Addus HomeCare Corp
Form 10-K
March 16, 2015
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2014

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	**(I.R.S. Employer**
incorporation or organization)	**Identification No.)**

2300 Warrenville Road

Downers Grove, IL 60515

(Address of principal executive offices)

630-296-3400

(Registrant s telephone number, including area code)

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

Title of each class	**Name of each Exchange on which Registered**
Common Stock, par value $0.001	The NASDAQ Stock Market LLC

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

None

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes x No ¨

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

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

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

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

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the registrant, based on the last sale price on The NASDAQ Global Market on June 30, 2014 (the last business day of the registrant s most recently completed second fiscal quarter) was $246,868,346.

As of March 1, 2015, there were 11,009,879 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Certain portions of the registrant s Definitive Proxy Statement for its 2015 Annual Meeting of Stockholders (which is expected to be filed with the Commission within 120 days after the end of the registrant s 2014 fiscal year) are incorporated by reference into Part III of this Annual Report on Form 10-K.

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SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

When included in this Annual Report on Form 10-K, or in other documents that we file with the Securities and Exchange Commission (SEC) or in statements made by or on behalf of the Company, words like believes, belief, expects, plans, anticipates, intends, projects, estimat might, would, should and similar expressions are intended to identify forward-looking statements as defined by the Private Securities Litigation Reform Act of 1995. These forward-looking statements involve a variety of risks and uncertainties that could cause actual results to differ materially from those described therein. These risks and uncertainties include, but are not limited to the following: changes in operational and reimbursement processes at the state level, changes in Medicaid, Medicare and other medical payment levels, changes in or our failure to comply with existing federal and state laws or regulations or the inability to comply with new government regulations on a timely basis, competition in the home and community based service industry, changes in the case mix of consumers and payment methodologies, operational changes resulting from the assumption by managed care organizations of responsibility for managing and paying for home and community based services to consumers, changes in estimates and judgments associated with critical accounting policies, our ability to maintain or establish new referral sources, our ability to attract and retain qualified personnel, changes in payments and covered services due to the overall economic conditions and deficit spending by federal and state governments, future cost containment initiatives undertaken by third party payors, our access to financing due to the volatility and disruption of the capital and credit markets, our ability to meet debt service requirements and comply with covenants in debt agreements, business disruptions due to natural disasters or acts of terrorism, our ability to integrate and manage our information systems, our expectations regarding the size and growth of the market for our services, the acceptance of privatized social services, our expectations regarding changes in reimbursement rates, authorized hours and eligibility standards of state governmental agencies, the potential to settle litigation, and the effect of those changes on our results of operations in 2014 or for periods thereafter, our ability to successfully implement our coordinated care model to grow our business, our ability to attract referrals, our ability to continue identifying and pursuing acquisition opportunities and expand into new geographic markets, the impact of acquisitions on our business, the effectiveness, quality and cost of our services and various other matters, many of which are beyond our control.

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

Unless otherwise provided, Addus, we, us, our, and the Company refer to Addus HomeCare Corporation and our consolidated subsidiaries a Holdings refers to Addus HomeCare Corporation. When we refer to 2014, 2013 and 2012, we mean the twelve month period then ended December 31, unless otherwise provided.

A copy of this Annual Report on Form 10-K for the year ended December 31, 2014 as filed with the SEC, including all exhibits, is available on our internet website at http://www.addus.com on the Investor Relations page link. Information contained on, or accessible through, our website is not a part of, and is not incorporated by reference into, this Annual Report on Form 10-K.

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PART I

ITEM 1. BUSINESS

Overview

We are a provider of comprehensive home and community based services, which are provided primarily in the home, and focused on the dual eligible (Medicare/Medicaid) population. Our services include personal care and assistance with activities of daily living, and adult day care. Our consumers are primarily persons 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, managed care organizations, commercial insurers and private individuals. We currently provide home and community based services to over 31,000 consumers through 129 locations across 22 states, including 5 adult day centers in Illinois. Over the course of 2014, we served over 43,000 consumers.

A summary of our financial results for 2014, 2013 and 2012 is provided in the table below:

	2014	2013	2012
		(Amounts in Thousands)	
Net service revenues continuing operations	$ 312,942	$ 265,941	$ 244,315
Net service revenues discontinued operations		6,462	38,822
Net income from continuing operations	11,963	11,163	9,288
Earnings (loss) from discontinued operations	280	7,982	(1,653)
Net income	$ 12,243	$ 19,145	$ 7,635
Total assets	$ 180,803	$ 163,934	$ 149,857

Historically our services were provided under agreements with state and local government agencies established to meet the needs of our consumers. Our consumers are predominately dual eligible and as such are eligible to receive both Medicare and Medicaid funded home-based care. As a result of certain legislation enacted by the federal government, states are being incentivized to initiate dual eligible demonstration programs and other managed Medicaid initiatives, which are designed to coordinate the services provided through these two programs, with the overall objective to better coordinate service delivery and over the long term to reduce costs. Increasingly states are implementing these managed care programs and as such are transitioning management of individuals such as our consumers to local and national managed care organizations. Under these arrangements the managed care organizations have an economic incentive to provide home and community based services to consumers as a means to better manage the acute care expenditures of their membership.

The home and community based services we provide include assistance with bathing, grooming, dressing, personal hygiene and medication reminders, and other activities of daily living. We provide these services on a long-term, continuous basis, with an average duration of approximately 20 months per consumer. Our adult day centers provide a comprehensive program of skilled and support services and designated medical services for adults in a community-based group setting. Services provided by our adult day centers include social activities, transportation services to and from the centers, the provision of meals and snacks, personal care and therapeutic activities such as exercise and cognitive interaction.

We utilize a coordinated care model that is designed to improve consumer outcomes and satisfaction as well as lower the cost of acute care treatment and reduce service duplication. We believe this coordinated care model to be especially valuable to managed care organizations that have economic responsibility for both home and community services as well as acute care expenditures. Over the long term, we believe this model will be a differentiator and as a result we expect to receive increased referrals from the managed care organizations.

Through our coordinated care model, we utilize our home care aides to observe and report changes in the condition of our consumers for the purpose of early intervention in the disease process, thereby preventing or

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reducing the cost of medical services by avoiding emergency room visits, and/or reducing the need for hospitalization. We will coordinate the services provided by our team with those of selected health care agencies as appropriate. Changes in consumers condition are evaluated by appropriately trained managers and referred to either appropriate medical personnel including the consumers primary care physicians or managed care organizations for treatment and follow-up. We believe this approach to the provision of care to our consumers and the integration of our services into the broader healthcare continuum are attractive to managed care organizations and others who are ultimately responsible for the healthcare needs and costs of our consumers and over time will increase our business with them.

We are investing in technology based solutions to support and facilitate our coordinated care model. We utilize an Integrated Voice Response, IVR system and smart phones applications to communicate with the homecare aides. Through these applications we are able to identify changes in health conditions with automated alerts forwarded to appropriate management team for triaging and evaluation. In addition, the technology is used to record basic transaction information about each visit including: start and end times to a scheduled shift, mileage reimbursement, text messages to the homecare aide and communication of basic payroll information. Our plans for this technology include development of a web portal to provide the ability to communicate this basic information about individual clients to the managed care organizations.

We are growing through selective acquisitions, based on an overall strategy to expand our presence in current markets and to expand our footprint in markets where the home and community business is moving to managed care organizations. We completed two acquisitions in December 2013 and June 2014 that expanded our presence in two existing markets and provided us with a base of operations in two new targeted managed care states. Effective January 1, 2015, we acquired Priority Home Health Care, Inc., a company headquartered in Cleveland, Ohio that operates six offices in the Cleveland, Akron and Columbus areas. We anticipate these transactions to be accretive to earnings in 2015.

Effective March 1, 2013, we sold substantially all of the assets used in our home health business (the Home Health Business) in Arkansas, Nevada and South Carolina, and 90% of the Home Health Business in California and Illinois, to subsidiaries of LHC Group, Inc. (the Purchasers) for a cash purchase price of approximately $20,000,000. We retained a 10% ownership interest in the Home Health Business in California and Illinois. The assets sold included 19 home health agencies and two hospice agencies in five states. On December 30, 2013, we sold one home health agency in Pennsylvania for approximately $200,000. The results of the Home Health Business sold and one additional agency in Idaho which was closed in November 2012, are reflected as discontinued operations for all periods presented herein. Continuing operations include the results of operations previously included in our home & community segment and three agencies previously included in our home health segment. Following the sale of the Home Health Business, we manage and internally report our business in one segment. Because regulatory requirements in Delaware and Indiana require home and community based services to be provided by a licensed home health agency, we will continue to provide limited home health services reimbursable by Medicare in these agencies in order to maintain these licenses. In addition, Priority Home Health Care maintains enrollment in but does not derive significant revenues from Medicare.

We believe the sale of the Home Health Business substantially positioned us for future growth. The sale allowed us to focus both management and financial resources to address changes in the home and community based services industry and to address the needs of managed care organizations as they become more responsible for the state sponsored programs. We have improved our financial performance by concentrating our efforts on our home and community business that is growing and profitable. We have improved our overall financial position by eliminating our debt and adding to our cash reserves.

Addus HomeCare Corporation was incorporated in Delaware in 2006 under the name Addus Holding Corporation for the purpose of acquiring Addus HealthCare, Inc. (Addus HealthCare). Addus HealthCare was founded in 1979. Our principal executive offices are located at 2300 Warrenville Road, Downers Grove, Illinois 60615. Our telephone number is 630-296-3400. Our internet address is www.addus.com. Through our

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website, we make available, free of charge, our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and all amendments to those reports as soon as reasonably practicable after we electronically file such material with, or furnish such information to the SEC.

Our Market and Opportunity

We provide home and community based services to the elderly and other adult infirm who need long-term care and assistance with activities of daily living. A report by CMS, in consultation with Truven Health Analytics, from April 28, 2014, estimated total Medicaid expenditures for home and community based services in 2012 (the most recent year in their data set) to be almost $70 billion, representing an annual compound rate of growth of 8.2% over the period from 2007-2012. The report also notes that spending on home and community based services constituted about 50% of total spending in 2012 by Medicaid on the group of programs Medicaid refers to as long-term services and supports (with the remaining 50% being spent on institutional programs, i.e. nursing homes and mental health facilities), up from 18% in 1995 (the earliest year in the data set).

In addition to the projected growth of government-sponsored home and community based services, the private duty market for our services is growing rapidly. We provide our private duty consumers with all of the services we provide to our government-sponsored home and community based consumers.

Historically, there were limited barriers to entry in the home and community based services industry. As a result, the home and community based services industry developed in a highly fragmented manner, with many small local providers. Few companies have a significant market share across multiple regions or states. According to the National Association for Home Care & Hospice, or NAHC, as of 2013, there were over 33,000 homecare and hospice agencies in the United States. Approximately 15,000 were Medicare-certified homecare and hospice agencies, while the remaining 18,000 represent the number of licensed home and community based services agencies in the United States providing services similar to those we provide. In addition, while difficult to estimate, there are many non-licensed, non-certified home and community based services agencies.

More recently, the home and community based services industry has been subject to increased regulation. In several states, providers are now required to obtain state licenses or registrations and must comply with laws and regulations governing standards of practice. Providers must dedicate substantial resources to ensure continuing compliance with all applicable regulations and significant expenditures may be necessary to offer new services or to expand into new markets. Any failure to comply with this growing and changing regulatory regime could lead to the termination of rights to participate in federal and state-sponsored programs and the suspension or revocation of licenses. We believe limitations on the availability of new licenses, the increasing focus on improving health outcomes, the rising cost and complexity of operations and pressure on reimbursement rates due to constrained government resources may create barriers for new providers and may encourage industry consolidation.

The Federal Coordinated Health Care Office was established to effectively integrate benefits for consumers who are enrolled in both Medicare and Medicaid, also known as dual eligibles, and improve coordination between the federal and state governments to ensure that dual eligibles have full access to items and services to which they are entitled. Stated goals of the Federal Coordinated Health Care Office are to ensure that the dual eligible population has full access to seamless high quality health care and to make the system as cost-effective as possible. The Federal Coordinated Health Care Office works with the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and other federal and state agencies, as well as physicians and others, to provide technical assistance and educational tools to improve care coordination between Medicare and Medicaid and to reduce costs, improve beneficiary experience and educate dual eligibles regarding care coverage. It also performs policy and program analysis and develops policy and program recommendations regarding dual eligibles.

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), encourages states to integrate the state managed Medicaid home and community based programs with managed Medicare programs. The objective of these initiatives is to enhance the coordination of benefits between the two programs and to lower overall costs. The integrated programs are being structured as three year pilots. Nationally, 18 states are currently pursuing financial or administrative alignment for dual eligible beneficiaries, including 6 of the 22 states in which we provide services.

We believe that our coordinated care program and our commitment to our technology platform make us well-suited to partner with managed care organizations to address the needs of the dual eligible population. These programs will eliminate service duplication between home and community based programs and traditional Medicare home health. We believe our ability to identify changes in our consumers health and condition before the medical need requires acute intervention will lower the overall cost of care and will be recognized as an added benefit of our services. We believe this approach to the provision of care to our consumers and the integration of our services into the broader healthcare continuum is particularly attractive to managed care organizations and others who are ultimately responsible for the healthcare needs of our consumers and over time will increase our business with them.

Our Growth Strategy

Our net service revenues growth is closely correlated with the number of consumers to whom we provide our services. Our continued growth depends on our ability to provide consistently good care, maintain our existing payor client relationships, establish relationships with new payors 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 and community based services is more cost-effective than the provision of similar services in an institutional setting for long-term care. The following are the key elements of our growth strategy:

Consistently provide high-quality care. We schedule our home care aides to perform their services at times mutually determined by our consumers. The home care aides are required to perform tasks as defined within the individual plan of care. We manage the performance of our home care aides through regular visits while in our consumer homes.

Drive growth in existing markets. We are growing in our existing markets overall by enhancing the breadth of our services, increasing the number of referral sources and leveraging and expanding our payor relationships in each market. We are achieving this growth by continuing to educate referral sources about the benefits of our services.

Market the benefits of our coordinated care model to managed care organizations serving the dual eligible populations. Our coordinated care model provides significant opportunities to effectively market to a wide range of payor clients and referral sources, many of whom are responsible for consumers with both social and medical service needs. We are seeking to partner with managed care organizations to address the needs of the dual eligible population in light of governmental incentives for consumers to enroll in managed care plans. We believe that our approach to the provision of care to our consumers and the integration of our services into the broader healthcare industry is particularly attractive to managed care organizations and others who are ultimately responsible for the healthcare needs of our consumers and over time we believe this approach will increase our business.

Grow through acquisitions. We continue to grow with selective acquisitions. Our strategy is to expand within our existing markets and to enter markets where states are transitioning the management of home and community services to managed care organizations.

Expand into new markets. We offer our services in geographic markets contiguous to our existing markets through de novo agency development. We also anticipate we will have opportunities to develop new agencies in response to requests from managed care organizations.

Our Services

We deliver services to our consumers through 129 individual agencies located in 22 states and 5 adult day centers in Illinois. Our home and community based services assist consumers, who would otherwise be at risk of placement in a long-term care institution, with activities of daily living.

Services are primarily provided to older adults and younger disabled persons in consumers homes on an as-needed, hourly basis. These services, generally provided by home and community based service aides, include non-medical care such as personal care, home support services and adult day care.

Personal care and home support services are provided to consumers who are unable to independently perform some or all of their activities of daily living. Our services are needed when assistance from family or community members is insufficient or where caregivers respite is needed. Personal care services include bathing, grooming, oral care, skincare, assistance with feeding and dressing and medication reminders. Home support services include meal planning and preparation, housekeeping and transportation services. Many consumers need such services on a long-term basis to address chronic or acute conditions. Each payor client establishes its own eligibility standards, determines the type, amount, duration and scope of services, and establishes the applicable reimbursement rate in accordance with applicable law. The average duration of our provision of home and community based services is approximately 20 months per consumer.

