an increase in consulting costs primarily related to interim home health management services provided until the search for a permanent vice president position was completed and an increase in other administrative costs consisting primarily of data processing costs and increased travel related costs. We completed our search for the vice president of our home health division with the new leadership commencing in July 2011.

Table of Contents

Depreciation and amortization, expressed as a percentage of net service revenues, decreased by 0.2% to 1.0% for the three months ended June 30, 2011, from 1.2% for the three months ended June 30, 2010. Amortization of intangibles, which are principally amortized using accelerated methods, totaled $0.2 million and $0.1 million for the three months ended June 30, 2011 and 2010, respectively.

Corporate General and Administrative Expense

Corporate general and administrative expenses increased $0.3 million, or 6.6%, to $4.0 million for the three months ended June 30, 2011, from $3.7 million for the three months ended June 30, 2010. These expenses, expressed as a percentage of net service revenues, were 5.8% and 5.6% for the three months ended June 30, 2011 and 2010, respectively. This increase was primarily due to an increase in wage related costs as a result of an increase in our corporate infrastructure to position us for future growth and an increase in other administrative expenses.

Interest Expense

Net interest expense was consistent at $0.7 million for the three months ended June 30, 2011 and 2010. 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. We did not record any prompt payment interest income for the three months ended June 30, 2011 and 2010.

Income Tax Expense

Our effective tax rates for the three months ended June 30, 2011 and 2010 were 34.1% and 34.4%, respectively. The principal difference between the Federal and state statutory rates and our effective tax rate is the use of Federal employment opportunity tax credits. The increase in our second quarter 2011 effective tax rate is principally due to a State of Illinois tax increase that became effective at the beginning of 2011.

Six Months Ended June 30, 2011 Compared to Six Months Ended June 30, 2010

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

	Six Months Ended June 30, 2011		Six Months Ended June 30, 2010		Change	
	Amount	% of Net Service Revenues	Amount	% of Net Service Revenues	Amount	%
	(in thousands, except percentages)					
Net service revenues:						
Home & Community	$ 109,152	80.8%	$ 106,845	81.1%	$ 2,307	2.2%
Home Health	25,942	19.2	24,925	18.9	1,017	4.1
Total	135,094	100.0	131,770	100.0	3,324	2.5
Operating income before corporate expenses:						
Home & Community	11,345	10.4	10,983	10.3	362	3.3
Home Health	1,538	5.9	2,694	10.8	(1,156)	(42.9)
Total	12,883	9.6	13,677	10.4	(794)	(5.8)
Corporate general and administrative expenses	7,807	5.8	7,372	5.6	435	5.9
Corporate depreciation and amortization	380	0.3	341	0.3	39	11.4
Total operating income	4,696	3.5	5,964	4.5	(1,268)	(21.3)
Interest expense, net	1,381	1.0	1,468	1.1	(87)	(5.9)

Income from operations before taxes	3,315	2.5	4,496	3.4	(1,181)	(26.3)
Income tax expense	1,129	0.9	1,484	1.1	(355)	(23.9)
Net income	$ 2,186	1.6%	$ 3,012	2.3%	$ (826)	(27.4)%

Our net service revenues increased by $3.3 million, or 2.5%, to $135.1 million for the six months ended June 30, 2011 compared to $131.8 million for the six months ended June 30, 2010. This increase represents 2.2% growth in home & community net service revenues and 4.1% growth in home health net service revenues. Home & community revenue growth was driven by revenues attributable to the acquisition of Advantage on July 26, 2010 partially offset by a reduction in services revenues from the loss of certain programs during the second half of 2010. Our home health growth in revenue for the six months ended June 30, 2011 was primarily due to the revenue contribution from the acquisition of Advantage partially offset by the 2011 Medicare reduction in payment base rates, a decrease in Medicare admissions, and due to a decline in non-Medicare service revenues.

Total operating income, expressed as a percentage of net service revenues, for the six months ended June 30, 2011 and 2010, was 3.5% and 4.5%, respectively. Corporate general and administrative expenses increased by 0.2% to 5.8% of net service revenues for the six months ended June 30, 2011 compared to 5.6% for the six months ended June 30, 2010.

Table of Contents

Home & Community Segment

The following table sets forth, for the periods indicated, a summary of our home & community segment s unaudited results of operations through operating income, before corporate expenses:

	Six Months Ended June 30, 2011		Six Months Ended June 30, 2010		Change	
	Amount	% of Net Service Revenues	Amount	% of Net Service Revenues	Amount	%
	(in thousands, except percentages)					
Net service revenues	$ 109,152	100.0%	$ 106,845	100.0%	$ 2,307	2.2%
Cost of service revenues	81,853	75.0	79,724	74.6	2,129	2.7
Gross profit	27,299	25.0	27,121	25.4	178	0.7
General and administrative expenses	14,735	13.5	14,903	13.9	(168)	(1.1)
Depreciation and amortization	1,219	1.1	1,235	1.2	(16)	(1.3)
Operating income	$ 11,345	10.4%	$ 10,983	10.3%	$ 362	3.3%
Segment Data:						
Billable hours (in thousands)	6,414		6,424		(10)	(0.2)%
Billable hours per business day	50,506		50,582		(76)	(0.2)%
Revenues per billable hour	$ 17.02		$ 16.63		$ 0.39	2.3%
Average weekly census	20,948		20,421		527	2.6%

Net service revenues from state, local and other governmental programs accounted for 94.5% and 94.3% of home & community net service revenues for the six months ended June 30, 2011 and 2010, respectively. Private duty and, to a lesser extent, commercial payors accounted for the remainder of net service revenues.

Net service revenues increased $2.3 million, or 2.2%, to $109.2 million for the six months ended June 30, 2011 compared to $106.8 million for the six months ended June 30, 2010. Net service revenue growth in the home & community segment included the Advantage acquisition, which contributed $4.9 million in service revenues for the six months ended June 30, 2011. Excluding $3.8 million in revenue from the loss of certain programs and locations closed during the second half of 2010, organic revenue increased by $1.2 million, or 1.1%. This increase is primarily due to a 2.5% increase in revenues per billable hour.