We also operate five adult day centers in Illinois which provide a comprehensive program of skilled and support services and designated health services for adults in a community-based group setting. Services provided by our adult day centers include social activities, transportation services to and from the centers, the provision of meals and snacks, personal care and therapeutic activities such as exercise and cognitive interaction.

Our payor clients are principally federal, state and local governmental agencies and managed care organizations. The federal, state and local programs under which they operate are subject to legislative, budgetary and other risks that can influence reimbursement rates. Managed care organizations as an extension of our state payors are subject to similar economic pressures. Our commercial insurance carrier payor clients are typically for profit companies and are continuously seeking opportunities to control costs. We are also seeking to grow our private duty business.

Most of our services are provided pursuant to agreements with state and local governmental social and aging service agencies. These agreements generally have a term of one to two years and may be terminated with 60 days notice. They are typically renewed for one to five-year terms, provided that we have complied with licensing, certification and program standards, and other regulatory requirements. Reimbursement rates and methods vary by state and service type, but are typically based on an hourly or unit-of-service basis. Managed care organizations are becoming an increasing portion of our payor mix as states shift from the management of their programs to managed care organizations. In 2014, approximately 86.4% of our net service revenues from continuing operations were derived from state and local government programs, with 9.1% derived from managed care organizations, while approximately 4.5% of net service revenues from continuing operations were derived from insurance programs and private duty consumers.

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For 2014, 2013 and 2012, our revenue mix by payor type for continuing operations was as follows:

	Year Ended December 31,		
	2014	2013	2012
State, local and other governmental programs	86.4%	94.1%	94.9%
Managed care organizations	9.1	1.0	0.0
Private duty	3.4	3.9	4.1
Commercial	1.1	1.0	1.0
	100.0%	100.0%	100.0%

We derive a significant amount of our net service revenues from our operations in Illinois, New Mexico, Washington and California. The percentages of total revenue for each of these significant states for 2014, 2013 and 2012 are listed below.

	% of Total Revenue for the Years Ended December, 31		
State	2014	2013	2012
Illinois	60.6%	65.5%	63.7%
New Mexico	8.2	2.1	1.7
Washington	5.0	6.5	7.2
California	4.9	5.8	6.9

A significant amount of our net service revenues from continuing operations are derived from one specific payor client, the Illinois Department on Aging, which accounted for 53.2%, 58.8% and 57.3% of our total net service revenues from continuing operations for the years ended December 31, 2014, 2013 and 2012, respectively.

We also measure the performance of our business through review of our billable hours per client, billable hours per business day, revenues per billable hour and the number of consumers served, or census.

Competition

The home and community based services industry is highly competitive, fragmented and market specific. Each local market has its own competitive profile and no single competitor has significant market share across all of our markets. Our competition consists of home and community based service providers, home health providers, private caregivers, larger publicly held companies, privately held companies, privately held single-site agencies, hospital-based agencies, not-for-profit organizations, community-based organizations, managed care organizations and self-directed care programs. In addition, certain governmental payors contract for services with independent providers such that our relationships with these payors are not exclusive. This is particularly true in California where the independent provider is an individual who provides services for one consumer and is paid directly by the county where services are delivered. We have experienced, and expect to continue to experience, competition from new entrants into our markets. Increased competition may result in pricing pressures, loss of or failure to gain market share or loss of consumers or payors, any of which could harm our business. In addition, some of our competitors may have greater financial, technical, political and marketing resources and name recognition with consumers and payors.

Sales and Marketing

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

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We are establishing new referral relationships with various managed care organizations who are contracting with the states for the management of the state Medicaid programs under dual eligible demonstration and similar Medicaid managed care programs. We have met with all contracted managed care organizations in markets where we serve our clients and are building those relationships necessary to insure continued referrals of new clients.

We receive substantially all of our consumers from third-party referrals. Generally, family members of potential consumers are made aware of available in-home or alternative living arrangements through a state or local case management system. These systems are operated by governmental or private agencies. We receive referrals from state departments on aging, rehabilitation, mental health and children s services, county departments of social services, the Veterans Health Administration and city departments on aging.

We provide ongoing education and outreach to our target communities, both to inform the community about state and locally-subsidized care options and to communicate our role in providing quality home and community based services. We also utilize consumer-direct sales, marketing and advertising programs designed to attract consumers.

Payment for Services

We are compensated for substantially all of our services by federal, state and local government programs, such as Medicaid funded programs and Medicaid waiver programs, other state agencies, the Veterans Health Administration, commercial and managed care organizations and private duty consumers.

The following table sets forth net service revenues from continuing operations derived from each of our major payors during the indicated periods as a percentage of total net service revenues from continuing operations.

	Year Ended December 31,		
Payor	**2014**	**2013**	**2012**
Illinois Department on Aging	53.2%	58.8%	57.3%
Washington Department of Social and Health Services	4.6	6.6	6.4
United HealthCare of New Mexico	3.4	0.0	0.0
Other federal, state and local payors	25.7	28.7	31.2
Other managed care organizations	8.6	1.0	0.0
Private duty	3.4	3.9	4.1
Commercial insurance	1.1	1.0	1.0
Total	100.0%	100.0%	100.0%

Illinois Department on Aging

We provide home and community based services pursuant to agreements with the Illinois Department on Aging, which is funded by Medicaid and general revenue funds of the State of Illinois. Consumers are identified by case managers contracted independently with the Illinois Department on Aging. Once a consumer has been evaluated and determined to be eligible for the program, the case manager refers the consumer to a list of authorized providers, from which the consumer selects the provider. We provide our services in accordance with a care plan developed by the case manager and under administrative directives from the Illinois Department on Aging. We are reimbursed on an hourly fee for service basis.

Due to its revenue deficiencies and financing issues, the State of Illinois is currently providing reimbursement on a delayed basis with respect to these agreements. These payment delays could adversely impact our liquidity, and may result in the need to increase borrowings under our credit facility. Other delayed payor reimbursements from the State of Illinois could contribute to an increase in our receivables balances.

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Washington Department of Social and Health Services

We provide home and community based services pursuant to agreements with the Washington Department of Social and Health Services, which is funded by Medicaid and general revenue funds of the State of Washington. Consumers are identified by area Agency on Aging case managers contracted independently with the Washington Department of Social and Health Services. Once a consumer has been evaluated and determined to be eligible for the program, the case manager refers the consumer to a list of authorized providers, from which the consumer selects the provider. We provide our services in accordance with a care plan developed by the case manager and under administrative directives from the Washington Department of Social and Health Services. We are reimbursed on an hourly fee for service basis.

United HealthCare of New Mexico

We provide services under contract with United HealthCare of New Mexico (United HealthCare) under the Community Long Term Care Services (CoLTS) program. This is a managed Medicaid program pursuant to which the State of New Mexico has contracted with several commercial insurance payers to manage home and community based services as well as other long-term social services. Under this agreement, consumers are qualified for services and referred to us by United Healthcare. We provide personal care and other in-home support services under this program. Our relationship with United HealthCare is not exclusive as United HealthCare has a network of providers who provide similar services to it. All services are reimbursed on an hourly fee for service basis.

Other Federal, State and Local Payors

Medicaid Funded Programs and Medicaid Waiver Programs

Medicaid is a state-administered program that provides certain social and medical services to qualified low-income individuals, and is jointly funded by the federal government and individual states. Reimbursement rates and methods vary by state and service type, but are typically based on an hourly or unit-of-service basis. Rates are subject to adjustment based on statutory and regulatory changes, administrative rulings, government funding limitations and interpretations of policy by individual state agencies. Within guidelines established by federal statutes and regulations, each state establishes its own eligibility standards, determines the type, amount, duration and scope of services, sets the rate of payment for services and administers its own program, subject to federal oversight. Most states cover Medicaid beneficiaries for intermittent home health services, as well as continuous services for children and young adults with complicated medical conditions, and certain states cover home and community-based services.

In an effort to control escalating Medicaid costs, states are increasingly requiring Medicaid beneficiaries to enroll in managed care plans. Under a health reform bill signed into law in January 2012, Illinois set a goal to increase the percentage of Medicaid beneficiaries in Medicaid managed care plans from the then current 8% to 50% by 2015. The State fell just short of that goal, enrolling approximately 1,400,000 of its 3,100,000 Medicaid population in managed care plans as of January 2015. The State plans to enroll an additional 800,000 people in managed care plans in the next few months. Under these managed care programs, states are increasingly requiring Medicaid beneficiaries to work with case managers.

Veterans Health Administration

The Veterans Health Administration operates the nation s largest integrated health care system, with more than 1,800 sites of care, and provides health care benefits, including home and community based services, to eligible military veterans. The Veterans Health Administration provides funding to regional and local offices and facilities that support the in-home care needs of eligible aged and disabled veterans by contracting directly with local in-home care providers, and to the aid and attendance pension, which pays veterans for their otherwise unreimbursed health and long-term care expenses. We currently have relationships and agreements with the Veterans Health Administration to provide home and community based services in several states, with the largest Veterans Health Administration services being provided in Illinois, Arkansas and California.

Other

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

Other Managed Care Organizations

Many states are moving the administration of their Medicaid home and community based programs to commercially-managed care insurance companies. This transition is due to federal and state initiatives to address the needs of the dual eligible population and an overall desire to better manage the costs of the Medicaid long term care programs. Reimbursement from the managed care organizations is generally on an hourly, fee for service basis with rates consistent with the individual state funded rates.

Private Duty

Our private duty services are provided on an hourly basis. Our rates are established to achieve a pre-determined gross profit margin, and are competitive with those of other local providers. We bill our private duty consumers for services rendered either bi-monthly or monthly, and in certain circumstances we obtain a two- week deposit from the consumer. Other private duty payors include workers compensation programs/insurance, preferred provider organizations and employers.

Commercial Insurance/Long-Term Care Insurance

Most long-term care insurance policies contain benefits for in-home services and adult day care. Policies are generally subject to dollar limitations on the amount of daily, weekly or monthly coverage provided. Depending on the type of service, coverage for services may be predicated on a physician or nurse determination that the care is necessary or on the development of a plan for care in the home.

Exposure for Payments Previously Received

As described above under the caption Business Overview, we sold our Home Health Business effective March 1, 2013, pursuant to an Asset Purchase Agreement, dated as of February 7, 2013 (the Home Health Purchase Agreement), with LHC Group, Inc. and the Purchasers identified therein. Pursuant to the Home Health Purchase Agreement, we retained a 10% ownership interest in the Home Health Business in California and Illinois. In addition, not included in the sale were four home health agencies in Delaware, Idaho, Indiana and Pennsylvania. The home health agency in Pennsylvania was sold on December 30, 2013 and the agency in Idaho was closed in November 2012 and efforts to sell the Idaho agency were abandoned in December 2013.

While we no longer receive substantial payments from Medicare for home health services, pursuant to the Home Health Purchase Agreement, we are obligated to indemnify the Purchasers for, among other things, (i) penalties, fines, judgments and settlement amounts arising from a violation of certain specified statutes, including the False Claims Act, the Civil Monetary Penalties Law, the federal Anti-Kickback Statute, the Stark Law or any state law equivalent in connection with the operation of the Home Health Business prior to the consummation of the sale (the Closing), and (ii) any liability related to the failure of any reimbursement claim submitted to certain government programs for services rendered by the Home Health Business prior to the

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Closing to meet the requirements of such government programs, or any violation prior to the Closing of any health care laws. Such liabilities include amounts to be recouped by, or repaid to, such government programs as a result of improperly submitted claims for reimbursement or those discovered as a result of audits by investigative agencies. All services that we have provided that have been or may be reimbursed by Medicare are subject to retroactive adjustments and/or total denial of payments received from Medicare under various review and audit provisions included in the program regulations. The review period is generally described as six years from the date the services are provided but could be expanded to ten years under certain circumstances if fraud is found to have existed at the time of original billing. In the event that there are adjustments relating to the period prior to the Closing, we may be required to reimburse the Purchasers for the amount of such adjustments.

Medicare is the U.S. government s health insurance program funded by the Social Security Administration for individuals aged 65 or older, individuals under the age of 65 with certain disabilities and individuals of all ages with end-stage renal disease. Eligibility for Medicare does not depend on income, and coverage is restricted to reasonable and medically-necessary treatment.

Medicare home health rates are based on a Medicare episodic rate set annually through federal legislation. The rate covers a 60-day episode of care. Payment for each patient s episode of care is based on the severity of the consumer s condition, his or her service needs and other factors relating to the cost of providing services and supplies.

In addition, Medicare payments can be adjusted through changes in the payment rate and recoveries of overpayments for, among other things, unusually costly care for a particular consumer, low utilization, transfers to another provider, the level of therapy services required, the number of episodes of care provided, and if the consumer is discharged but readmitted within the same 60-day episodic period. In addition, Medicare can also reduce levels of reimbursement if a provider is unable to produce appropriate billing documentation or acceptable medical authorizations.

Insurance Programs and Costs

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

Employees

The following is a breakdown of our part- and full-time employees, as well as the employees in our National Support Center, as of December 31, 2014:

		Full-time	Part-time	Total
Continuing Operations	Home and Community Based Services	3,388	14,501	17,889
National Support Center		138	27	165
		3,526	14,528	18,054

Our home and community based service aides provide substantially all of our services and comprise approximately 96.3% of our total workforce. Our home and community based services aides undergo a criminal background check, and are provided with pre-service training and orientation and an evaluation of their skills. In many cases, home and community based services aides are also required to attend ongoing in-services education. In certain states, our home and community based services aides are required to complete certified training programs and maintain a state certification; however, no state in which we operate requires home and community based services aides to maintain a license similar to that of a nurse or therapist. Approximately 61.3% of our total employees are represented by labor unions. We maintain strong working relationships with these labor unions. We have a national agreement with the Service Employees International Union (the SEIU). Wages and benefits are negotiated at the local level at various times throughout the year.

Technology

We have licensed the Horizon Homecare software solution (Horizon Homecare) from McKesson Information Solutions, LLC (McKesson), to address our administrative, office, clinical and operating information system needs, including compliance with the Health Insurance Portability and Accountability Act, or HIPAA, requirements. Horizon Homecare assists our staff in gathering information to improve the quality of consumer care, optimize financial performance, adjust consumer mix, promote regulatory compliance and enhance staff efficiency. Horizon Homecare supports intake, personnel scheduling, office clinical and reimbursement management in an integrated database. The Horizon Homecare software is hosted by McKesson in a secure data center, which provides multiple redundancies for storage, power, bandwidth and security. Using this technology, we are able to standardize the care delivered across our network of locations and effectively monitor our performance and consumer outcomes. We have also leveraged this technology to implement a centralized billing and collections function at our national support center.

During most of 2014, we used an internally developed and customized payroll management system to calculate and produce our payroll. We transitioned all payroll and human resource functions to a commercial human resource and payroll system vendor, provided by Ultimate Software during the fourth quarter of 2014 and the first quarter of 2015. The Ultimate Software solution is a web based provider of integrated human resource and payroll software, which supports our management with the systems and reporting necessary to manage our employees. Both software systems are integrated with Horizon Homecare and other clinical data-management systems, and include features for tax reporting, managing wage assignments and garnishments, on-site check printing, general ledger population and direct-deposit paychecks. Secure management reports are made available centrally and through our internal reporting module.

We utilize commercial vendors for electronic visit verification pursuant to which our home and community based service aids record their beginning and ending times for services provided through either an interactive voice recognition (IVR) system or cell phone based system. We have supplemented these commercial systems with company developed mobile applications that allow our homecare aides the ability to communicate with our support center, to request additional work if available, to monitor or change their schedules and to inquire about payroll information. In addition, our software development includes features to allow our homecare aides to communicate changes in the health condition of our consumers. We utilize this information to support our coordinated care model and to communicate to managed care organizations.

Government Regulation

Overview

Our business is subject to extensive and increasing federal, state and local regulation. Changes in the law or new interpretations of existing laws may have a dramatic effect on the definition of permissible activities, the relative cost of doing business, and the methods and amounts of payment for care by both governmental and other payors. Departments of the federal government are currently considering how to implement programs and policy changes and mandated demonstration projects in the Health Reform Act. As a result of the Health Reform Act, it is expected that the number of Medicaid beneficiaries will increase (although several states in which we operate have declined to expand Medicaid eligibility) and in addition, there may be additional increases if employers terminate their employee health plans. It is impossible to know at this time what effect, if any, this will have on budgetary allocations for our services. The health care industry has experienced, and is expected to continue to experience, extensive and dynamic change. In addition, differences among state laws may impede our ability to expand into certain markets. If we fail to comply with applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal or state programs. See also Management s Discussion and Analysis of Financial Condition and Results of Operations Overview.

Medicaid Participation

To participate in and qualify for reimbursement under Medicaid programs, we are subject to various requirements imposed by federal and state authorities. If we were to violate the applicable federal and state regulations, we could be excluded from participation in federal and state healthcare programs and be subject to substantial civil and criminal penalties. New federal regulations took effect on March 17, 2014 setting forth eligibility requirements for home and community based services provided under Medicaid waiver programs. The regulations specify that home and community based settings must be integrated in and support full access to the greater community, selected by individuals from among different setting options, ensure privacy rights of individuals, optimize autonomy and independence in making life choices, and facilitate individual choice regarding services and supports. In addition, the regulations impose several conditions on provider-owned or controlled residential settings. All states are required to submit transition plans to CMS by March 17, 2015, detailing any actions necessary for the state to achieve compliance with the new requirements. Several states have submitted transition plans already or made draft plans available for public comment prior to submission to CMS. Home and community based service providers will face costs associated with compliance with these regulations, but it is difficult to ascertain the impact of these costs at this time and these costs will vary from state to state depending on how the requirements are implemented.

Health Reform Act

The Health Reform Act includes several provisions that may affect reimbursement for our services. 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. Although the Health Reform Act provides for expansion of eligibility for Medicaid enrollment, 21 states, including some in which we do business, have opted not to participate in Medicaid expansion. The Health Reform Act also creates within CMS a Center for Medicare and Medicaid Innovation, or CMMI, to test innovative payment and service delivery systems to reduce program expenditures while maintaining or enhancing quality. Among the issues that are to be addressed by CMMI are: allowing the states to test new models of care for individuals dually eligible for Medicare and Medicaid, supporting continuing care hospitals that offer post-acute care during the 30 days following discharge, funding home health providers that offer chronic care management services, and establishing pilot programs that bundle acute care hospital services with physician services and post-acute care services, including home health services for patients with certain selected conditions. We may have difficulty negotiating for a fair share of the bundled payment. In addition, we may be unfairly penalized if a consumer is readmitted to the hospital within 30 days of discharge for reasons beyond our control.

We cannot assure you that the provisions described above, or that any other provisions of the Health Reform Act or amendment thereto, will not adversely impact our business, results of operations or financial position.

Permits and Licensure

Our home and community based services are authorized and / or licensed under various state and county requirements. Our home and community based aides generally have no licensure requirements, although in certain states, they are required to complete training programs and maintain state certification. We believe we are currently licensed appropriately where required by the laws of the states in which we operate, but additional licensing requirements may be imposed upon us in existing markets or markets that we enter in the future.

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Applicable Federal and State Laws

Anti-Kickback Laws: The federal government enforces the federal law, commonly known as the Anti-Kickback Statute that prohibits the offer, payment, solicitation or receipt of any remuneration to or from any person or entity to induce or in exchange for the referral of patients covered by federal health care programs such as Medicare and Medicaid. The federal Anti-Kickback Statute also prohibits the purchasing, leasing, ordering or arranging for any item, facility or service covered by the government payment programs (or the recommendation thereof) in exchange for such referrals. Many states, including Illinois, Nevada and California also have similar laws proscribing kickbacks, some of which are not limited to services for which government-funded payment may be made. Violations of these provisions are punishable by criminal fines, civil penalties, imprisonment or exclusion from participation in reimbursement programs.

The Stark Law and other Prohibitions on Physician Self-Referral: We may also be affected by the federal law, commonly known as the Stark Law, that prohibits physicians from making a referral for health care items or services, including home health services, if they, or their family members, have a financial relationship with the entity receiving the referral unless certain conditions are met. Violations are punishable by civil monetary penalties on both the person making the referral and the provider rendering the service. Such persons or entities are also subject to exclusion from federal and state healthcare programs. We believe our compensation agreements with physicians who served as medical directors in our home health agencies meet the requirements for the personal services exception and that our operations comply with the Stark Law.

Many states, including Illinois, Nevada and California have also enacted statutes similar in scope and purpose to the Stark Law.

Beneficiary Inducement Prohibition: The federal Civil Monetary Penalties Law (CMPL) imposes substantial penalties for offering remuneration or other inducements to influence federal health care beneficiaries decisions to seek specific governmentally reimbursable items or services, or to choose particular providers. The CMPL also can be used for civil prosecution of the Anti-Kickback Statute. Sanctions under the CMPL include substantial financial penalties as well as exclusion from participation in all federal and state health care programs.

The False Claims Act: Under the federal False Claims Act, the government may fine any person, company or corporation that knowingly submits, or participates in submitting, claims for payment to the federal government which are false or fraudulent, or which contain false or misleading information. Any such person or entity that knowingly makes or uses a false record or statement to avoid paying the federal government may also be subject to fines under the False Claims Act. Private parties may initiate whistleblower lawsuits against any person or entity under the False Claims Act in the name of the government and may share in the proceeds of a successful suit. The penalty for violation of the False Claims Act is a minimum of $5,500 and a maximum of $11,000 for each fraudulent claim plus three times the amount of damages caused to the government as a result of each fraudulent claim. A False Claims Act violation may provide the basis for the imposition of administrative penalties as well as exclusion from participation in governmental health care programs, including Medicare and Medicaid. In addition to the False Claims Act, the federal government may use several criminal statutes to prosecute the submission of false or fraudulent claims for payment to the federal government.

Amendments to the False Claims Act in the Health Reform Act provide that a provider must report and return overpayments within 60 days of identifying the overpayment or the claims for the services that generated the overpayments become false claims subject to the False Claims Act. Overpayments include payments for services for which the provider does not have proper documentation. On February 13, 2015, CMS announced that it will delay finalizing regulations that were intended to clarify when a payment is identified for purposes of the 60-day rule. Notwithstanding the delay, providers are still required to comply with the rule even though there is considerable uncertainty over exactly when the 60-day period begins.

Many states, including Illinois, Nevada and California have similar false claims statutes that impose additional liability for the types of acts prohibited by the False Claims Act.

Fraud Alerts: From time to time, various federal and state agencies, such as the U.S. Department of Health and Human Services (HHS), issue pronouncements that identify practices that may be subject to heightened scrutiny, as well as practices that may violate fraud and abuse laws. We believe, but cannot assure you, that our operations comply with the principles expressed by the Office of the Inspector General (the OIG) in these reports and special fraud alerts.

HIPAA and the HITECH Act: HIPAA privacy regulations contain detailed requirements concerning the use and disclosure of individually identifiable health information by HIPAA covered entities, which includes our company. In addition to the privacy requirements, HIPAA covered entities must implement certain security standards to protect the integrity, confidentiality and availability of certain electronic health information. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) imposes additional privacy and security requirements and breach notification obligations on health care providers and on their business associates. Failure to comply with HIPAA or the HITECH Act could result in fines and penalties that could have a material adverse effect on us.

Most states, including Illinois, Nevada and California also have laws that protect the privacy and security of confidential personal information.

Civil Monetary Penalties: HHS may impose civil monetary penalties upon any person or entity that presents, or causes to be presented, certain ineligible claims for medical items or services. The amount of penalties varies, depending on the offense, from $2,000 to $50,000 per violation plus treble damages for the amount at issue and exclusion from federal health care programs, including Medicare and Medicaid. In addition, persons who have been excluded from the Medicare or Medicaid program may not retain ownership in a participating entity. Participating entities that permit continued ownership by excluded individuals, that contract with excluded individuals, and the excluded individuals themselves, may be penalized. Penalties are also applicable in certain other cases, including violations of the federal Anti-Kickback Law, payments to limit certain patient services and improper execution of statements of medical necessity.

Surveys and Audits

We are subject to routine and periodic surveys and audits by various governmental agencies and other payors. From time to time, we receive and respond to survey reports containing statements of deficiencies. Periodic and random audits conducted or directed by these agencies could result in a delay in receipt or an adjustment to the amount of reimbursements due or received under federal or state programs. Violation of the applicable federal and state health care regulations can result in excluding a health care provider from participating in the Medicare and/or Medicaid and other federal and state healthcare programs and can subject the provider to substantial civil and/or criminal penalties.

Pursuant to the Tax Relief and Health Care Act of 2006, HHS created a permanent and national recovery audit program to identify improper Medicare payments made on claims of health care services provided to Medicare beneficiaries. The program uses recovery audit contractors, or RACs, to identify the improper Medicare payments and protect the Medicare Trust Fund from fraud, waste and abuse. Since the start of the program, RACs have identified more than $8 billion in improper payments. RACs are paid a contingent fee based on the improper payments identified. On December 30, 2014, CMS announced a series of changes to the RAC audit program aimed at reducing the burden on providers, enhancing CMS oversight of RACs and increasing program transparency. CMS also instituted Zone Program Integrity Contracts (ZPICs) for additional audit of Medicare providers, including home health agencies.

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Environmental, Health and Safety Laws

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

ITEM 1A. RISK FACTORS

The risks described below, and risks described elsewhere in this Form 10-K, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows and the actual outcome of matters as to which forward-looking statements are made in this Form 10-K. The risk factors described below and elsewhere in this Form 10-K are not the only risks we face. Our business and consolidated financial condition, results of operations and cash flows may also be materially adversely affected by factors that are not currently known to us, by factors that we currently consider immaterial or by factors that are not specific to us, such as general economic conditions.

If any of the following risks are actually realized, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected. In that case, the trading price of our common stock could decline.

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

Changes to Medicaid, Medicaid waiver or other state and local medical and social programs could adversely affect our client caseload, units of service, net service revenues, gross profit and profitability.

For the year ended December 31, 2014, we derived approximately 86.4% of our net service revenues from continuing operations from agreements that are directly or indirectly paid for by state and local governmental agencies, such as Medicaid funded programs and Medicaid waiver programs. Governmental agencies generally condition their agreements with us upon a sufficient budgetary appropriation. If a governmental agency does not receive an appropriation sufficient to cover its contractual obligations with us, it may terminate an agreement or defer or reduce the amount of the reimbursement we receive. Almost all the states in which we operate experience periodic financial pressures and budgetary shortfalls due to changing economic conditions and the rising costs of health care, and as a result, have made, are considering or may consider making changes in their Medicaid, Medicaid waiver or other state and local medical and social programs. The Deficit Reduction Act of 2005 permits states to make benefit cuts to their Medicaid programs, which could affect the services for which states contract with us. Changes that states have made or may consider making to address their budget deficits include:

- limiting increases in, or decreasing, reimbursement rates;
- redefining eligibility standards or coverage criteria for social and medical programs or the receipt of home and community based services under those programs;
- increasing the consumer s share of costs or co-payment requirements;
- decreasing the number of authorized hours for recipients;
- slowing payments to providers;
- increasing utilization of self-directed care alternatives or all inclusive programs; or

shifting beneficiaries to managed care organizations.

Certain of these measures have been implemented by, or are proposed in, states in which we operate. The Governor of Illinois has proposed a budget that contemplates many of these above-mentioned changes in order to

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control costs in the Illinois. In 2014, we derived approximately 60.6% of our total net service revenues from continuing operations from services provided in Illinois, 8.2% of our total net service revenues from continuing operations in New Mexico, 5.0% of our total net service revenues from continuing operations from services provided in Washington and 4.9% of our total net service revenues from continuing operations from services provided in California. Riverside, California is planning to move substantially all of its Medicaid recipients to a self-directed model for care delivery beginning in July 2015. Because a substantial portion of our business is concentrated in these states, any significant reduction in expenditures that pay for our services in these states and other states in which we do business may have a disproportionately negative impact on our future operating results. Provisions in the Health Reform Act increase eligibility for Medicaid, which may cause a reallocation of Medicaid funding. It is difficult to predict at this time what the effect of these changes would be on our business. If changes in Medicaid policy result in a reduction in available funds for the services we offer, our net service revenues could be negatively impacted.

Under the Health Reform Act, the federal medical assistance percentage (the FMAP) paid by the federal government to states that elect to provide Medicaid coverage to low income adults who were previously ineligible for Medicaid is 100% for calendar years 2014-2016 and gradually decreases to 90% in 2020 and thereafter. Not all states in which we do business may elect to provide coverage to newly eligible individuals. We are not able at this time to determine the impact that these changes will have on our business.

In March 2013, the federal government implemented certain budgetary restrictions, commonly known as sequestration. Although Medicaid is exempt from these automatic cuts, sequestration remains in place and could negatively impact reimbursement or authorizations for services under our federal or state contracts.

A number of states have initiated efforts to combat Medicaid fraud and overpayments. If the number of Medicaid applicants or recipients is significantly reduced as a result of these efforts, the number of consumers we serve could be reduced, which could negatively affect our business and results of operations.

State efforts to transition their home and community based programs to being administered by managed care organizations could adversely affect our net service revenues and our profitability.

Under the Health Reform Act, states are encouraged to integrate the state managed Medicaid home and community based programs with managed Medicare programs. The objective of these initiatives is to enhance the coordination of benefits between the two programs and to lower overall costs.

Nationally, 18 states are currently pursuing financial or administrative alignment for dual eligible beneficiaries, including 6 of the 22 states in which we provide services. However, the timing for implementation of these demonstration projects are unknown at this time. In addition, the final regulations implementing these programs modify the requirements and definitions around home and community-based settings. We cannot assure you that: we will be able to secure favorable contracts with all or some of the managed care organizations; our reimbursement under these programs will remain at current levels; that the authorizations for services will remain at current levels or that our profitability will remain at levels consistent with past performance. If states in which we provide services transition their home and community based programs to managed care organizations and we are not able to participate through contracts with managed care organization or otherwise, we could lose revenue generated in those states, even in states in which we currently have contracts to provide home and community based services.

In certain states, where the transition to managed care organizations is occurring, operational processes are not well defined. Membership is being assigned by the respective state agency to the managed care organizations, but often communication of the changes is not clear to either the managed care organizations or the consumers. Membership, new referrals and the related authorization for services to be provided are being delayed, resulting in delays in service delivery to our consumers. Payments for services rendered are often delayed due to confusion in membership assignment and the referral processes. To the extent these processes are not improved, revenue growth rates, cash flow and profitability for services provided may be negatively affected.

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The implementation of Accountable Care Organizations (ACOs) may limit our ability to increase our market share and could adversely affect our revenues.

CMS published final ACO regulations in October 2011, which established a shared savings program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. These programs are focused on efforts by hospitals and physician groups to organize and coordinate patient care and are not directed toward home and community based service providers. In addition, several states have implemented, or plan to implement, accountable care models for their Medicaid populations. If we are not included in development of these programs, or if the ACOs establish similar services to include home and community based programs for their participants, we are at risk for losing market share and for a loss of our current business. Other cost savings initiatives may be presented by the government and commercial payors to control costs and reduce hospital admissions / readmissions in which we could be financially at risk. We cannot predict at this time what effect ACOs or like organizations may have on our company.

Efforts to reduce the costs of the Illinois Department on Aging program could adversely affect our service revenues and profitability.

In 2014, we derived approximately 53.2% of our revenue from continuing operations from the Illinois Department on Aging programs. Since 2011, the State of Illinois has undertaken a number of initiatives to reduce the costs of the Illinois Department on Aging program, such as the mandated utilization of an electronic visit verification (EVV) system by all providers. In his budget proposal for 2016, the Governor of Illinois has suggested several measures to reduce the costs of the Illinois Department on Aging, including restrictions on new referrals and reduced authorized hours for new and existing clients. The proposal includes additional changes aimed at reducing expenditures by the Illinois Department on Aging, including an income cap and a higher threshold of need for eligibility in the Community Care Program and elimination of the add-on rate the Illinois Department on Aging had been paying Community Care Program service providers to help those providers pay for employee healthcare. It is difficult to ascertain how significant an impact these initiatives will have on our business. If they impact the eligibility of our consumers, the number of hours authorized or services provided to existing consumers, they would adversely affect our service revenues and profitability.