Gross profit, expressed as a percentage of net service revenues, decreased by 0.4% to 25.0% for the six months ended June 30, 2011, from 25.4% for the six months ended June 30, 2010. Excluding the gross profit contribution attributable to Advantage, gross profit, expressed as a percentage of net service revenues, decreased by 0.6% to 24.8% for six months ended June 30, 2011 compared to 25.4% for the six months ended June 30, 2010. The decrease of 0.6% was principally due to contractual field wage increases that became effective during the third quarter of 2010 and increases in unemployment payroll taxes.

General and administrative expenses, expressed as a percentage of net service revenues, decreased 0.4% to 13.5% for the six months ended June 30, 2011, from 13.9% for the six months ended June 30, 2010. Excluding the $0.8 million of general and administrative expenses attributable to Advantage, general and administrative expenses decreased by $0.9 million, or 6.3%, to $14.0 million for the six months ended June 30, 2011 compared to $14.9 million for the six months ended June 30, 2010. The decrease was primarily due to a reduction in wage related

costs due to our focus on administrative staffing requirements and cost controls.

Depreciation and amortization, expressed as a percentage of net service revenues, decreased by 0.1% to 1.1% for the six months ended June 30, 2011, from 1.2% for the six months ended June 30, 2010. Amortization of intangibles, which are principally amortized using accelerated methods, totaled $0.6 million for the six months ended June 30, 2011 and 2010.

Table of Contents

Home Health Segment

The following table sets forth, for the periods indicated, a summary of our home health segment s unaudited results of operations through operating income, before corporate expenses:

	Six Months Ended June 30, 2011		Six Months Ended June 30, 2010		Change	
	Amount	% of Net Service Revenues	Amount	% of Net Service Revenues	Amount	%
	(in thousands, except percentages)					
Net service revenues	$ 25,942	100.0%	$ 24,925	100.0%	$ 1,017	4.1%
Cost of service revenues	14,077	54.3	13,490	54.1	587	4.4
Gross profit	11,865	45.7	11,435	45.9	430	3.8
General and administrative expenses	10,070	38.8	8,420	33.8	1,650	19.6
Depreciation and amortization	257	1.0	321	1.3	(64)	(19.9)
Operating income	$ 1,538	5.9%	$ 2,694	10.8%	$ (1,156)	(42.9)%
Segment Data:						
Average weekly census:						
Medicare	1,470		1,533		(63)	(4.1)%
Non-Medicare	1,521		1,515		6	0.4%
Medicare admissions	4,547		4,315		232	5.4%
Medicare revenues per episode completed	$ 2,692		$ 2,598		$ 94	3.6%

Net service revenues from Medicare accounted for 65.9% and 64.0% of home health net service revenues for the six months ended June 30, 2011 and 2010, respectively. Non-Medicare net service revenues, in order of significance, include Medicaid and other governmental programs, commercial insurers and private duty payors.

Net service revenues increased $1.0 million, or 4.1%, to $25.9 million for the six months ended June 30, 2011 compared to $24.9 million for the six months ended June 30, 2010. Revenue from the Advantage acquisition contributed $1.9 million to net service revenues for the six months ended June 30, 2011. Excluding the acquisition of Advantage, net service revenues decreased $0.9 million, or 3.5%, to $24.0 million for the six months ended June 30, 2011 compared to $24.9 million for the six months ended June 30, 2010. This decline in net service revenue is primarily attributable to the 2011 Medicare reduction in payment base rates and a decline in non-Medicare service revenues.

Gross profit, expressed as a percentage of net service revenues, decreased by 0.2% to 45.7% for the six months ended June 30, 2011, from 45.9% for the six months ended June 30, 2010. Excluding the gross profit contribution attributable to Advantage, gross profit, expressed as a percentage of net service revenues, decreased by 1.0% to 44.9% for the six months ended June 30, 2011 compared to 45.9% for the six months ended June 30, 2010. The decrease in gross margin is primarily due to the reduction in 2011 Medicare payment base rates partially offset by an increase in our revenue mix from our higher margin Medicare business in the first six months of 2011.

General and administrative expenses, expressed as a percentage of net service revenues, increased 5.0% to 38.8% for the six months ended June 30, 2011, from 33.8% for the six months ending June 30, 2010. Excluding the acquisition of Advantage, general and administrative expenses, expressed as a percentage of net service revenues, increased 5.0% to 38.8% for the six months ended June 30, 2011, from 33.8% for

the six months ended June 30, 2010. General and administrative expenses, when excluding $0.7 million attributable to Advantage, increased $0.9 million, or 10.8%, to $9.3 million for the six months ended June 30, 2011 compared to $8.4 million for the six months ended June 30, 2010. This increase was due to an increase in consulting costs primarily related to interim home health management services provided until the search for a permanent vice president position was completed and an increase in other administrative costs consisting primarily of data processing costs and increased travel related costs. We completed our search for the vice president of our home health division with the new leadership commencing in July 2011.

Table of Contents

Depreciation and amortization, expressed as a percentage of net service revenues, decreased by 0.3% to 1.0% for the six months ended June 30, 2011, from 1.3% for the six months ended June 30, 2010. Amortization of intangibles, which are principally amortized using accelerated methods, totaled $0.3 million for the six months ended June 30, 2011 and 2010.

Corporate General and Administrative Expense

Corporate general and administrative expenses increased $0.4 million, or 5.9%, to $7.8 million for the six months ended June 30, 2011, from $7.4 million for the six months ended June 30, 2010. These expenses, expressed as a percentage of net service revenues, were 5.8% and 5.6% for the six months ended June 30, 2011 and 2010, respectively. This increase was primarily due to an increase in wage related costs as a result of an increase in our corporate infrastructure to position us for future growth and an increase in other administrative expenses.

Interest Expense

Net interest expense was $1.4 million and $1.5 million for the six months ended June 30, 2011 and 2010, respectively. The first half of 2010 included an existing interest rate agreement with a notional value of $22.5 million that expired on March 10, 2010. This agreement did not qualify as an accounting hedge under ASC Topic 815. As such, changes in the value of this agreement are reflected in interest expenses in the period of change. For the six months ended March 31, 2010 the mark-to-market adjustment included in interest expense was a decrease of $0.2 million. Excluding this mark-to-market adjustment, interest expense decreased $0.3 million during the first six months of 2011 which was due to a reduction in outstanding debt.