Delays in reimbursement due to state budget deficits may increase in the future, adversely affecting our liquidity.

There is generally a delay between the time that we provide services and the time that we receive reimbursement or payment for these services. The majority of the 22 states in which we operate are operating with budget deficits for their current fiscal year. These and other states may in the future delay reimbursement, which would adversely affect our liquidity. Specifically, the State of Illinois is currently reimbursing us on a delayed basis, including with respect to our agreements with the Illinois Department on Aging, our largest payor. Our reimbursements from the State of Illinois could be further delayed because current forecasts indicate higher state deficits in the near future. In addition, from time to time, procedural issues require us to resubmit claims before payment is remitted, which contributes to our aged receivables. Additionally, unanticipated delays in receiving reimbursement from state programs due to changes in their policies or billing or audit procedures may adversely impact our liquidity and working capital. Because we fund our operations primarily through the collection of accounts receivable, any significant delays in reimbursement could result in the need to increase borrowings under our credit facility.

Our revenue may be negatively impacted by a failure to appropriately document services, resulting delays in reimbursement and related indemnification obligations.

Reimbursement to us is conditioned upon providing the correct administrative and billing codes and properly documenting the services themselves, including the level of service provided, and the necessity for the services. If incorrect or incomplete documentation is provided or inaccurate reimbursement codes are utilized, this could result in nonpayment for services rendered and could lead to allegations of billing fraud. This could subsequently lead to civil and criminal penalties, including exclusion from government healthcare programs, such as Medicare and Medicaid. In addition, third-party payors may disallow, in whole or in part, requests for reimbursement based on determinations that certain amounts are not covered, services provided were not medically necessary, or supporting documentation was not adequate. Pursuant to the Home Health Purchase Agreement, we are obligated to indemnify the Purchasers for, among other things, (i) penalties, fines, judgments and settlement amounts arising from a violation of certain specified statutes, including the False Claims Act, the Civil Monetary Penalties Law, the federal Anti-Kickback Statute, the Stark Law or any state law equivalent in connection with the operation of the Home Health Business prior to the Closing, and (ii) any liability related to the failure of any reimbursement claim submitted to certain government programs for services rendered by the Home Health Business prior to the Closing to meet the requirements of such government programs, or any violation prior to the Closing of any health care laws. Such liabilities include amounts to be recouped by, or repaid to, such government programs as a result of improperly submitted claims for reimbursement or those discovered as a result of audits by investigative agencies. All services that we have provided that have been or may be reimbursed by Medicare are subject to retroactive adjustments and/or total denial of payments received from Medicare under various review and audit provisions included in the program regulations. The review period is generally described as six years from the date the services are provided but could be expanded to ten years under certain circumstances if fraud is found to have existed at the time of original billing. In the event that there are adjustments relating to the period prior to the Closing, we may be required to reimburse the Purchasers or the government for the amount of such adjustments, which could adversely affect our business and financial condition. In addition, timing delays may cause working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in achieving our financial results and maintaining liquidity. It is possible that documentation support, system problems, provider issues or industry trends may extend our collection period, which may materially adversely affect our working capital, and our working capital management procedures may not successfully mitigate this risk.

The implementation or expansion of self-directed care programs in states in which we operate may limit our ability to increase our market share and could adversely affect our revenue.

Self-directed care programs are funded by Medicaid and state and local agencies and allow the consumer to exercise discretion in selecting home and community based service providers. Consumers may hire family members, friends or neighbors to provide services that might otherwise be provided by a home and community based service agency provider, such as our company. Most states and the District of Columbia have implemented self-directed care programs, to varying degrees and for different types of consumers. States are under pressure from the federal government and certain advocacy groups to expand these programs. CMS has provided states with specific Medicaid waiver options for programs that offer person-centered planning, individual budgeting or self-directed services and support as part of the CMS Independence Plus initiative introduced in 2002 under an Executive Order of the President. Certain private foundations have also granted resources to states to develop and study programs that provide financial accounts to consumers for their long-term care needs, and counseling services to help prepare a plan of care that will help meet those needs. Expansion of these self-directed programs may erode our Medicaid consumer base and could adversely affect our net service revenues.

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

In 2014, we derived approximately 53.2% of our net service revenues from continuing operations under agreements with the Illinois Department on Aging, 4.6% of our net service revenues from continuing operations under an agreement with the State of Washington and 3.4% of our net service revenues from continuing operations under an agreement with United HealthCare of New Mexico. Each of our agreements is generally in effect for a specific term. For example, the services we provide to the Illinois Department on Aging are provided under a number of agreements that expire at various times through 2015.

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

Our industry is highly competitive, fragmented and market-specific, with limited barriers to entry.

We compete with home and community based service providers, home health providers, private caregivers, larger publicly held companies, privately held companies, privately held single-site agencies, hospital-based agencies, not-for-profit organizations, community-based organizations and self-directed care programs. In addition, certain governmental payors contract for services with independent providers such that our relationships with these payors are not exclusive, particularly in California. Some of our competitors have greater financial, technical, political and marketing resources, name recognition or a larger number of consumers and payors than we do. In addition, some of these organizations offer more services than we do in the markets in which we operate. Consumers or referral sources may perceive that local service providers and not-for-profit agencies deliver higher quality services or are more responsive. These competitive advantages may limit our ability to attract and retain referrals in local markets and to increase our overall market share.

There are limited barriers to entry in providing home-based social and medical services, and the trend has been for states to eliminate many of the barriers that historically existed. For example, Illinois changed the way in which it procures home and community based service providers in 2009, allowing all providers that are willing and capable to obtain state approval and provide services. This may increase competition in that state, and because we derived approximately 60.6% of our net service revenues from continuing operations from services provided in Illinois in 2014, this increased competition could negatively impact our business.

Local competitors may develop strategic relationships with referral sources and payors. This could result in pricing pressures, loss of or failure to gain market share or loss of consumers or payors, any of which could harm our business. In addition, existing competitors may offer new or enhanced services that we do not provide, or be viewed by consumers as a more desirable local alternative. The introduction of new and enhanced service offerings, in combination with the development of strategic relationships by our competitors, could cause a decline in revenue, a loss of market acceptance of our services and a negative impact on our results of operations.

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

States such as Illinois are experiencing large budget deficits, which may result in lower payments. The Governor of Illinois has proposed a budget for the State s fiscal year 2016 which has certain provisions that would limit the budget and related services provided by the Illinois Department on Aging. While not yet passed by the State, if enacted these changes could affect the number of clients we serve and our growth in the State. To the extent the State continues to have fiscal issues, reimbursement from the State may be negatively impacted. In addition, private payors, including commercial insurance companies, could also reduce reimbursement. Any reduction in reimbursements or imposition of copayments that dissuade the use of our services, or any reduction in reimbursement from private payors, could materially adversely affect our profitability.

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We are subject to extensive government regulation. Changes to the laws and regulations governing our business could negatively impact our profitability and any failure to comply with these regulations could adversely affect our business.

The federal government and the states in which we operate regulate our industry extensively. The laws and regulations governing our operations, along with the terms of participation in various government programs, impose certain requirements on the way in which we do business, the services we offer, and our interactions with consumers and the public. These requirements include matters related to:

- licensure and certification;
- adequacy and quality of services;
- qualifications and training of personnel;
- confidentiality, maintenance and security issues associated with medical records and claims processing;
- the use and disclosure of protected health information;
- relationships with physicians and other referral sources;
- operating policies and procedures;
- addition of facilities and services; and
- billing for services.

These laws and regulations, including the Health Reform Act, and their interpretations, are subject to frequent change. These changes could reduce our profitability by increasing our liability, increasing our administrative and other costs, increasing or decreasing mandated services, forcing us to restructure our relationships with referral sources and providers or requiring us to implement additional or different programs and systems. Failure to comply could lead to the termination of rights to participate in federal and state-sponsored programs, the suspension or revocation of licenses and other civil and criminal penalties and a delay in our ability to bill and collect for services provided. We cannot assure you that the provisions described above will not adversely impact our business, results of operations or financial results. Further, we may be unable to mitigate any adverse effects resulting from the Health Reform Act.

The Health Reform Act amended the False Claims Act to provide that a provider must report and return overpayments within 60 days of identifying the overpayment or the claims for the services that generated the overpayments become false claims subject to the False Claims Act. Overpayments include payments for services for which the provider does not have proper documentation. If we were to identify documentation failures that could not be corrected we could be required to return payments received for those claims within the mandated 60-day time period. If we fail to identify and return overpayments within the required 60-day period we could be subject to suits under the False Claims Act by the government or relators (whistleblowers). On February 13, 2015, CMS announced that it will delay finalizing regulations that were intended to clarify when a payment is identified for purposes of the 60-day rule. Notwithstanding the delay, providers are still required to comply with the rule even though there is considerable uncertainty over exactly when the 60-day period begins. These requirements could have a material adverse impact on our business and operations. During an internal evaluation of billing processes, we discovered documentation errors in a number of claims that we had submitted to Medicare and consistent with applicable law, in March 2014, we voluntarily remitted approximately $1,800,000 to the government. See Note 7 to the Consolidated Financial Statements, Details of Certain Balance Sheet Accounts, included elsewhere herein for more information.

As noted in Business-Overview section above, new federal regulations took effect on March 17, 2014 setting forth eligibility requirements for home and community based services provided under Medicaid waiver programs. Home and community based service providers will face costs associated with compliance with these regulations, but it is difficult to ascertain the impact of these costs at this time and these costs will vary from state to state depending on how the requirements are implemented.

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On October 6, 2014, CMS issued a proposed rule that would revise the Medicare and Medicaid conditions of participation for home health agencies. The proposed rule would require home health agencies to develop, implement and maintain an agency-wide, data-driven quality assessment and improvement program and a system of communication and integration to identify patient needs and coordinate care. The proposed rule also aims to clarify and expand current patient rights requirements and contains several other clarifications and updates largely focused on creating a more patient-centered, data-driven, outcome-oriented process for patient care. While we sold our Home Health Business, as discussed in Business-Overview above, we retain some limited Medicare business as a result of our acquisition of Priority Home Health Care, Inc. and otherwise. If the proposed rule is finalized, we expect to face costs associated with compliance with such changes.

On December 11, 2014, CMS proposed a star rating methodology for home health agencies to meet the Health Reform Act s call for more transparent, public information on provider quality. All Medicare-certified home health agencies would be eligible to receive a star rating (from one to five stars) based on a number of quality measures, such as timely initiation of care, drug education provided to patients, fall risk assessment, depression assessments, improvements in bed transferring and bathing, among others. Ratings would be available on the Home Health Compare website. CMS is currently soliciting feedback from stakeholders on the proposed program and has set an implementation target of Summer 2015. It is not clear at this time what impact, if any, the proposed rating system would have on our remaining home health business.

In October 2013, California enacted the Home Care Services Consumer Protection Act. The act establishes a licensing program for home care organizations, and requires background checks, basic training, and tuberculosis screening for the aides that are employed by home care organizations. Home care organizations and aides will have until January 1, 2016 to comply with the new licensing and background check requirements. Although we sold the bulk of our home health business in California in March 2013, we continue to operate in California. The requirements of the act are expected to impose additional costs on us.

We are subject to various other federal and state regulations and laws, including anti-referral laws, the Anti-Kickback Statute, the Stark Law, the False Claims Act, Fraud Alerts, HIPPA and the HITECH Act as described in the Section Government Regulation . Failure to comply with these regulations or violations of these laws could lead to fines and exclusions or other sanctions that could have a material effect on our business.

We are subject to federal and state laws that govern our employment practices. Failure to comply with these laws, or changes to these laws that increase our employment-related expenses, could adversely impact our operations.

We are required to comply with all applicable federal and state laws and regulations relating to employment, including occupational safety and health requirements, wage and hour requirements, employment insurance and equal employment opportunity laws. These laws can vary significantly among states and can be highly technical. Costs and expenses related to these requirements are a significant operating expense and may increase as a result of, among other things, changes in federal or state laws or regulations requiring employers to provide specified benefits to employees, increases in the minimum wage and local living wage ordinances, increases in the level of existing benefits or the lengthening of periods for which unemployment benefits are available. We may not be able to offset any increased costs and expenses. Furthermore, any failure to comply with these laws, including even a seemingly minor infraction, can result in significant penalties which could harm our reputation and have a material adverse effect on our business.

In addition, certain individuals and entities, known as excluded persons, are prohibited from receiving payment for their services rendered to Medicaid, Medicare and other federal and state healthcare program beneficiaries. If we inadvertently hire or contract with an excluded person, or if any of our current employees or contractors becomes an excluded person in the future without our knowledge, we may be subject to substantial civil penalties, including up to $10,000 for each item or service furnished by the excluded individual to a federal or state healthcare program beneficiary, an assessment of up to three times the amount claimed and exclusion from the program.

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Under the Health Reform Act, we are required to provide a minimum level of coverage for 70 percent of our full-time employees in 2015 or be subject to an annual penalty. For 2016, coverage must extend to 95% of our full-time employees. Approximately 22% of our employees are not provided any medical coverage. We are evaluating our options to minimize our exposure as a result of this requirement. If we determine that we will provide medical coverage for these employees, the costs could be material and have a significant effect on our profitability. If we determine not to offer medical coverage, we could be assessed fines or penalties for individuals who seek medical coverage through federal and state health exchanges. Depending on the number of employees who seek coverage in this manner, the penalties could be material and have a significant effect on our profitability.

In September 2013, the United States Department of Labor (the Department of Labor) announced the adoption of a rule that extended the minimum wage and overtime pay requirements of federal law to most direct care workers, such as home health aides, personal care aides and certified nursing assistants. These employees have been exempt from federal wage laws since 1974. The new rule was slated to take effect on January 1, 2015, (though the Department of Labor announced on October 7, 2014 that it would delay enforcement of the rule until June 30, 2015). However, two decisions from the United States District Court for the District of Columbia, handed down on December 22, 2014 and January 14, 2015, invalidated key provisions in the rule, effectively restoring the status quo in which home care agencies and other third party employers can utilize the companionship services exemption to the minimum wage and overtime requirements of the Fair Labor Standards Act. The applicability of the rule remains uncertain, however, as the Department of Labor filed a notice of appeal of these rulings with the United States Court of Appeals for the District of Columbia on January 23, 2015.

A number of states already require that direct care workers receive state-mandated minimum wage and/or overtime pay. Opponents say that the new protections will make in-home care more expensive for government programs such as Medicaid that pay for such services, and that the new rule could result in a reduction in covered services. We will continue to evaluate the effect of the new rule on our operations.

We are subject to reviews, compliance audits and investigations that could result in adverse findings that negatively affect our net service revenues and profitability.

As a result of our participation in Medicaid, Medicaid waiver, Medicare programs, Veterans Health Administration programs and other state and local governmental programs, and pursuant to certain of our contractual relationships, we are subject to various reviews, audits and investigations by governmental authorities and other third parties to verify our compliance with these programs and agreements as well as applicable laws, regulations and conditions of participation. Pursuant to the Home Health Purchase Agreement, we are obligated to indemnify the Purchasers for, among other things, (i) penalties, fines, judgments and settlement amounts arising from a violation of certain specified statutes, including the False Claims Act, the Civil Monetary Penalties Law, the federal Anti-Kickback Statute, the Stark Law or any state law equivalent in connection with the operation of the Home Health Business prior to the Closing, and (ii) any liability related to the failure of any reimbursement claim submitted to certain government programs for services rendered by the Home Health Business prior to the Closing to meet the requirements of such government programs, or any violation prior to the Closing of any health care laws. Such liabilities include amounts to be recouped by, or repaid to, such government programs as a result of improperly submitted claims for reimbursement or those discovered as a result of audits by investigative agencies. All services that we have provided that have been or may be reimbursed by Medicare are subject to retroactive adjustments and/or total denial of payments received from Medicare under various review and audit provisions included in the program regulations. The review period is generally described as six years from the date the services are provided but could be expanded to ten years under certain circumstances if fraud is found to have existed at the time of original billing. In the event that there are adjustments relating to the period prior to the Closing, we may be required to reimburse the Purchasers for the amount of such adjustments, which could adversely affect our business and financial condition. Payments we receive in respect of Medicaid and Medicare can be retroactively adjusted after a new examination during the

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claims settlement process or as a result of pre- or post-payment audits. Federal, state and local government payors may disallow our requests for reimbursement based on determinations that certain costs are not reimbursable because proper documentation was not provided or because certain services were not covered or deemed necessary. In addition, other third-party payors may reserve rights to conduct audits and make reimbursement adjustments in connection with or exclusive of audit activities. Significant adjustments as a result of these audits could adversely affect our revenues and profitability.