Income Tax Expense

Our effective tax rates for the six months ended June 30, 2011 and 2010 were 34.1% and 33.0%, respectively. The principal difference between the Federal and state statutory rates and our effective tax rate is the use of Federal employment opportunity tax credits. The increase in our 2011 effective tax rate is principally due to a State of Illinois tax increase that became effective at the beginning of 2011.

Liquidity and Capital Resources

Overview

Our primary sources of liquidity are cash from operations and borrowings under our credit facility. At June 30, 2011 and December 31, 2010, we had cash balances of $24.1 million and $0.8 million, respectively. The $23.3 million increase in cash reflects a significant payment received from the State of Illinois at the end of June 2011.

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. Due to its revenue deficiencies and financing issues, the State of Illinois has reimbursed us on a delayed basis with respect to our various agreements including with our largest payor, the Illinois Department on Aging. However, we experienced an improvement in the payment amounts received from the State of Illinois during the first half of 2011 which resulted in a decrease in the open net receivable balance from the State of Illinois of $20.5 million for the six months ended June 30, 2011, from $47.7 million as of December 31, 2010 to $27.2 million as of June 30, 2011. This improvement as of June 30, 2011 reflects a significant payment received from the State of Illinois at the end of June 2011. We do not expect to continue to receive this level of payments on a consistent basis in the near term and anticipate that our open net receivable balance from the State of Illinois will increase over the remainder of the year.

While the net receivable balance has decreased as of June 30, 2011, the State of Illinois continues to reimburse us on a delayed basis. These payment delays have adversely impacted, and may further adversely impact, our liquidity, and may result in the need to increase borrowings under our credit facility. Delayed reimbursements from our other State of Illinois payors and deterioration in the aging in the private duty business have also contributed to the increase in our receivables balances.

On March 18, 2010, we entered into the first amendment (the First Amendment) to our credit facility. The First Amendment (i) increased the maximum aggregate amount of revolving loans available to us by $5.0 million to $55.0 million, (ii) modified our maximum senior debt leverage ratio from 2.75 to 1.0 to 3.00 to 1.0 for the twelve (12) month period ending March 31, 2010 and each twelve (12) month period ending on the last day of each fiscal quarter thereafter and (iii) increased the advance multiple used to determine the amount of the borrowing base from 2.75 to 3.00.

On March 18, 2010, we also amended our subordinated dividend notes that we issued on November 2, 2009 in the aggregate original principal amount of $12.9 million. A balance of $7.8 million was outstanding on the dividend notes as of December 31, 2009. Pursuant to the amendments, the dividend notes were amended to (i) extend the maturity date of the notes from September 30, 2011 to December 31, 2012, (ii) modify the amortization schedule of the notes to reduce the annual principal payment amounts from $4.5 million to $1.3 million in 2010; from $3.3 million to $2.5 million in 2011; and provide for total payments in 2012 of $4.0 million and (iii) permit, based on our leverage ratio, the prepayment of all or a portion of the principal amount of the notes, together with interest on the principal amount.

On July 26, 2010, we entered into a second amendment (the Second Amendment) to our credit facility. The Second Amendment provided for a $5.0 million term loan component of the credit facility, the proceeds of which were used to finance a portion of the purchase price payable in connection with our acquisition of certain assets of Advantage effective July 25, 2010. The term loan will be repaid in 24 equal monthly installments, which commenced 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 term loan has a maturity date of January 5, 2013. 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. The contingent earn-out obligation has been recorded at its fair value of $1.6 million, which is the present value of our obligation based on probability-weighted estimates of the achievement of certain performance targets, as defined. In April 2011, we paid the first earn-out payment of $0.5 million to the sellers of Advantage. The second earn-out payment obligation is recorded at $1.1 million as of June 30, 2011 and will be payable, if required, during the second quarter of 2012.

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

On July 26, 2011, we entered into a fourth amendment (the Fourth Amendment) to our credit facility. The Fourth Amendment (i) modified our 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 (ii) 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 available borrowings under our credit facility.

As of June 30, 2011 we had $30.5 million outstanding on our credit facility. After giving effect to the amount drawn on our credit facility, approximately $6.8 million of outstanding letters of credit, borrowing limits based on an advanced multiple of adjusted EBITDA and the Fourth Amendment, we had $14.1 million available for borrowing under the credit facility as of June 30, 2011. Subsequent to June 30, 2011, we made a payment of approximately $25.5 million on our credit facility resulting from a significant payment received from the State of Illinois at the end of June 2011.

While our growth plan is not dependent on the completion of acquisitions, if we do not have sufficient cash resources or availability under our credit facility, or we are otherwise prohibited from making acquisitions, our growth could be limited unless we obtain additional equity or debt financing or unless we obtain the necessary

Table of Contents

consents from our lenders. We believe the available borrowings under our credit facility which, when taken together with cash from operations, will be sufficient to cover our working capital needs for at least the next 12 months.

Table of Contents

Cash Flows

The following table summarizes historical changes in our cash flows for the six months ended June 30, 2011 and 2010:

	Six Months Ended June 30,	
	2011	2010
	(unaudited)	
Net cash provided by operating activities	$ 29,098	$ 795
Net cash used in investing activities	(632)	(695)
Net cash (used in) provided by financing activities	(5,177)	317

Six Months Ended June 30, 2011 Compared to Six Months Ended June 30, 2010

Net cash provided by operating activities was $29.1 million in the six months ended June 30, 2011, compared to $0.8 million for the same period in 2010. The improvement of $28.3 million for the six months ended June 30, 2011 was primarily due to improvements in accounts receivable resulting from an increase in payments received from the State of Illinois and our continued focus on cash collections. The $25.7 million accounts receivable improvement for the six months ended June 30, 2011 over the same period in 2010 resulted from a decrease in net accounts receivable of $19.7 million for the six months ended June 30, 2011 compared to an increase in net accounts receivable of $6.2 million in the same period in 2010.

Net cash used in investing activities was $0.6 million for the six months ended June 30, 2011, compared to $0.7 million for the same period in 2010. Our investing activities for the six months ended June 30, 2011 were $0.1 million for capital expenditures and a $0.5 million earn-out payment for Advantage. Our investing activities for the same period in 2010 included payments of $0.4 million in contingent consideration made on previously acquired businesses, and $0.3 million in capital expenditures.

Net cash used in financing activities was $5.2 million for the six months ended June 30, 2011 compared to net cash proceeds of $0.3 million for the same period in 2010. Our financing activities for the six months ended June 30, 2011 were primarily driven by net payments of $2.8 million on the revolving credit portion of our credit facility, $1.0 million in payments on our term loan, payments of $1.0 million on our dividend notes and net payments of $0.4 million on all other notes. Our financing activities during the same period in 2010 were primarily driven by net borrowings from our revolving credit facility of $0.8 million which was partially offset by payments of $0.5 million on our subordinated dividend notes. Subsequent to June 30, 2011, we made a payment of approximately $25.5 million on our revolving credit loan resulting from a significant payment received from the State of Illinois at the end of June 2011.

Outstanding Accounts Receivable

Outstanding accounts receivable, net of the allowance for doubtful accounts, decreased by $19.7 million as of June 30, 2011 as compared to December 31, 2010. The decrease was primarily attributable to an increase in payments received from the State of Illinois during the first half of 2011 and our continued focus on cash collections.

We establish our allowance for doubtful accounts to the extent it is probable that a portion or all of a particular account will not be collected. Our provision for doubtful accounts is estimated and recorded primarily by aging receivables utilizing eight aging categories and applying our 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 our evaluation of these estimates, we also consider 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. We have experienced increases in the aging of our accounts receivable resulting from billing delays during the conversion process, either procedural or internal, related to both acquired agencies and transferring our existing home & community locations from a legacy system to the centralized McKesson operating system. Reasons for the delays include obtaining approvals from federal and state governmental agencies of provider numbers we acquired with our acquisitions, McKesson payor and billing set-up processes and required staff training. We have also experienced an increase in our home & community private duty business, which inherently carries a higher collection risk. Unlike our state, local and other governmental payors, these customers are responsible for their own payment (a portion of which may be funded through qualified veteran benefits). Contributing to higher receivable balances are veteran benefits that may take several months to be awarded by the Veterans Health Administration.

30

Table of Contents

Our collection procedures include review of account agings and direct contact with our payors. We have historically not used collection agencies. An uncollectible amount, not governed by amount or aging, is written off to the allowance account only after reasonable collection efforts have been exhausted. The following tables detail our accounts receivable before reserves by payor category, showing Illinois governmental payors separately, and segment and the related allowance amount at June 30, 2011 and December 31, 2010:

	June 30, 2011				
	0-90 Days	91-180 Days	181-365 Days	Over 365 Days	Total
	(in thousands, except percentages)				
Home & Community					
Illinois governmental based programs	$ 23,410	$ 1,422	$ 342	$ 1,596	$ 26,770
Other state, local and other governmental programs	10,830	880	986	1,720	14,416
Private duty and commercial	1,740	575	795	835	3,945
	35,980	2,877	2,123	4,151	45,131
Home Health					
Medicare	5,412	1,384	471	31	7,298
Other state, local and other governmental programs	1,780	422	388	179	2,769
Private duty and commercial	1,151	266	347	177	1,941
Illinois governmental based programs	243	73	23	58	397
	8,586	2,145	1,229	445	12,405
Total	$ 44,566	$ 5,022	$ 3,352	$ 4,596	$ 57,536
Related aging %	77.5%	8.7%	5.8%	8.0%	
Allowance for doubtful accounts					$ 6,251
Reserve as % of gross accounts receivable					10.9%

	December 31, 2010				
	0-90 Days	91-180 Days	181-365 Days	Over 365 Days	Total
	(in thousands, except percentages)				
Home & Community					
Illinois governmental based programs	$ 30,228	$ 14,060	$ 960	$ 1,926	$ 47,174
Other state, local and other governmental programs	10,730	248	1,188	1,636	13,802
Private duty and commercial	2,095	790	1,026	830	4,741
	43,053	15,098	3,174	4,392	65,717
Home Health					
Medicare	4,768	1,294	246	36	6,344
Other state, local and other governmental programs	2,317	600	360	181	3,458
Private duty and commercial	1,011	241	253	163	1,668
Illinois governmental based programs	303	69	24	94	490

	8,399	2,204	883	474	11,960
Total	$ 51,452	$ 17,302	$ 4,057	$ 4,866	$ 77,677
Related aging %	66.2%	22.3%	5.2%	6.3%	
Allowance for doubtful accounts					$ 6,723
Reserve as % of gross accounts receivable					8.7%

Table of Contents

We calculate our days sales outstanding (DSO) by taking the accounts receivable outstanding net of the allowance for doubtful accounts and deducting deferred revenues at the end of the period, divided by the total net service revenues for the last quarter, multiplied by the number of days in that quarter. The adjustment for deferred revenues relates to Medicare receivables which are recorded at the inception of each 60 day episode of care at the full requested anticipated payment (RAP) amount. Our DSOs at June 30, 2011 and December 31, 2010 were 65 days and 90 days, respectively. The DSO for our largest payor, the Illinois Department on Aging, at June 30, 2011 and December 31, 2010 were 65 days and 138 days, respectively. Our DSOs and the DSO for our largest payor as of June 30, 2011 reflects a significant payment received from the State of Illinois at the end of June 2011. We do not expect to continue to receive this level of payments on a consistent basis in the near term and anticipate our DSOs and the DSO for our largest payor to increase over the remainder of the year.

Indebtedness

Credit Facility

Our credit facility, most recently amended on July 26, 2011, provides a $55.0 million revolving line of credit expiring November 2, 2014, and a $5.0 million term loan maturing January 5, 2013, and includes a $15.0 million sublimit for the issuance of letters of credit. Substantially all of the subsidiaries of Holdings are co-borrowers, and Holdings has guaranteed the borrowers obligations under the credit facility. The credit facility is secured by a first priority security interest in all of Holdings and the borrowers current and future tangible and intangible assets, including the shares of stock of the borrowers.

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, 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) $55.0 million less the outstanding revolving loans and letters of credit. Interest on the revolving line of credit and term loan amounts outstanding 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 on the credit facility will be paid monthly on 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.