If we fail to meet any of the conditions of participation or coverage with respect to state licensure or our participation in Medicaid, Medicaid waiver, Medicare programs, Veterans Health Administration programs and other state and local governmental programs, we may receive a notice of deficiency from the applicable surveyor or authority. Failure to institute a plan of action to correct the deficiency within the period provided by the surveyor or authority could result in civil or criminal penalties, the imposition of fines or other sanctions, damage to our reputation, cancellation of our agreements, suspension or revocation of our licenses or disqualification from federal and state reimbursement programs. These actions may adversely affect our ability to provide certain services, to receive payments from other payors and to continue to operate. Additionally, actions taken against one of our locations may subject our other locations to adverse consequences. We may also fail to discover all instances of noncompliance by our acquisition targets, which could subject us to adverse remedies once those acquisitions are complete. Any termination of one or more of our locations from any federal, state or local program for failure to satisfy such program s conditions of participation could adversely affect our net service revenues and profitability.

Negative publicity or changes in public perception of our services may adversely affect our ability to receive referrals, obtain new agreements and renew existing agreements.

Our success in receiving referrals, obtaining new agreements and renewing our existing agreements depends upon maintaining our reputation as a quality service provider among governmental authorities, physicians, hospitals, discharge planning departments, case managers, nursing homes, rehabilitation centers, advocacy groups, consumers and their families, other referral sources and the public. While we believe that the services that we provide are of high quality, if studies mandated by Congress in the Health Reform Act to make public quality measures are implemented and if our quality measures are deemed to be not of the highest value, our reputation could be negatively affected. Negative publicity, changes in public perceptions of our services or government investigations of our operations could damage our reputation and hinder our ability to receive referrals, retain agreements or obtain new agreements. Increased government scrutiny may also contribute to an increase in compliance costs and could discourage consumers from using our services. Any of these events could have a negative effect on our business, financial condition and operating results.

In addition, in connection with the sale of our Home Health Business, we granted a license to the Purchasers that allows them to use certain of our intellectual property, including the Addus name, for the provision of skilled nursing and related physical therapy healthcare services to individuals in their homes and hospice services in California, Illinois, Arkansas, South Carolina and Nevada. Although the use of the intellectual property is required to be consistent and at least equal to the level of quality and brand perception prior to the sale, we do not have operational control over the Purchasers. As a result, home health agencies operated by the Purchasers may not be operated in a manner consistent with the standards we uphold at our agencies. If such agencies do not maintain operational standards consistent with the standards we demand of our agencies, the image and brand reputation of Addus may suffer and our business may be materially affected.

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

Our business plan calls for significant growth in business over the next several years through the expansion of our services in existing markets and the establishment of a presence in new markets. This growth will place significant demands on our management team, systems, internal controls and financial and professional

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resources. In addition, we will need to further develop our financial controls and reporting systems to accommodate future growth. This could require us to incur expenses for hiring additional qualified personnel, retaining professionals to assist in developing the appropriate control systems and expanding our information technology infrastructure. Our inability to effectively manage growth could have a material adverse effect on our financial results.

Future acquisitions or growth initiatives may be unsuccessful and could expose us to unforeseen liabilities.

Our growth strategy includes geographical expansion into new markets and the addition of new services in existing markets through the acquisition of local service providers. These acquisitions involve significant risks and uncertainties, including difficulties assimilating acquired personnel and other corporate cultures into our business, the potential loss of key employees or consumers of acquired providers, and the assumption of liabilities and exposure to unforeseen liabilities of acquired providers. In the past, we have made acquisitions that have not performed as expected or that we have been unable to successfully integrate with our existing operations. In addition, our due diligence review of acquired businesses may not successfully identify all potential issues. For example, we were unable to fully integrate one acquired business because we were unable to procure a necessary government endorsement. The failure to effectively integrate future acquisitions could have an adverse impact on our operations.

We have grown our business through de novo locations and we may in the future open new locations in existing and new markets. De novo locations involve risks, including those relating to accreditation, hiring new personnel, establishing relationships with referral sources and delays or difficulty in installing our operating and information systems. We may not be successful in establishing de novo locations in a timely manner due to generating insufficient business activity and incurring higher than projected operating cost that could have a material adverse effect on our financial condition, results of operations and cash flows.

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

At December 31, 2014 and December 31, 2013, we had cash balances of $13,363,000 and $15,565,000, respectively. As of December 31, 2014, we had no outstanding debt on our credit facility. After giving effect to the amount drawn on our credit facility, approximately $15,464,000 of outstanding letters of credit and borrowing limits based on an advanced multiple of adjusted EBITDA, we had $39,536,000 available for borrowing under the credit facility as of December 31, 2014. Since our credit facility provides for borrowings based on a multiple of an EBITDA ratio, any declines experienced in our EBITDA would result in a decrease in our available borrowings under our credit facility.

We cannot predict the timing, size and success of our acquisition efforts, our efforts to expand into new geographic regions or the associated capital commitments. If we do not have sufficient cash resources or availability under our credit facility, our growth could be limited unless we obtain additional equity or debt financing. In the future, we may elect to issue additional equity securities in conjunction with raising capital, completing an acquisition or expanding into a new geographic region. Such issuances would be dilutive to existing shareholders. In addition, our credit facility prohibits us from consummating more than three acquisitions in any calendar year, and, in any event, does not permit the purchase price for any one acquisition to exceed $2,000,000, in each case without the consent of the lenders. The consideration we paid in connection with 12 of the 15 acquisitions we completed exceeded $2,000,000. In addition, our credit facility requires, among other things, that we are in pro forma compliance with the financial covenants set forth therein and that no event of default exists before and after giving effect to any proposed acquisition. Our ability to expand in a manner consistent with historic practices may be limited if we are unable to obtain such consent from our lenders.

Access to additional capital and credit markets, at a reasonable cost, may be necessary for us to fund our operations, including potential acquisitions and working capital requirements. We currently rely on one financial institution for funding under our credit facility and any instability in the financial markets or the negative impact of local, national and worldwide economic conditions on that financial institution could impact our short and long-term liquidity needs to meet our business requirements.

As a result of the indemnification provisions of the Home Health Purchase Agreement pursuant to which we sold Home Health Business, we may incur expenses and liabilities related to periods up to the date of sale or pursuant to our other indemnification obligations thereunder.

As a result of the indemnification provisions of the Home Health Purchase Agreement pursuant to which we sold the Home Health Business, we have agreed to indemnify the Purchasers for, among other things, (i) penalties, fines, judgments and settlement amounts arising from a violation of certain specified statutes, including the False Claims Act, the Civil Monetary Penalties Law, the federal Anti-Kickback Statute, the Stark Law or any state law equivalent in connection with the operation of the Home Health Business prior to the Closing, and (ii) any liability related to the failure of any reimbursement claim submitted to certain government programs for services rendered by the Home Health Business prior to the Closing to meet the requirements of such government programs, or any violation prior to the Closing of any health care laws. Such liabilities include amounts to be recouped by, or repaid to, such government programs as a result of improperly submitted claims for reimbursement or those discovered as a result of audits by investigative agencies. All services that we have provided that have been or may be reimbursed by Medicare are subject to retroactive adjustments and/or total denial of payments received from Medicare under various review and audit provisions included in the program regulations. The review period is generally described as six years from the date the services are provided but could be expanded to ten years under certain circumstances if fraud is found to have existed at the time of original billing. In the event that there are adjustments relating to the period prior to the Closing, we may be required to reimburse the Purchasers for the amount of such adjustments, which could adversely affect our business and financial condition.

In addition, pursuant to the Home Health Purchase Agreement, we are obligated to indemnify the Purchasers for breaches of representations, warranties and covenants, certain taxes and liabilities related to the pre-Closing period (other than specifically identified assumed liabilities). Any liability we have to the Purchasers under the Home Health Purchase Agreement could adversely affect our results of operations.

Our business may be harmed by labor relations matters.

We are subject to a risk of work stoppages and other labor relations matters because our hourly workforce is highly unionized. As of December 31, 2014, approximately 61.3% of our workforce was represented by two national unions, including the Service Employees International Union, which is our largest union. We have a national agreement with the SEIU. Wages and benefits are negotiated at the local level at various times throughout the year. These negotiations are often initiated when we receive increases in our hourly rates from various state agencies. Upon expiration of these collective bargaining agreements, we may not be able to negotiate labor agreements on satisfactory terms with these labor unions. A strike, work stoppage or other slowdown could result in a disruption of our operations and/or higher ongoing labor costs, which could adversely affect our business. Labor costs are the most significant component of our total expenditures and, therefore, an increase in the cost of labor could significantly harm our business.

Our operations subject us to risk of litigation.

Operating in the home and community based services industry exposes us to an inherent risk of wrongful death, personal injury, professional malpractice and other potential claims or litigation brought by our consumers and employees. Because we operate in this industry, from time to time, we are subject to claims alleging that we did not properly treat or care for a consumer that we failed to follow internal or external procedures that resulted in death or harm to a consumer or that our employees mistreated our consumers, resulting in death or harm. We are also subject to claims arising out of accidents involving vehicle collisions brought by consumers whom we are transporting or from employees driving to or from home visits. We operate five adult day centers which provide transportation for our elderly and disabled consumers. Each of our vehicles transports 7 to 14 passengers to and from our locations. The concentration of consumers in one vehicle increases the risk of larger claims being brought against us in the event of an accident.

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

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

Although we maintain insurance consistent with industry practice, the insurance we maintain may not be sufficient to satisfy all claims made against us. For example, we have a $350,000 deductible per person/per occurrence under our workers compensation insurance program. We cannot assure you that claims will not be made in the future in excess of the limits of our insurance, and any such claims, if successful and in excess of such limits, may have a material adverse effect on our business or assets. We utilize historical data to estimate our reserves for our insurance programs. If losses on asserted claims exceed the current insurance coverage and accrued reserves, our business, results of operations and financial condition could be adversely affected. Changes in our annual insurance costs and self-insured retention limits depend in large part on the insurance market, and insurance coverage may not continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms.

Inclement weather or natural disasters may impact our ability to provide services.

Inclement weather may prevent our employees from providing authorized services. We are not paid for authorized services that are not delivered due to these weather events. Furthermore, prolonged inclement weather or the occurrence of natural disasters in the markets in which we operate could disrupt our relationships with consumers, employees and referral sources located in affected areas and, in the case of our corporate office, our ability to provide administrative support services, including billing and collection services. For example, our corporate headquarters and a number of our agencies are located in the midwestern United States and California, increasing our exposure to blizzards and other major snowstorms, ice storms, tornados, flooding and earthquakes. Future inclement weather or natural disasters may adversely affect our business and consolidated financial condition, results of operations and cash flows.

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

Our business depends on effective and secure information systems that assist us in, among other things, gathering information to improve the quality of consumer care, optimizing financial performance, adjusting consumer mix, monitoring regulatory compliance and enhancing staff efficiency. We rely on an external service provider, McKesson, to provide continual maintenance, upgrading and enhancement of our primary information systems used for our operational needs. The software we license from McKesson supports intake, personnel scheduling, office clinical and centralized billing and receivables management in an integrated database, enabling us to standardize the care delivered across our network of locations and monitor our performance and consumer outcomes. To the extent that McKesson fails to support the software or systems, or if we lose our license with McKesson, our operations could be negatively affected.

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

Because of the confidential health information and consumer records we store and transmit, loss of electronically-stored information for any reason could expose us to a risk of regulatory action, litigation and liability.

If we experience a reduction in the performance, reliability, or availability of our information systems, our operations and ability to process transactions and produce timely and accurate reports could be adversely affected. If we experience difficulties with the transition and integration of information systems or are unable to implement, maintain, or expand our systems properly, we could suffer from, among other things, operational disruptions, regulatory problems, and increases in administrative expenses.

We have full backup of our key information systems. Should our support center become inoperable as a result of a natural disaster or terrorist acts, it would take substantial amount of time and resources to restore our business to the current state of operation. This risk is becoming even more critical as we are centralizing more of our business operations. The disruption to the business would be material and would affect our operational and financial performance.

We rely on several vendors for telecommunication and internet access, with a high percentage of our agencies supported by one vendor. To the extent services are interrupted, our individual offices may lose basic telephone service and access to our centralized computer systems. To the extent these delays are frequent, or impact a large number of offices, or occur for extended periods of time, it could disrupt our business and would have a negative effect on our ability to serve our clients and potentially have a negative impact on our financial performance.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other events or developments could result in compromises or breaches of our security systems and consumer data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in our services or operations. The Internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the Internet. Computer viruses could be introduced into our systems which could disrupt our operations or make our systems inaccessible. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of consumers if security breaches are not prevented.

In addition, we are required to comply with the privacy and security laws and regulations of HIPAA and the HITECH Act. If our privacy and security practices are not in compliance with HIPAA and/or if we fail to satisfy the breach notification requirements of the HITECH Act in the event of a security breach, we could be subject to significant fines and penalties. Penalties under the HIPAA (as increased by the HITECH Act) can be as high as $50,000 per violation (with an annual maximum of $1,500,000) depending on the degree of culpability.

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The agreements that govern our credit facility contain various covenants that limit our discretion in the operation of our business.

Our credit facility agreement requires us to comply with customary financial and non-financial covenants. The financial covenants require us to maintain a maximum fixed charge ratio and a maximum leverage ratio, and limit our capital expenditures. Our credit facility also includes non-financial covenants including restrictions on our ability to:

- transfer assets, enter into mergers, make acquisitions or experience fundamental changes;
- make investments, loans and advances;
- incur additional indebtedness and guarantee obligations;
- create liens on assets;
- enter into affiliate transactions;
- enter into transactions other than in the ordinary course of business;
- incur capital lease obligations;
- make capital expenditure; and
- pay dividends.

Our current principal stockholders have significant influence over us, and they could delay, deter or prevent a change of control or other business combination or otherwise cause us to take action with which you might not agree.

Eos Capital Partners III, L.P. and Eos Partners SBIC III, L.P., or the Eos Funds, together beneficially own approximately 36.5% of our outstanding common stock as of December 31, 2014. As a result, the Eos Funds have the ability to significantly influence all matters submitted to our stockholders for approval, including:

- changes to the composition of our board of directors, which has the authority to direct our business and appoint and remove our officers;
- proposed mergers, consolidations or other business combinations; and
- amendments to our certificate of incorporation and bylaws which govern the rights attached to our shares of common stock.

In addition, one of our directors is affiliated with the Eos Funds.

This concentration of ownership of shares of our common stock could delay or prevent proxy contests, mergers, tender offers, open-market purchase programs or other purchases of shares of our common stock that might otherwise give you the opportunity to realize a premium over the then-prevailing market price of our common stock. The interests of the Eos Funds may not always coincide with the interests of the other holders of our common stock. This concentration of ownership may also adversely affect our stock price.

We may not be able to attract, train and retain qualified personnel.

We must attract and retain qualified personnel in the markets in which we operate in order to provide our services. We compete for personnel with other providers of social and medical services as well as companies in other service-based industries. Competition may be greater for skilled personnel, such as regional and agency directors. Our ability to attract and retain personnel depends on several factors, including our ability to provide employees with attractive assignments and competitive benefits and salaries.