The credit facility 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 facility also contains certain customary financial covenants and negative covenants that, among other things, include a requirement to maintain a minimum fixed charge coverage ratio, a requirement to stay below a maximum senior leverage ratio and a requirement to stay below a maximum permitted amount of capital expenditures, as well as restrictions on guarantees, indebtedness, liens, dividends, distributions, investments and loans, subject to customary carve outs, restrictions on Holdings and the borrowers ability to enter into transactions other than in the ordinary course of business, a restriction on the ability to consummate more than three acquisitions in any calendar year, or for the purchase price of any one acquisition to exceed $0.5 million, in each case without the consent of the lenders, restrictions on mergers, transfers of assets, acquisitions, equipment, subsidiaries and affiliate transactions, subject to customary carve outs, and restrictions on fundamental changes and lines of business. We were in compliance with all of our credit facility covenants at June 30, 2011.

Dividend Notes

On March 18, 2010, we amended our subordinated dividend notes. 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 $4.5 million to $1.3 million in 2010; from $3.4 million to $2.5 million in 2011; and amended total payments in 2012 to $4.1 million, and (iii) permit, based on our leverage ratio, the prepayment of all or a portion of the principal amount of the dividend notes, together with interest on the principal amount. A balance of $5.6 million was outstanding on the dividend notes as of June 30, 2011.

Off-Balance Sheet Arrangements

As of June 30, 2011, 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 accounting principles generally accepted in the United States. 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. 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. We consider the items discussed below to be critical because of their impact on operations and their application requires our judgment and estimates.

Revenue Recognition

Approximately 95% of our home & community segment revenues for the three and six months ended June 30, 2011 and 2010, are derived from Medicaid and Medicaid waiver programs under agreements with various state and local authorities. These agreements provide for a service term from one year to an indefinite term. Services are provided based on authorized hours, determined by the relevant state or local agency, at an hourly rate specified in the agreement or fixed by legislation. Services to other payors, such as private or commercial clients, are provided at negotiated hourly rates and recognized in net service revenues as services are provided. We provide for appropriate allowances for uncollectible amounts at the time the services are rendered.

Approximately 65% of our home health segment revenues are derived from Medicare. Home health services are reimbursed by Medicare based on episodes of care. Under the Medicare Prospective Payment System, or PPS, an episode of care is defined as a length of care up to 60 days per patient with multiple continuous episodes allowed. Billings per episode under PPS vary based on the severity of the patient s condition and are subject to adjustment, both higher and lower, for changes in the patient s medical condition and certain other reasons. At the inception of each episode of care, we submit a request for anticipated payment, or RAP, to Medicare for 50% to 60% of the estimated PPS reimbursement. We estimate 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 net service 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. For open episodes, we estimate net revenues based on historical data, and adjust net service revenues for the difference, if any, between the initial RAP and ultimate final claim amount. We did not record any significant adjustments of prior period net PPS estimates.

The other approximately 35% of revenues in our home health segment are from state and local governmental agencies, commercial insurers and private individuals. Services are primarily provided to these payors on a per visit basis based on negotiated rates. As such, net service revenues are readily determinable and recognized at the

Table of Contents

time the services are rendered. We provide for appropriate allowances for uncollectible amounts at the time the services are rendered.

Accounts Receivable and Allowance for Doubtful Accounts

We are paid for our services primarily by state and local agencies under Medicaid or Medicaid waiver programs, Medicare, commercial insurance companies and private individuals. While our accounts receivable are uncollateralized, our credit risk is somewhat limited due to the significance of Medicare and state agency payors to our results of operations. Laws and regulations governing the Medicaid and Medicare programs are complex and subject to interpretation. Amounts collected may be different than amounts billed due to client eligibility issues, insufficient or incomplete documentation, services at levels other than authorized and other reasons unrelated to credit risk.

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. We did not record any prompt payment interest income for the three and six months ended June 30, 2011 and 2010.

We establish our allowance for doubtful accounts to the extent it is probable that a portion or all of a particular account will not be collected. Our allowance for doubtful accounts is estimated and recorded primarily by aging receivables utilizing eight aging categories and applying our 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 our evaluation of these estimates, we also consider 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. Historically, we have not experienced any write-off of accounts as a result of a state operating with budget deficits. While we regularly monitor state budget and funding developments for the states in which we operate, we consider losses due to state credit risk on outstanding balances as remote. We believe that our recorded allowance for doubtful accounts is sufficient to cover potential losses; however, actual collections in subsequent periods may require changes to our estimates.

Goodwill

Our 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. 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. 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. We use 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 our 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 our capital structure and external industry data. As part of the second step of this evaluation, if the carrying value of goodwill exceeds its fair value an impairment loss would be recognized.

We completed our annual impairment test of goodwill as of October 1, 2010 and determined that no goodwill impairment existed as of October 1, 2010. Although we believe that the financial projections used in the assessment are reasonable and appropriate for our two reporting units, there is uncertainty inherent in those projections. As of December 31, 2010 we determined that no events or circumstances from October 1, 2010 through December 31, 2010 indicated that a further assessment was necessary. However, the current Federal and state economic and reimbursement environments and state budgetary pressures to decrease or eliminate services we provide could have a negative effect on future earnings and cash flows from operations, and are all factors indicating the possibility of future impairment to our goodwill.

Our total stockholders equity was $90.4 million as of June 30, 2011 and our market capitalization was approximately $58.5 million based on 10,774 shares of common stock outstanding as of June 30, 2011. While the market capitalization of approximately $58.5 million is below our stockholders equity, the market capitalization metric is only one indicator of fair value. In our opinion, the market capitalization approach, by itself, is not a reliable indicator of the value for our company.

We will continue to monitor market conditions and determine if any additional interim review of goodwill is warranted. Further deterioration in the market or actual results as compared with our projections may ultimately result in a future impairment. In the event that we determine goodwill is impaired in the future, we would need to recognize a non-cash impairment charge, which could have a material adverse effect on our

consolidated balance sheet and results of operations.

Long-Lived Assets

We review our long-lived assets and finite lived intangibles for impairment whenever changes in circumstances indicate that the carrying amount of an asset may not be recoverable. To determine if impairment exists, we compare 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.

We also have indefinite-lived assets that are not subject to amortization expense such as certificates of need and licenses to conduct specific operations within geographic markets. Our management 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 we intend 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.

Workers Compensation Program

Our workers compensation insurance program has a $350,000 deductible component. We recognize our 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. We monitor our claims quarterly and adjust our reserves accordingly. These costs are recorded primarily in the cost of services caption in the consolidated statement of income. Under the agreement pursuant to which we acquired Addus HealthCare, claims under our workers compensation insurance program that relate to December 31, 2005 or earlier are the responsibility of the selling shareholders in the acquisition, subject to certain limitations. 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 June 30, 2011, we recorded $2.1 million in workers compensation insurance recovery receivables and a corresponding increase in its workers compensation liability as of June 30, 2011. We will record this new presentation of our workers compensation insurance recovery receivable and corresponding obligation on a prospective basis. The workers compensation insurance recovery receivable is included in our prepaid expenses and other current assets on the balance sheet.

Interest Expense, net

Our net interest expense consists of interest costs on our credit facility and other debt instruments and is recorded net of any interest income recorded by us. Legislation enacted in Illinois entitles designated service program providers to receive a prompt payment interest penalty based on qualifying services approved for

Table of Contents

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. We did not record any prompt payment interest income for the three and six months ended June 30, 2011 and 2010.

Income Taxes

We account for income taxes under the provisions of ASC Topic 740, *Accounting for 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 our financial statements or tax returns. Deferred taxes, resulting from differences between the financial and tax basis of our assets and liabilities, are also adjusted for changes in tax rates and tax laws when changes are enacted. ASC 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.

ITEM 4. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of June 30, 2011. The term disclosure controls and procedures, as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the Exchange Act), means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company 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. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company s management, including its principal executive and principal financial officers, 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 as of June 30, 2011, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective.

Changes in Internal Control over Financial Reporting

There was no change 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 period covered by this report that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Table of Contents

PART II OTHER INFORMATION

Item 1. 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. We 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, we and the other named defendants entered into a stipulation of settlement with the plaintiffs with respect to the class action, pursuant to which we 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 effectiveness of the settlement is conditioned on the judgment of dismissal entered by the court becoming final (which will occur if no appeal is filed by August 25, 2011). There can be no assurance the settlement will become effective.

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, we and the other defendants entered into a stipulation of settlement with the plaintiff with respect to the shareholder derivative action, pursuant to which we have caused the plaintiff s counsel s fees and expenses in an amount up to and including $0.2 million to be paid. In addition, we have 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 effectiveness of the settlement is conditioned upon the judgment of dismissal entered in the class action described above becoming final. There can be no assurance that the settlement will become effective.

Illinois Attorney General s Investigation

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. While the CID primarily sought general information regarding our administration of the program, there were specific details sought concerning certain

individuals.

The Company submitted its response to the CID on January 7, 2011. On February 15, 2011, the Assistant Attorney General issued a Supplemental CID, which contained a written complaint from an individual in the program. The Supplemental CID sought additional information concerning the administration of the program and many of the questions appear to be tailored to respond to specific complaints received by the Illinois Attorney General s office. The Company submitted its response to the Supplemental CID on April 15, 2011. In March and April of 2011, the Company received requests for information related to specific individuals and it has responded to the first of such requests. The Company is cooperating with the investigation and submitted responses to the requests for information related to specific individuals. Given the preliminary stage of this investigation and the uncertainty regarding its direction, we are unable at this time to offer an assessment as to whether the investigation will have any impact on the Company s financial position or operations.

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.

Item 1A. Risk Factors

Investing in our common stock involves a high degree of risk. In addition to the other information set forth in this quarterly report on Form 10-Q, you should carefully consider the risk factors discussed under the caption Risk Factors set forth in Part I, Item 1A, of our Annual Report on Form 10-K for the year ended

Table of Contents

December 31, 2010. All references in the Risk Factors in our Annual Report on Form 10-K to the Health Reform Act should be read to mean both the Patient Protection and Affordable Care Act signed into law on March 23, 2010 and the Health Care Education Reconciliation Act of 2010 signed into law on March 30, 2010. Except as set forth below, there have been no material changes to the risk factors previously disclosed under the caption Risk Factors in our Annual Report on Form 10-K. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition or operating results.

Our profitability could be negatively affected by a reduction in reimbursement from Medicare or other payors.

For the year ended December 31, 2010, we received approximately 12% of our net service revenues from Medicare. We generally receive fixed payments from Medicare for our services based on a projection of the services required by our consumers, which is generally based on acuity. For our Medicare consumers, we typically receive a 60-day episodic-based payment. Although Medicare currently provides for an annual adjustment of payment rates based on the increase or decrease of the medical care expenditure category of the Consumer Price Index, these rate increases may be less than actual inflation or costs, and could be eliminated or reduced in any given year. The base episode rate for home health services is also subject to an annual market basket adjustment. A market basket is a fixed-weight index that measures the cost of a specified mix of goods and services as compared to a base period. The home health market basket, which is used to adjust annually the Medicare base episodic rate for home health services, measures inflation or deflation in the prices of a mix of home health goods and services. This annual adjustment could also be eliminated or reduced in any given year. The Health Reform Act mandates a 1% reduction in the market basket update for 2011 and 2012 and a market basket productivity adjustment for 2015 and subsequent years. The market basket reductions may result in a negative adjustment. Medicare has in the past reclassified home health resource groups. As a result of reclassifications, we could receive lower reimbursement rates depending on the consumer s case mix and services provided. Medicare reimbursement rates could also decline due to the imposition of co-payments or other mechanisms that shift responsibility for a portion of the amount payable to beneficiaries. Rates could also decline due to adjustments to the wage index. Changes could also occur in the therapy payment thresholds. Our profitability for Medicare reimbursed services largely depends upon our ability to manage the cost of providing these services. If we receive lower reimbursement rates, or if our cost of providing services increases by more than the annual Medicare price adjustment, our profitability could be adversely impacted.

The amount of reimbursement based on the home health market basket may be reduced with respect to an agency seeking reimbursement if certain requirements are not met. Reduction in the payments and cost limits for the identified basket of goods based on deflation or failure to meet certain requirements is referred to in the industry as a market basket reduction. Under the 2010 final regulations, the home health market basket increase will be reduced by two percentage points to zero if an agency fails to submit certain required quality data. The required quality data consists of a set of data elements that are used to assess outcomes for adult homecare patients, which include, among other things, improvements in ambulation, bathing and surgical wound status.