The loss of one or more of the members of the executive management team or the inability of a new management team to successfully execute our strategies may adversely affect our business. If we are unable to attract and retain qualified personnel, we may be unable to provide our services, the quality of our services may decline, and we could lose consumers and referral sources.

We may be more vulnerable to the effects of a public health catastrophe than other businesses due to the nature of our consumers.

The majority of our consumers are older individuals with complex medical challenges, many of whom may be more vulnerable than the general public during a pandemic or in a public health catastrophe. Our employees are also at greater risk of contracting contagious diseases due to their increased exposure to vulnerable consumers. For example, if a flu pandemic were to occur, we could suffer significant losses to our consumer population or a reduction in the availability of our employees and, at a high cost, be required to hire replacements for affected workers. Accordingly, certain public health catastrophes could have a material adverse effect on our financial condition and results of operations.

We depend on the services of our executive officers and other key employees.

Our success depends upon the continued employment of certain members of our senior management team. We also depend upon the continued employment of the individuals that manage several of our key functional areas, including operations, business development, accounting, finance, human resources, marketing, information systems, contracting and compliance. The departure of any member of our senior management team may materially adversely affect our operations.

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

Goodwill and intangible assets with finite lives represent a significant portion of our assets. Goodwill represents the excess of cost over the fair market value of net assets acquired in business combinations. If our market capitalization drops significantly below the amount of net equity recorded on our balance sheet, it might indicate a decline in our fair value and would require us to further evaluate whether our goodwill has been impaired. If as part of our annual review of goodwill and intangibles, we were required to write down all or a significant part of our goodwill and/or intangible assets, our net earnings and net worth could be materially adversely affected, which could affect our flexibility to obtain additional financing. In addition, if our assumptions used in preparing our valuations for purposes of impairment testing differ materially from actual future results, we may record impairment charges in the future and our financial results may be materially adversely affected. We had $64,220,000 of goodwill and $10,347,000 of intangible assets recorded on our consolidated balance sheet at December 31, 2014.

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

The market price of our common stock may be volatile and this may adversely affect our stockholders.

The price at which our common stock trades may be volatile. The stock market has recently experienced significant price and volume fluctuations that have affected the market prices of all securities, including securities of health care companies. The market price of our common stock may be influenced by many factors, including:

- our operating and financial performance;
- variances in our quarterly financial results compared to expectations;
- the depth and liquidity of the market for our common stock;

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- we have a small base of registered shares of common stock consisting of the 5,400,000 shares we issued in our initial public offering (IPO), which represents approximately 49.0% of our total common shares outstanding, that could result in significant stock price movements upward or downward based on low levels of trading volume in our common stock;

- future sales of common stock or the perception that sales could occur;

- investor perception of our business and our prospects;

- developments relating to litigation or governmental investigations;

- changes or proposed changes in health care laws or regulations or enforcement of these laws and regulations, or announcements relating to these matters; or

- general economic and stock market conditions.

In addition, the stock market in general has experienced price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of homecare companies. These broad market and industry factors may materially reduce the market price of our common stock, regardless of our operating performance. In the past, securities class-action litigation has often been brought against companies following periods of volatility in the market price of their respective securities. We have been and may become involved in this type of litigation in the future. Litigation of this type is often expensive to defend and may divert our management team s attention as well as resources from the operation of our business.

We do not anticipate paying dividends on our common stock in the foreseeable future and, consequently, your ability to achieve a return on your investment will depend solely on appreciation in the price of our common stock.

We do not pay dividends on our shares of common stock and intend to retain all future earnings to finance the continued growth and development of our business and for general corporate purposes. In addition, we do not anticipate paying cash dividends on our common stock in the foreseeable future. Any future payment of cash dividends will depend upon our financial condition, capital requirements, credit facility limitations, earnings and other factors deemed relevant by our board of directors.

If securities or industry analysts fail to publish research or reports about our business or publish negative research or reports, or our results are below analysts estimates, our stock price and trading volume could decline.

The trading market for our common stock may depend in part on the research and reports that industry or securities analysts publish about us or our business. We do not have any control over these analysts. If analysts fail to publish reports on us regularly or at all, we could fail to gain visibility in the financial markets, which in turn could cause our stock price or trading volume to decline. If one or more analysts do cover us and downgrade their evaluations of our stock or our results are below analysts estimates, our stock price would likely decline. In addition, due to the small number of analysts covering us, a single comment or report from one of the analysts whether positive or negative, could result in a significant increase or decrease in our stock price.

Provisions in our organizational documents and Delaware law could delay or prevent a change in control of our company, which could adversely affect the price of our common stock.

Provisions in our amended and restated certificate of incorporation and bylaws and anti-takeover provisions of the Delaware General Corporation Law, could discourage, delay or prevent an unsolicited change in control of our company, which could adversely affect the price of our common stock. These provisions may also have the effect of making it more difficult for third parties to replace our current management without the consent of the board of directors. Provisions in our amended and restated certificate of incorporation and bylaws that could delay or prevent an unsolicited change in control include:

- a staggered board of directors;
- limitations on persons authorized to call a special meeting of stockholders; and
- the authorization of undesignated preferred stock, the terms of which may be established and shares of which may be issued without stockholder approval.

As a Delaware corporation, we are subject to Section 203 of the Delaware General Corporation Law. This section generally prohibits us from engaging in mergers and other business combinations with stockholders that beneficially own 15% or more of our voting stock, or with their affiliates, unless our directors or stockholders approve the business combination in the prescribed manner. However, because the Eos Funds acquired their shares prior to our IPO, Section 203 is currently inapplicable to any business combination with the Eos Funds or their affiliates. In addition, our amended and restated bylaws require that any stockholder proposals or nominations for election to our board of directors must meet specific advance notice requirements and procedures, which make it more difficult for our stockholders to make proposals or director nominations.

If we fail to achieve and maintain effective internal control over financial reporting, our business and stock price could be adversely impacted.

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

As a result of our increased stock price and overall market value as of the end of the second quarter of 2013, we became subject to the requirements of Section 404 of Sarbanes-Oxley. Accordingly, we are now required to have an audit of our internal controls over financial reporting.

If we fail to satisfy the requirements of Section 404 on a timely basis, we could be subject to regulatory scrutiny and sanctions, our ability to raise capital could be impaired, investors may lose confidence in the accuracy and completeness of our financial reports and our stock price could be adversely affected.

Compliance with changing regulations including specific program compliance, corporate governance and public disclosure will result in additional expenses and pose challenges for our management team.

The state agencies that contract for our services require our compliance with various rules and regulations affecting the services we provide. We have a compliance officer who monitors and reports on our efforts for achieving the desired results. State agencies are recommending increased rules and regulations in an effort to control the growth of these programs and their overall costs. The implementation of these changes may require the Company to increase their efforts to remain compliant, may reduce the authorizations for services to be provided, may result in certain consumers no longer being eligible for our services all of which may result in lower revenues and increased costs, reducing our operating performance and profitability. If we continue to serve our consumers without addressing these increased regulations we are at risk for non-compliance with program requirements and potential penalties.

Changing laws, regulations and standards relating to corporate governance and public disclosure, including the Dodd-Frank Wall Street Reform and Consumer Protection Act and the rules and regulations promulgated there-under, the Sarbanes-Oxley Act and SEC regulations, have created uncertainty for public companies and

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significantly increased the costs and risks associated with accessing the U.S. public markets. We are committed to maintaining high standards of internal controls over financial reporting, corporate governance and public disclosure. As a result, we intend to continue to invest appropriate resources to comply with evolving standards, and this investment has resulted and will likely continue to result in increased general and administrative expenses and a diversion of management time and attention from revenue-generating activities to compliance activities.

Declines in earnings could create future liquidity problems.

The availability of funds under the revolving credit portion of our credit facility, is based on the lesser of (i) the product of adjusted EBITDA, as defined in the credit agreement, for the most recent 12-month period for which financial statements have been delivered under the credit agreement multiplied by the specified advance multiple, up to 3.25, less the outstanding senior indebtedness and letters of credit, and (ii) $55,000,000 less the outstanding revolving loans and letters of credit. Interest on the revolving line of credit may be payable at (i) a floating rate equal to the one-month LIBOR, plus a margin of 3.5%, (ii) the LIBOR rate for term periods of one, two or three months, plus a margin of 3.5% or (iii) the base rate, plus a margin of 1.6%, where the base rate is equal to the greatest of (a) the rate of interest last quoted by The Wall Street Journal as the prime rate, (b) the sum of the federal funds rate, plus a margin of 0.5% and (c) the sum of the adjusted LIBOR that would be applicable to a loan with a one month interest period advanced on such day, plus a margin of 3%. We 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 are charged at a rate of 2.0% per annum payable monthly. We did not have any amounts outstanding under the credit facility as of December 31, 2014, and the total availability under the revolving credit loan facility was $39,536,000 as of December 31, 2014.

The current federal and state economic and reimbursement environments and state budgetary pressures to decrease or eliminate services we provide could negatively affect our future earnings. This decrease in earnings would reduce the availability of funds under our credit facility which could have a negative impact on our future operating results.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

We do not own any real property. As of December 31, 2014, we operated at 130 leased properties including our National Support Center. Home and community based services are operated out of 129 of these facilities. As part of the sale of the Home Health Business, a portion of 10 of the facilities are currently subleased to the Purchasers. We lease approximately 59,000 square feet of office space in Downers Grove, Illinois, which serves as our corporate headquarters.

ITEM 3. LEGAL PROCEEDINGS

From time to time, we are subject to claims and suits arising in the ordinary course of our business, including claims for damages for personal injuries. In our management s opinion, the ultimate resolution of any of these pending claims and legal proceedings will not have a material adverse effect on our financial position or results of operations.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

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PART II

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

Market Information

Our common stock has been trading on The NASDAQ Global Market under the symbol ADUS since our IPO on October 27, 2009. Prior to that time, there was no public market for our common stock. The holders of our common stock are entitled to one vote per share on any matter to be voted upon by stockholders. All shares of common stock rank equally as to voting and all other matters. The table below sets forth the high and low sales prices for our common stock, as reported by The NASDAQ Global Market, for each of the periods indicated.

	High	Low
2014		
Fourth Quarter	$ 24.29	$ 24.00
Third Quarter	23.50	23.24
Second Quarter	24.32	23.51
First Quarter	29.45	28.56
2013		
Fourth Quarter	$ 32.40	$ 21.13
Third Quarter	29.94	17.62
Second Quarter	20.72	11.17
First Quarter	14.07	7.12

Holders

As of December 31, 2014, 38.6% of our shares were held by Company insiders. An additional 47.6% of the stock was held by 95 institutional investors. As of February 23, 2015, Addus HomeCare Corporation had approximately 2,200 shareholders, including 32 shareholders of record.

Dividends

Historically, we have not paid dividends on our common stock, and we currently do not intend to pay any dividends on our common stock. We currently plan to retain any earnings to support the operation, and to finance the growth, of our business rather than to pay cash dividends. Payments of any cash dividends in the future will depend on our financial condition, results of operations and capital requirements as well as other factors deemed relevant by our board of directors. Our credit facility restricts our ability to declare or pay any dividend or other distribution unless no default then exists or would occur as a result thereof, and we are in pro forma compliance with the financial covenants contained in our credit facility after giving effect thereto.

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Equity Compensation Plan

The following table presents securities authorized for issuance under our equity compensation plans at December 31, 2014.

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (1)	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights (2)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in the First Column) (3)
Equity Compensation Plans Approved by Security Holders	684,370	$ 11.43	1,389,387
Equity Compensation Plans Not Approved by Security Holders			
Total	684,370	$ 11.43	1,389,387

(1) Includes both grants of stock options and unvested share awards.

(2) Includes weighted-average exercise price of outstanding stock options only.

(3) Represents shares of common stock that may be issued pursuant to our 2006 stock incentive plan (the 2006 Plan) or our 2009 stock incentive plan (the 2009 Plan). We do not plan on issuing any further grants under the 2006 Plan. There are 825,583 shares of common stock that may be issued pursuant to the 2009 Plan.

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ITEM 6. SELECTED FINANCIAL DATA

The following table sets forth selected financial information derived from our consolidated financial statements for the periods and at the dates indicated. The information is qualified in its entirety by and should be read in conjunction with the consolidated financial statements and related notes included elsewhere in this Annual Report on Form 10-K.

	For the Years Ended December 31,				
	2014	2013	2012	2011	2010
	(Amounts In Thousands, Except Per Share Data)				
Consolidated Statements of Income Data:					
Net service revenues (1)	$ 312,942	$ 265,941	$ 244,315	$ 230,105	$ 230,099
Cost of service revenues	229,207	198,202	180,264	168,632	170,376
Gross profit	83,735	67,739	64,051	61,473	59,723
General and administrative expenses	61,834	50,118	46,362	45,858	47,042
Revaluation of contingent consideration (4)				(469)	
Gain on sale of agency			(495)		
Depreciation and amortization	3,830	2,160	2,521	3,167	3,408
Total operating expenses	65,664	52,278	48,388	48,556	50,450
Operating income from continuing operations	18,071	15,461	15,663	12,917	9,273
Interest income (5)	(18)	(188)	(155)	(2,263)	(155)
Interest expense	698	674	1,723	2,524	3,159
Total interest expense, net	680	486	1,568	261	3,004
Income from continuing operations before income taxes	17,391	14,975	14,095	12,656	6,269
Income tax expense	5,428	3,812	4,807	4,244	1,902
Net income from continuing operations	11,963	11,163	9,288	8,412	4,367
Discontinued Operations					
Net income (loss) from Home Health Business (3)	280	(980)	(1,653)	(10,393)	1,661
Gain on sale of Home Health Business, net of tax		8,962			
Earnings (losses) from discontinued operations	280	7,982	(1,653)	(10,393)	1,661
Net income (loss)	$ 12,243	$ 19,145	$ 7,635	$ (1,981)	$ 6,028
Basic income (loss) per common share:					
Continuing operations	$ 1.10	$ 1.03	$ 0.86	$ 0.78	$ 0.41
Discontinued operations	0.02	0.74	(0.15)	(0.96)	0.16
Basic income (loss) per common share:	$ 1.12	$ 1.77	$ 0.71	$ (0.18)	$ 0.57
Diluted income (loss) per common share:					
Continuing operations	$ 1.08	$ 1.01	$ 0.86	$ 0.78	$ 0.41
Discontinued operations	0.02	0.72	(0.15)	(0.96)	0.16
Diluted income (loss) per common share:	$ 1.10	$ 1.73	$ 0.71	$ (0.18)	$ 0.57
Weighted average number of common shares and potential common shares outstanding:					
Basic	10,900	10,826	10,764	10,752	10,604
Diluted	11,114	11,075	10,784	10,752	10,606

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	For the Years Ended December 31, 2014	2013	2012	2011	2010
	(Actual Numbers, Except Adjusted EBITDA and Billable Hours in Thousands)				
Key Metrics:					
General:					
Adjusted EBITDA (2)	$ 23,759	$ 18,796	$ 18,525	$ 16,415	$ 12,936
States served at period end	22	21	19	19	19
Locations at period end	129	121	96	96	107
Employees at period end	18,054	16,585	13,836	12,463	11,716
Operational Data:					
Average billable census	31,019	26,802	25,104	23,877	23,743
Billable hours	18,335	15,621	14,388	13,504	13,599
Average billable hours per census per month	49	49	48	47	48
Billable hours per business day	71,903	59,850	55,126	51,938	52,103
Revenues per billable hour	$ 17.07	$ 17.02	$ 16.98	$ 17.04	$ 16.92
Percentage of Revenues by Payor:					
State, local and other governmental	87%	94%	95%	94%	93%
Managed care organizations	9	1			
Private duty	3	4	4	5	6
Commercial	1	1	1	1	1

	As of December 31, 2014	2013	2012	2011	2010
	(Amounts In Thousands)				
Consolidated Balance Sheet Data:					
Cash	$ 13,363	$ 15,565	$ 1,737	$ 2,020	$ 816
Accounts receivable, net of allowances	68,333	61,354	71,303	72,368	70,954
Goodwill and intangibles	74,567	68,788	56,906	58,739	77,500
Total assets	180,803	163,934	149,857	154,692	166,924
Total debt	3,663		16,458	31,527	45,185
Stockholders equity	127,956	113,856	94,417	86,441	88,091

(1) Acquisitions completed in 2014 accounted for $7,536,000 of growth in net service revenues from continuing operations for the year ended December 31, 2014. Acquisitions completed in 2013 accounted for $21,945,000 and $1,692,000 of growth in net service revenues from continuing operations for the years ended December 31, 2014 and 2013, respectively.