In its March 2011 report to Congress, MedPAC made several recommendations that could adversely affect the home health industry and potentially our business, including recommendations that Congress rebase the payment system in a manner that would increase payments for non-therapy services and decrease payments for therapy services and a recommendation to impose a beneficiary copayment for individuals that do not begin home health services following an inpatient stay or a stay in a post acute care facility. The Health Reform Act requires CMS to rebase payments for home health services, reducing payments beginning in 2013 with a four-year phase-in and full implementation in 2016. On July 23, 2010, CMS published the 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 NRS of 3.79%. The 3.79% 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 into effect in 2009, including greater use of high therapy treatment plans above what CMS believes is any increase in patient acuity. CMS warned that it will continue to monitor changes in case-mix and if new data identifies additional increases in case-mix, CMS will impose further reductions that will not be phased in over multiple years.

In November 2010, CMS released the Final 2011 Home Health PPS Update. There is a 1.1% market basket increase for 2011 (after application of the mandated 1% reduction) and a mandated 3.79% rate reduction. The final 2011 payment base rate reflects a 0.3% decrease from the proposed market basket rate in July 2010. Home health agencies that do not submit required quality data are subject to a 2% reduction in the market basket update. In the Final 2011 Home Health PPS Update, CMS announced that would postpone its proposed 3.79% reduction in home health rates for calendar year 2012 pending its further monitoring of case-mix changes. CMS also announced that it is going to assess a variety of home health issues, including the current therapy threshold reimbursement.

In its proposed Medicare Home Health Prospective Payment System Update for Calendar Year 2012 (the Proposed 2012 Home Health PPS Update) published on July 12, 2011, CMS proposed a 5.06% reduction to the national standardized 60-day episode rates to account for its perceived nominal case-mix growth from the inception of the home health PPS through 2009. CMS proposed three additional payment changes. Removing two codes from the home health PPS case-mix model s hypertension group, revising payment weights by lowering the relative weights for home health episodes with high numbers of therapy visits and increasing the weights for episodes with little or no therapy (which will lower

payments for episodes with high numbers of therapy visits and increase payments for episodes with little or no therapy), and increasing payments of episodes of care with three to five therapy visits so that these episodes would have higher payment to cost ratios and reducing payments for episodes with 20 or just higher than 20 therapy visits, lowering the cost ratios for these episodes. 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 -5%. CMS also proposed to clarify the definition of confined to the home (homebound status) for purposes of qualification for home health services, to make the requirements clear and specific.

In the Final 2011 Home Health PPS Update CMS finalized regulations requiring a physician or non-physician practitioner to have a face-to-face encounter with the patient within 90 days of the home health start date. 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. A face-to-face encounter is required for the initial certification in order for a home health agency to receive payment. 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. 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. CMS also is requiring 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. 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. The face-to-face encounter requirement became effective April 1, 2011.

On July 12, 2011, CMS also published proposed regulations that would require physicians or their designee to have a face-to-face encounter with a beneficiary in order to certify the beneficiary for home health services reimbursed by Medicaid. The Medicaid face-to-face requirements are essentially the same as those imposed for Medicare. The face-to-face requirement may make it more difficult for Medicaid patients to obtain certification for home health services which could result in a reduction in demand for our services.

In the Final 2011 Home Health PPS Update 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.

Over time there have been recommendations to impose copayments for home health services.

As mandated by the Health Reform Act, on April 7, 2011 CMS published proposed regulations for the Medicare Shared Savings Program, which will be in place no later than January 1, 2012. The Medicare Shared Savings Program is designed to give financial incentives to healthcare providers and suppliers that meet criteria established by HHS that that work together to manage and coordinate care through 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, to a certain extent, bear the risk of losses. CMS requested comments on a number of issues including the range of providers and suppliers that could participate in an ACO. The reaction to the proposed regulations has been 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. It is not known when final regulations will be published. Although provider and supplier participation in an ACO is voluntary, participation by our competitors in some markets may force us to participate as well. Even where we do not participate we will need to be mindful of quality measure criteria and 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 form ACOs will take, what our participation might be, or what would be the affect on our company.

Any reduction in Medicare and Medicaid reimbursements, imposition of copayments that dissuade beneficiary use of our services, or material reduction in demand for our services would materially adversely affect our profitability. If we were to participate in ACOs that produced losses or if we do not participate in ACOs and our competitors do resulting in a material loss of referrals, our revenues and profits could be materially adversely affected.

Private payors, including commercial insurance companies, could also reduce reimbursement. Any reduction in reimbursement from private payors would adversely affect our profitability.

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. At this point it is uncertain what services will mandated for coverage by exchanges or at what level services will be paid or what impact the exchanges will have on reimbursement from other payors.

Our profitability could be negatively affected by deficit reduction mandated by the Budget Control Act of 2011.

On August 2, 2011 the President signed into law the Budget Control Act of 2011 (Budget Control Act), 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 over ten years. The committee could impose reductions in Medicare and Medicaid. If the committee is unable to achieve its targeted savings that will trigger automatic across the board reductions in spending of $1.2 trillion. Medicare payments are subject to the trigger although they 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. The Budget Control Act did not address reductions in physician payments mandated by the sustainable growth rate (SGR), which if implemented for calendar year 2012 would impose a reduction in physician payments of almost 30%. In order to reduce or eliminate SGR physician payment reductions and not adversely affect deficit reduction, Congress could impose other reductions in Medicare or Medicaid spending. Any reductions in Medicare or Medicaid reimbursement would materially adversely affect our profitability.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