(2) We define Adjusted EBITDA as earnings before discontinued operations, interest expense, taxes, depreciation, amortization, stock-based compensation expense and M&A expense. Adjusted EBITDA is a performance measure used by management that is not calculated in accordance with generally accepted accounting principles in the United States (GAAP). It should not be considered in isolation or as a substitute for net income, operating income or any other measure of financial performance calculated in accordance with GAAP.
Management believes that Adjusted EBITDA is useful to investors, management and others in evaluating our operating performance for the following reasons:

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

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and depreciation), tax consequences and non-cash stock-based compensation expense from our results of operations, M&A expense and also facilitates comparisons with the core results of our public company peers.

We believe that Adjusted EBITDA is a measure widely used by securities analysts, investors and others to evaluate the financial performance of other public companies, and therefore may be useful as a means of comparison with those companies, when viewed in conjunction with traditional GAAP financial measures.

We adopted Accounting Standards Codification (ASC) Topic 718 Share-Based Payment, on September 19, 2006, the effective date of our 2006 Stock Incentive Plan (the 2006 Plan), and recorded stock-based compensation expense of $827,000, $515,000, $341,000, $331,000 and $255,000 for the years ended December 31, 2014, 2013, 2012, 2011 and 2010, respectively. By comparing our Adjusted EBITDA in different periods, our investors can evaluate our operating results without stock-based compensation expense, which is a non-cash expense that is not a key measure of our operations.

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

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

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

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

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

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

in communications with our board of directors concerning our financial performance.

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

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

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

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Adjusted EBITDA does not reflect interest expense or interest income;

Adjusted EBITDA does not reflect cash requirements for income taxes;

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

Adjusted EBITDA does not reflect any goodwill and intangible asset impairment charges;

Adjusted EBITDA does not reflect any revaluation of contingent consideration;

Adjusted EBITDA does not reflect any stock based compensation; and

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

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

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

	Year Ended December 31, (Amounts In Thousands)				
	2014	**2013**	**2012**	**2011**	**2010**
Reconciliation of Adjusted EBITDA to net income (loss):					
Net income (loss)	$ 12,243	$ 19,145	$ 7,635	$ (1,981)	$ 6,028
Less: (Earnings) loss from discontinued operations, net of tax	(280)	(7,982)	1,653	10,393	(1,661)
Net income from continuting operations	11,963	11,163	9,288	8,412	4,367
Interest expense, net	680	486	1,568	261	3,004
Income tax expense from continuing operations	5,428	3,812	4,807	4,244	1,902
Depreciation and amortization	3,830	2,160	2,521	3,167	3,408
M&A expenses	1,031	660			
Stock-based compensation expense	827	515	341	331	255
Adjusted EBITDA (1)	$ 23,759	$ 18,796	$ 18,525	$ 16,415	$ 12,936

(1) The selected historical Consolidated Statements of Income data for the fiscal years ended December 31, 2014, 2013, 2012, 2011 and 2010, were derived from our audited consolidated financial statements included in the Annual Report on Form 10-K for the applicable year.

(3) During December 2012, in anticipation of the sale of the Home Health Business we reported the operating results of our Home Health Business as discontinued operations. On February 7, 2013, we entered into the Home Health Purchase Agreement with the Purchasers. In

2011, we determined that all of the $15,989,000 allocated to goodwill and intangible assets for our home health reportable unit was impaired and recorded an impairment loss of $15,989,000.

(4) Adjusted EBITDA for 2011 includes a $469,000 non-cash gain for the revaluation of contingent consideration originally estimated for the purchase of assets from Advantage Health Systems, Inc.

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(5) 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. We recorded no prompt payment interest income for the year ended December 31, 2014 and $185,000, $155,000, $2,263,000 and $155,000 in prompt payment interest for the years ended December 31, 2013, 2012, 2011 and 2010, respectively.

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

You should read the following discussion together with our consolidated financial statements and the related notes included elsewhere in this Annual Report on Form 10-K. This discussion contains forward-looking statements about our business and operations. Our actual results may differ materially from those we currently anticipate as a result of the factors we describe under Risk Factors and elsewhere in this Annual Report on Form 10-K.

Overview

We are a provider of comprehensive home and community based services, which are provided primarily in the home, and focused on the dual eligible (Medicare/Medicaid) population. Our services include personal care and assistance with activities of daily living, and adult day care. Our consumers are primarily persons 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, managed care organizations, commercial insurers and private individuals. We currently provide home and community based services to over 31,000 consumers through 129 locations across 22 states, including 5 adult day centers in Illinois. Over the course of 2014, we served over 43,000 consumers.

A summary of our financial results for 2014, 2013 and 2012 is provided in the table below:

	2014	2013	2012
		(Amounts in Thousands)	
Net service revenues continuing operations	$ 312,942	$ 265,941	$ 244,315
Net service revenues discontinued operations		6,462	38,822
Net income from continuing operations	11,963	11,163	9,288
Earnings (loss) from discontinued operations	280	7,982	(1,653)
Net income	$ 12,243	$ 19,145	$ 7,635
Total assets	$ 180,803	$ 163,934	$ 149,857

Historically our services were provided under agreements with state and local government agencies established to meet the needs of our consumers. Our consumers are predominately dual eligible and as such are eligible to receive both Medicare and Medicaid funded home-based care. As a result of certain legislation enacted by the federal government, states are being incentivized to initiate dual eligible demonstration programs and other managed Medicaid initiatives, which are designed to coordinate the services provided through these two programs, with the overall objectives to better coordinate service delivery and over the long term to reduce costs. Increasingly states are implementing these managed care programs and as such are transitioning management of individuals such as our consumers to local and national managed care organizations. Under these arrangements the managed care organizations have an economic incentive to provide home and community based services to consumers as a means to better manage the acute care expenditures of their membership.

The home and community based services we provide include assistance with bathing, grooming, dressing, personal hygiene and medication reminders, and other activities of daily living. We provide these services on a long-term, continuous basis, with an average duration of approximately 20 months per consumer. Our adult day centers provide a comprehensive program of skilled and support services and designated medical services for adults in a community-based group setting. Services provided by our adult day centers include social activities, transportation services to and from the centers, the provision of meals and snacks, personal care and therapeutic activities such as exercise and cognitive interaction.

We utilize a coordinated care model that is designed to improve consumer outcomes and satisfaction, as well as lower the cost of acute care treatment and reduce service duplication. We believe this coordinated care model to be especially valuable to managed care organizations that have economic responsibility for both home

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and community services as well as acute care expenditures. Over the long term, we believe this model will be a differentiator and as a result we expect to receive increased referrals from the managed care organizations.

Through our coordinated care model, we utilize our home care aides to observe and report changes in the condition of our consumers for the purpose of early intervention in the disease process, thereby preventing or reducing the cost of medical services by avoiding emergency room visits, and/or reducing the need for hospitalization. We will coordinate the services provided by our team with those of other health care agencies as appropriate. Changes in consumers conditions are evaluated by appropriately trained managers and referred to either appropriate medical personnel including the consumers primary care physicians or managed care organizations for treatment and follow-up. We believe this approach to the care to our consumers and the integration of our services into the broader healthcare continuum are attractive to managed care organizations and others who are ultimately responsible for the healthcare needs and costs of our consumers and over time will increase our business with them.

We are investing in technology based solutions to support and facilitate our coordinated care model. We utilize an Integrated Voice Response, IVR system and smart phones applications to communicate with the homecare aides. Through these applications we are able to identify changes in health conditions with automated alerts forwarded to appropriate management team for triaging and evaluation. In addition, the technology is used to record basic transaction information about each visit including: start and end times to a scheduled shift, mileage reimbursement, text messages to the homecare aide and communication of basic payroll information. Our plans for this technology include development of a web portal to provide the ability to communicate this basic information about individual clients to the managed care organizations.

We are growing through selective acquisitions, based on an overall strategy to expand our presence in current markets and to expand our footprint in markets where the home and community business is moving to managed care organizations. We completed two acquisitions in December 2013 and June 2014 that expanded our presence in two existing markets and provided us with a base of operations in two new targeted managed care states. Effective January 1, 2015, we acquired Priority Home Health Care, Inc., a company headquartered in Cleveland, Ohio and operating six offices in the Cleveland, Akron and Columbus areas. We anticipate these transactions to be accretive to earnings in 2015.

Effective March 1, 2013, we sold substantially all of the assets used in our home health business (the Home Health Business) in Arkansas, Nevada and South Carolina, and 90% of the Home Health Business in California and Illinois, to subsidiaries of LHC Group, Inc. (the Purchasers) for a cash purchase price of approximately $20,000,000. We retained a 10% ownership interest in the Home Health Business in California and Illinois. The assets sold included 19 home health agencies and two hospice agencies in five states. Effective December 30, 2013, we sold one home health agency in Pennsylvania for approximately $200,000. The results of the Home Health Business sold and one additional agency in Idaho which was closed in November 2012, are reflected as discontinued operations for all periods presented herein. Continuing operations include the results of operations previously included in our home & community segment and three agencies previously included in our home health segment. Following the sale of the Home Health Business, we manage and internally report our business in one segment. Because regulatory requirements in Delaware and Indiana require home and community based services to be provided by a licensed home health agency, we will continue to provide limited home health services reimbursable by Medicare in these agencies in order to maintain these licenses. In addition, Priority Home Health Care maintains enrollment in but does not derive significant revenues from Medicare.

We believe the sale of the Home Health Business substantially positioned us for future growth. The sale allowed us to focus both management and financial resources on changes in the home and community based services industry and to address and the needs of managed care organizations as they become more responsible for state sponsored programs. We have improved our financial performance by concentrating our efforts on our home and community business that is growing and profitable. We have improved our overall financial position by eliminating our debt and adding to our cash reserves.

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Business

The results of the Home Health Business sold are reflected as discontinued operations for all periods presented herein. Continuing operations include the results of operations previously included in our home and community segment and three agencies previously included in our home health segment. Following the sale of the Home Health Business, we manage and internally report our business in one segment. As of December 31, 2014, we provided our home and community based services through 129 locations across 22 states including 5 adult day centers in Illinois.

Our payor clients are principally federal, state and local governmental agencies and, increasingly, managed care organizations. The federal, state and local programs under which the agencies operate are subject to legislative, budgetary and other risks that can influence reimbursement rates. We are beginning to experience and anticipate a further transition of business from government payors to managed care organizations with which we are seeking to grow our business given our emphasis on coordinated care and the prevention of acute care. Managed care organizations are commercial insurance carriers who are under contract with various federal and state governmental agencies to manage the provision of home and community based services. Their objective is to lower total health care costs by integrating the provision of home and community based services with those benefit programs responsible for the provision of acute care services to their consumers. We are also seeking to grow our private duty business. Our commercial insurance carrier payor clients are typically for-profit companies and are continuously seeking opportunities to control costs.

For the year ended December 31, 2014, 2013 and 2012, our payor revenue mix for continuing operations was:

	Year Ended December 31,		
	2014	**2013**	**2012**
State, local and other governmental programs	86.4%	94.1%	94.9%
Managed care organizations	9.1	1.0	0.0
Private duty	3.4	3.9	4.1
Commercial	1.1	1.0	1.0
	100.0%	100.0%	100.0%

We derive a significant amount of our net service revenues from our continuing operations in Illinois, which represented 60.6%, 65.5% and 63.7% and of our total net service revenues from continuing operations for the years ended December 31, 2014, 2013 and 2012, respectively.

A significant amount of our net service revenues from continuing operations are derived from one payor client, the Illinois Department on Aging, which accounted for 53.2%, 58.8% and 57.3% of our total net service revenues from continuing operations for the years ended December 31, 2014, 2013 and 2012, respectively.

We also measure the performance of our business using a number of different metrics. We consider billable hours, billable hours per business day, revenues per billable hour and the number of consumers, or census.

Components of our Statements of Income

Net Service Revenues

We generate net service revenues from continuing operations by providing our 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 consumers.

Net service revenues from continuing operations are typically generated based on services rendered and reimbursed on an hourly basis. Our net service revenues from continuing operations were generated principally through reimbursements by state, local and other governmental programs which are partially funded by Medicaid programs, managed care organizations and to a lesser extent from private duty and insurance programs. Net service revenues from continuing operations are principally provided based on authorized hours, determined by the relevant agency, at an hourly rate, which is either contractual or fixed by legislation or contract, and recognized as net service revenues at the time services are rendered.

Cost of Service Revenues

We incur direct care wages, payroll taxes and benefit-related costs from continuing operations in connection with providing our 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.

General and Administrative Expenses

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

Our general and administrative expenses from continuing operations consist principally of supervisory personnel, care coordination and office administration costs. These expenses include wages, payroll taxes and benefit-related costs; facility rent; operating costs such as utilities, postage, telephone and office expenses; and bad debt expense. We have initiated efforts to centralize administrative tasks currently conducted at the branch locations. The costs related to these initiatives are included in the general and administrative expenses from continuing operations. Other centralized expenses from continuing operations include 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 and non-compete agreements, principally using accelerated methods based upon their estimated useful lives. Depreciable assets consist principally of furniture and equipment, network administration and telephone equipment, and operating system software. Depreciable and leasehold assets are depreciated or amortized on a straight-line method over their useful lives or, if less and if applicable, their lease terms.

Interest Income

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 statement of operations as interest income. While we may be owed additional prompt payment interest, the amount and timing of receipt of such payments remains uncertain and we have determined that we will continue to recognize prompt payment interest income when received.

Interest Expense

Interest expense from continuing operations consists of interest costs on our credit facility, capital lease obligations and other debt instruments.

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Income Tax Expense

All of our income from continuing operations is from domestic sources. We incur state and local taxes in states in which we operate. The differences from the federal statutory rate of 34.5% and 35.0% in 2014 and 2013, respectively, are principally due to the inclusion of state taxes and the use of federal employment tax credits that lower our effective tax rate.

Discontinued Operations

Discontinued operations consists of the results of operations, net of tax for our Home Health Business that was sold effective March 1, 2013 and the results of operations for an agency in Pennsylvania that was sold on December 30, 2013 and an agency in Idaho that was closed in November 2012.

Results of Operations

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

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

	2014		2013		Change	
	Amount	Net Service Revenues	Amount	Net Service Revenues	Amount	%
	(Amounts In Thousands, Except Percentages)					
Net service revenues	$ 312,942	100.0%	$ 265,941	100.0%	$ 47,001	17.7%
Cost of service revenues	229,207	73.2	198,202	74.5	31,005	15.6
Gross profit	83,735	26.8	67,739	25.5	15,996	23.6
General and administrative expenses	61,834	19.8	50,118	18.8	11,716	23.4
Depreciation and amortization	3,830	1.2	2,160	0.8	1,670	77.3
Total operating expenses	65,664	21.0	52,278	19.8	13,386	25.6
Operating income from continuing operations	18,071	5.8	15,461	5.8	2,610	16.9
Interest income	(18)		(188)	(0.1)	170	(90.4)
Interest expense	698	0.2	674	0.3	24	3.6
Total interest expense, net	680	0.2	486	0.2	194	39.9
Income from continuing operations before income taxes	17,391	5.6	14,975	5.6	2,416	16.1
Income tax expense	5,428	1.7	3,812	1.4	1,616	42.4
Net income from continuing operations	11,963	3.8	11,163	4.2	800	7.2
Discontinued operations:						
Earnings from Home Health Business, net of tax	280	0.1	7,982	3.0	(7,702)	(96.5)
Net income	$ 12,243	3.9%	$ 19,145	7.2%	$ (6,902)	(36.1)%
Business Metrics (Actual Numbers, Except Billable Hours in Thousands)						
Average billable census	31,019		26,802		4,217	15.7%
Billable hours	18,335		15,621		2,714	17.4
Average billable hours per census per month	49		49			
Billable hours per business day	71,903		59,850		12,053	20.1

Revenues per billable hour	$ 17.07	$ 17.02	$ 0.05	0.3%

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Net service revenues from state, local and other governmental programs accounted for 86.4% and 94.1% of net service revenues for 2014 and 2013, respectively. Managed care organizations accounted for 9.1% and 1.0% of net serve revenues in 2014 and 2013 respectively, with private duty and commercial payors accounting for the remainder of net service revenues.