None

Item 5. Other Information

Table of Contents

None

Table of Contents

Item 6. Exhibits

3.1	Amended and Restated Certificate of Incorporation of the Company dated as of November 2, 2009 (filed on November 20, 2009 as Exhibit 3.1 to the Company s Quarterly Report on Form 10-Q and incorporated by reference herein)
3.2	Amended and Restated Bylaws of the Company (filed on September 21, 2009 as Exhibit 3.5 to Amendment No. 2 to the Company s Registration Statement on Form S-1 and incorporated by reference herein)
4.1	Form of Common Stock Certificate (filed on October 2, 2009 as Exhibit 4.1 to Amendment No. 4 to the Company s Registration Statement on Form S-1 and incorporated by reference herein)
10.1	Joinder, Consent and Amendment No. 3 to the Loan and Security Agreement, dated as of March 24, 2011, by and among Addus HealthCare, Inc., Addus HealthCare (Idaho), Inc., Addus HealthCare (Indiana), Inc., Addus HealthCare (Nevada), Inc., Addus HealthCare (New Jersey), Inc., Addus HealthCare (North Carolina), Inc., Benefits Assurance Co., Inc., Fort Smith Home Health Agency, Inc., Little Rock Home Health Agency, Inc., Lowell Home Health Agency, Inc., PHC Acquisition Corporation and Professional Reliable Nursing Service, Inc., Addus HealthCare (South Carolina), Inc. Addus HealthCare (Delaware), Inc., as borrowers, Fifth Third Bank, as agent, the financial institutions that are or may from time to time become parties thereto, and Addus HomeCare Corporation, as guarantor (filed on May 25, 2011 as Exhibit 99.1 to the Company s Current Report on Form 8-K and incorporated by reference herein)
10.2	Employment Agreement, effective July 15, 2011, by and between Addus HealthCare, Inc. and Gregory Breemes (filed on June 23, 2011 as Exhibit 99.1 to the Company s Current Report on Form 8-K and incorporated by reference herein)
10.3	Amendment No. 1 to Employment and Non-Competition Agreement, effective July 18, 2011, by and between Addus HealthCare, Inc. and Gregory Breemes (filed on July [19], 2011 as Exhibit 99.1 to the Company s Current Report on Form 8-K and incorporated herein by reference herein)
10.4	Amendment No. 4 to Loan and Security Agreement, dated as of July 26, 2011, effective as of June 30, 2011, by and among Addus HealthCare, Inc., Addus HealthCare (Idaho), Inc., Addus HealthCare (Indiana), Inc., Addus HealthCare (Nevada), Inc., Addus HealthCare (New Jersey), Inc., Addus HealthCare (North Carolina), Inc., Benefits Assurance Co., Inc., Fort Smith Home Health Agency, Inc., Little Rock Home Health Agency, Inc., Lowell Home Health Agency, Inc., PHC Acquisition Corporation, Professional Reliable Nursing Service, Inc., Addus HealthCare (South Carolina), Inc., Addus HealthCare (Delaware), Inc., as borrowers, Fifth Third Bank, as agent, the financial institutions from time to time parties thereto, and Addus HomeCare Corporation, as guarantor (filed on July 29, 2011 as Exhibit 99.1 to the Company s Current Report on Form 8-K and incorporated by reference herein)
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	Interactive Data Files***

* Filed herewith

** Furnished herewith

*** In accordance with Rule 406T of Regulation S-T, these interactive data files are deemed not filed or part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, are deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, and otherwise are not subject to liability under those sections.

Table of Contents

SIGNATURES

Pursuant to the requirements 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

Date: August 4, 2011	By:	/s/ Mark S. Heaney **Mark S. Heaney** **President and Chief Executive Officer** **(As Principal Executive Officer)**
Date: August 4, 2011	By:	/s/ Dennis B. Meulemans **Dennis B. Meulemans** **Chief Financial Officer** **(As Principal Financial Officer)**

Table of Contents

EXHIBIT INDEX

3.1	Amended and Restated Certificate of Incorporation of the Company dated as of November 2, 2009 (filed on November 20, 2009 as Exhibit 3.1 to the Company s Quarterly Report on Form 10-Q and incorporated by reference herein)
3.2	Amended and Restated Bylaws of the Company (filed on September 21, 2009 as Exhibit 3.5 to Amendment No. 2 to the Company s Registration Statement on Form S-1 and incorporated by reference herein)
4.1	Form of Common Stock Certificate (filed on October 2, 2009 as Exhibit 4.1 to Amendment No. 4 to the Company s Registration Statement on Form S-1 and incorporated by reference herein)
10.1	Joinder, Consent and Amendment No. 3 to the Loan and Security Agreement, dated as of March 24, 2011, by and among Addus HealthCare, Inc., Addus HealthCare (Idaho), Inc., Addus HealthCare (Indiana), Inc., Addus HealthCare (Nevada), Inc., Addus HealthCare (New Jersey), Inc., Addus HealthCare (North Carolina), Inc., Benefits Assurance Co., Inc., Fort Smith Home Health Agency, Inc., Little Rock Home Health Agency, Inc., Lowell Home Health Agency, Inc., PHC Acquisition Corporation and Professional Reliable Nursing Service, Inc., Addus HealthCare (South Carolina), Inc. Addus HealthCare (Delaware), Inc., as borrowers, Fifth Third Bank, as agent, the financial institutions that are or may from time to time become parties thereto, and Addus HomeCare Corporation, as guarantor (filed on May 25, 2011 as Exhibit 99.1 to the Company s Current Report on Form 8-K and incorporated by reference herein)
10.2	Employment Agreement, effective July 25, 2011, by and between Addus HealthCare, Inc. and Gregory Breemes (filed on June 23, 2011 as Exhibit 99.1 to the Company s Current Report on Form 8-K and incorporated by reference herein)
10.3	Amendment No. 1 to Employment and Non-Competition Agreement, effective July 18, 2011, by and between Addus HealthCare, Inc. and Gregory Breemes (filed on July [19], 2011 as Exhibit 99.1 to the Company s Current Report on Form 8-K and incorporated herein by reference herein)
10.4	Amendment No. 4 to Loan and Security Agreement, dated as of July 26, 2011, effective as of June 30, 2011, by and among Addus HealthCare, Inc., Addus HealthCare (Idaho), Inc., Addus HealthCare (Indiana), Inc., Addus HealthCare (Nevada), Inc., Addus HealthCare (New Jersey), Inc., Addus HealthCare (North Carolina), Inc., Benefits Assurance Co., Inc., Fort Smith Home Health Agency, Inc., Little Rock Home Health Agency, Inc., Lowell Home Health Agency, Inc., PHC Acquisition Corporation, Professional Reliable Nursing Service, Inc., Addus HealthCare (South Carolina), Inc., Addus HealthCare (Delaware), Inc., as borrowers, Fifth Third Bank, as agent, the financial institutions from time to time parties thereto, and Addus HomeCare Corporation, as guarantor (filed on July 29, 2011 as Exhibit 99.1 to the Company s Current Report on Form 8-K and incorporated by reference herein)
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	Interactive Data Files***

* Filed herewith

** Furnished herewith

*** In accordance with Rule 406T of Regulation S-T, these interactive data files are deemed not filed or part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, are deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, and otherwise are not subject to liability under those sections.

40