Net service revenues increased $47,001,000 or 17.7%, to $312,942,000 for 2014 compared to $265,941,000 for the same period in 2013. The increase was primarily due to a 15.7% increase in average billable census, of which 45.6% is same store census growth and 54.4% is related to acquisitions.

Gross profit, expressed as a percentage of net service revenues, increased to 26.8% for 2014, from 25.5% in 2013. The increase was primarily due to lower than anticipated workers compensation expense and recent acquisitions with higher margins.

General and administrative expenses, expressed as a percentage of net service revenues increased to 19.8% for 2014, from 18.8% in 2013. General and administrative expenses increased to $61,834,000 in 2014 as compared to $50,118,000 in 2013. The increase in general and administrative expenses was due to an increase in expenses related to our acquisitions, transaction costs for acquisitions and increased expenditures related to information technology, Sarbanes-Oxley compliance efforts and legal and consulting fees for the year ended December 31, 2014 as compared to 2013.

Depreciation and amortization, expressed as a percentage of net service revenues, increased to 1.2 % from 0.8 % for the year ended December 31, 2014 and 2013, respectively. Amortization of intangibles, which are principally amortized using accelerated methods, totaled $2,414,000 and $1,346,000 for the year ended December 31, 2014 and 2013, respectively.

Interest Income

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 income . We received no prompt payment interest in 2014 and $185,000 in 2013. We are not anticipating being owed additional prompt payment interest for the state s fiscal year ending June 30, 2014. While we may be owed additional prompt payment interest in the future, the amount and timing of receipt of such payments remains uncertain and we have determined that we will continue to recognize prompt payment interest income when received. The state amended its prompt payment interest terms, effective July 1, 2011, which changed the measurement period for outstanding invoices from a 60-day to a 90-day outstanding period.

Interest Expense, Net

Interest expense, net, increased to $680,000 from $486,000 for the year ended December 31, 2014 as compared to December 31, 2013. The increase is primarily as a result of the capital lease agreements entered into on July 12 and September 11, 2014 as described in the Notes to Consolidated Financial Statements 8. *Long-Term Debt*.

Income Tax Expense

Our effective tax rates from continuing operations for 2014 and 2013 were 31.2% and 25.5%, 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.

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Discontinued Operations

Effective March 1, 2013, we sold substantially all of the assets used in our Home Health Business as described in Item 1. Therefore, we have segregated the Home Health Business operating results and presented them separately as discontinued operations for all periods presented (see note 2 Discontinued Operations of the Notes to the Consolidated Financial Statements included elsewhere herein).

The table below summarizes the results of discontinued operations.

	2014	2013
	(Amounts In Thousands)	
Net service revenues	$	$ 6,462
Cost of service revenues		3,692
Gross profit		2,770
General and administrative expenses	(470)	4,442
Depreciation and amortization		
Operating income (loss) from discontinued operations	470	(1,672)
Income tax (benefit)	190	(692)
Earnings (loss) from discontinued operations	$ 280	$ (980)

No revenues were recorded for the year ended December 31, 2014 related to the Home Health Business because that business was sold. We retained the working capital of our Home Health Business when it was sold. The net earnings from discontinued operations for the year ended December 31, 2014 represents the final settlement of previously estimated working capital amounts. The losses for the year ended December 31, 2013 were primarily due to the wind down of our Home Health Business.

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Results of Operations

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

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

	2013		2012		Change	
	Amount	% of Net Service Revenues	Amount	% of Net Service Revenues	Amount	%
	(Amounts In Thousands, Except Percentages)					
Net service revenues	$ 265,941	100.0%	$ 244,315	100.0%	$ 21,626	8.9%
Cost of service revenues	198,202	74.5	180,264	73.8	17,938	10.0
Gross profit	67,739	25.5	64,051	26.2	3,688	5.8
General and administrative expenses	50,118	18.8	46,362	19.0	3,756	8.1
Gain on sale of agency			(495)	(0.2)	495	*
Depreciation and amortization	2,160	0.8	2,521	1.0	(361)	(14.3)
Total operating expenses	52,278	19.7	48,388	19.8	3,890	8.0
Operating income from continuing operations	15,461	5.8	15,663	6.4	(202)	(1.3)
Interest income	(188)	(0.1)	(155)	(0.1)	(33)	21.3
Interest expense	674	0.3	1,723	0.7	(1,049)	(60.9)
Total interest expense, net	486	0.2	1,568	0.6	(1,082)	(69.0)
Income from continuing operations before income taxes	14,975	5.6	14,095	5.8	880	6.2
Income tax expense	3,812	1.4	4,807	2.0	(995)	(20.7)
Net income from continuing operations	11,163	4.2	9,288	3.8	1,875	20.2
Discontinued operations:						
Earnings (loss) from home health business, net of tax	7,982	3.0	(1,653)	(0.7)	9,635	(582.9)
Net income	$ 19,145	7.2%	$ 7,635	3.1%	$ 11,510	150.8%
Business Metrics (Actual Numbers, Except Billable Hours in Thousands)						
Average billable census	26,802		25,104		1,698	6.8%
Billable hours	15,621		14,388		1,233	8.7
Average Billable hours per census per month	49		48		1	2.1
Billable hours per business day	59,850		55,126		4,724	8.6
Revenues per billable hour	$ 17.02		$ 16.98		$ 0.04	.02%

* *Percentage information not meaningful*

Net service revenues from state, local and other governmental programs accounted for 94.1% and 94.9% of net service revenues for 2013 and 2012, respectively. Private duty and, to a lesser extent, commercial payors accounted for the remainder of net service revenues.

Net service revenues increased $21,626,000, or 8.9%, to $265,941,000 for 2013 compared to $244,315,000 for the same period in 2012. The increase was primarily due to a 6.8% increase in average census and a related 8.7% increase in billable hours.

Gross profit, expressed as a percentage of net service revenues, decreased to 25.5% for 2013, from 26.2% in 2012. This decrease as a percent of revenue of 0.7% is primarily due to increased wage costs for home care aides.

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General and administrative expenses, expressed as a percentage of net service revenues decreased to 18.8% for 2013, from 19.0% in 2012. General and administrative expenses increased to $50,118,000 in 2013 as compared to $46,362,000 in 2012. In 2013, we had cost increases in administrative wages, an increase legal and consulting expenses for acquisitions and business development initiatives, increased telecom and technology related costs, an increase in management bonuses and an increase in bad debt expense.

Depreciation and amortization, expressed as a percentage of net service revenues, decreased to 0.8 % for 2013, from 1.0% in 2012. Amortization of intangibles, which are principally amortized using accelerated methods, totaled $1,346,000 and $1,674,000 for 2013 and 2012, respectively.

Interest Income

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 income. We received $185,000 in prompt payment interest in 2013 and $155,000 in 2012. While we may be owed additional prompt payment interest, the amount and timing of receipt of such payments remains uncertain and we have determined that we will continue to recognize prompt payment interest income when received. The state amended its prompt payment interest terms, effective July 1, 2011, which changed the measurement period for outstanding invoices from a 60-day to a 90-day outstanding period.

Interest Expense, Net

Interest expense was $674,000 and $1,723,000 for 2013 and 2012, respectively. Interest expense decreased $1,049,000 primarily due to a reduction in outstanding debt.

Income Tax Expense (Benefit)

Our effective tax rates from continuing operations for 2013 and 2012 were 25.5% and 34.1%, 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. Our effective tax rate for 2012 does not include any earned 2012 federal employment opportunity tax credits, which were recognized in 2013 as the federal employment opportunity tax credits were reinstated in January 2013.

Discontinued Operations

Effective March 1, 2013, we sold substantially all of the assets used in our Home Health Business as described in Item 1. Therefore, we have segregated the Home Health Business operating results and presented them separately as discontinued operations for all periods presented (see note 2 Discontinued Operations of the Notes to the Consolidated Financial Statements included elsewhere herein).

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The table below depicts the results of discontinued operations.

	2013	2012
	(Amounts In Thousands)	
Net service revenues	$ 6,462	$ 38,822
Cost of service revenues	3,692	20,818
Gross profit	2,770	18,004
General and administrative expenses	4,442	20,743
Depreciation and amortization		13
Operating income (loss) from discontinued operations	(1,672)	(2,752)
Income tax (benefit)	(692)	(1,099)
Net loss from discontinued operations	$ (980)	$ (1,653)

The losses for 2013 are primarily related to the wind-down of the business after the sale on March 1, 2013. Operating losses for 2012 were primarily due to reduced sales, higher costs to treat consumers and our inability to reduce fixed general and administrative costs at a rate consistent with revenue declines.

Liquidity and Capital Resources

Our discussion below regarding our liquidity and capital resources includes discontinued operations.

Overview

Our primary sources of liquidity are cash from operations and borrowings under our credit facility. We renewed our credit facility on the terms described below on August 11, 2014. At December 31, 2014 and December 31, 2013, we had cash balances of $13,363,000 and $15,565,000, respectively.

As of December 31, 2014 and 2013 we had no balances outstanding under the revolving credit portion of our credit facility. After giving effect to the amount drawn on our credit facility, approximately $15,464,000 and $12,411,000 of outstanding letters of credit as of December 31, 2014 and 2013, respectively and borrowing limits based on an advance multiple of adjusted EBITDA, we had $39,536,000 and $42,279,000 available for borrowing under the credit facility as of December 31, 2014 and 2013, respectively.

Cash flows from operating activities represent the inflow of cash from our payor clients and the outflow of cash for payroll and payroll taxes, operating expenses, interest and taxes. 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. The open receivable balance from the State of Illinois increased by $273,000 from $44,409,000 as of December 31, 2013 to $44,136,000 as of December 31, 2014.

The State of Illinois payments have been sporadic and delayed in the past. Should payments become delayed in the future, the delays would adversely impact our liquidity and may result in the need to increase borrowings under our credit facility.

Credit Facility

On August 11, 2014, we renewed our credit facility. Our credit facility provides a $55,000,000 revolving line of credit expiring November 2, 2019 and includes a $27,500,000 sublimit for the issuance of letters of credit. On November 6, 2014, we amended our credit facility, with retroactive effect to September 30, 2014. The credit facility was amended to (i) reduce the floating interest rate from one-month LIBOR, plus a margin of 4.6% to one-month LIBOR, plus a margin of 3.5%, (ii) reduce the interest rate for loans based on term periods of one,

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two or three months from the LIBOR rate, plus a margin of 4.6% to the LIBOR rate, plus a margin of 3.5% and (iii) increase the allowed capital expenditures for the fiscal year ending 2014 from $5,000,000 to $7,000,000. 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 in the credit agreement, for the most recent 12-month period for which financial statements have been delivered under the credit agreement multiplied by the specified advance multiple, up to 3.25, less the outstanding senior indebtedness and letters of credit, and (ii) $55,000,000 less the outstanding revolving loans and letters of credit. Interest on the revolving line of credit may be payable at (i) a floating rate equal to the one-month LIBOR, plus a margin of 3.5%, (ii) the LIBOR rate for term periods of one, two or three months, plus a margin of 3.5% or (iii) the base rate, plus a margin of 1.6%, where the base rate is equal to the greatest of (a) the rate of interest last quoted by The Wall Street Journal as the prime rate , (b) the sum of the federal funds rate, plus a margin of 0.5% and (c) the sum of the adjusted LIBOR that would be applicable to a loan with a one month interest period advanced on such day, plus a margin of 3.0%. We 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 are charged at a rate of 2.0% per annum payable monthly. We did not have any amounts outstanding on the credit facility as of December 31, 2014, and the total availability under the revolving credit loan facility was $39,536,000 and $42,279,000, as of December 31, 2014 and 2013, respectively.

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 our 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 $2,000,000, 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.

While our growth plan is not entirely 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 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.

Cash Flows

The following table summarizes historical changes in our cash flows for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
		(Amounts in Thousands)	
Net cash provided by operating activities	$ 7,028	$ 27,393	$ 15,405
Net cash provided by (used in) investing activities	(13,633)	2,893	(619)
Net cash provided by (used in) financing activities	4,403	(16,458)	(15,069)

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Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Net cash provided by operating activities was $7,028,000 for the year ended December 31, 2014, compared to $27,393,000 for the same period in 2013. This decrease in cash provided by operations was primarily due to a decrease in collections on our accounts receivable.

Net cash used in investing activities was $13,633,000 for the year ended December 31, 2014, compared to cash provided by investing activities of $2,893,000 for the year ended December 31, 2013. Our investing activities for the year ended December 31, 2014 included purchases of property and equipment related to our corporate headquarters in Downers Grove, IL, the purchase of a new payroll system and the acquisition of Aid & Assist as described in Note 4 to the Consolidated Financial Statements. Our investing activities for the year ended December 31, 2013 were $16,105,000 in net proceeds received from the sale of the Home Health Business less $12,325,000 related to acquisitions made during the year and the purchase of $887,000 of property and equipment.

Net cash provided by financing activities was $4,403,000 for the year ended December 31, 2014 as compared to net cash used by financing activities of $16,458,000 for the year ended December 31, 2013. Our financing activities for the year ended December 31, 2014 were primarily related to capital lease obligations entered into during the year to finance purchases of property and equipment related to our corporate headquarters in Downers Grove, IL. Our financing activities for the year ended December 31, 2013 were primarily driven by net payments of $16,250,000 on the revolving credit portion of our credit facility, and $208,000 in payments on our term loan.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Net cash provided by operating activities was $27,393,000 for 2013, compared to $15,405,000 in 2012. This increase in cash provided by operations was primarily due to an increase in cash generated from continuing operations totaling approximately $2,300,000, less cash used in discontinued operations totaling approximately $1,800,000, plus amounts provided by net changes in working capital of approximately $11,500,000.

Net cash provided by investing activities was $2,893,000 for 2013. Our investing activities for 2013 were $16,105,000 in net proceeds received from the sale of the Home Health Business less $12,325,000 related to acquisitions made during the year and the purchase of $887,000 of property and equipment. Our investing activities for 2012 were $1,114,000 for capital expenditures less a $495,000 payment received for the sale of an agency.

Net cash used in financing activities was $16,458,000 for 2013 as compared to net cash used of $15,069,000 in 2012. Our financing activities for 2013 were primarily driven by net payments of $16,250,000 on the revolving credit portion of our credit facility and $208,000 in payments on our term loan. Our financing activities in 2012 were primarily driven by $8,500,000 in payments on the revolving credit portion of our credit facility, $4,069,000 in payments on subordinated dividend notes and $2,500,000 in payments on our term loan.

Outstanding Accounts Receivable

Gross accounts receivable as of December 31, 2014 and 2013 were $72,214,000 and $65,494,000, respectively. Outstanding accounts receivable, net of the allowance for doubtful accounts, increased by $6,720,000 as of December 31, 2014 as compared to December 31, 2013. The increase in accounts receivable is primarily attributable to accounts receivable acquired as part of our acquisitions and the general increase in our overall business.

Gross accounts receivable as of December 31, 2013 was $65,494,000. Outstanding accounts receivable, net of the allowance for doubtful accounts, decreased by $10,275,000 as of December 31, 2013 as compared to December 31, 2012, with $7,373,000 representing the collection of Home Health Business accounts receivable.

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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 other factors including: 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 that our management believes is sufficient to cover potential losses. However, actual collections could differ from our estimates.

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 the related allowance amount at December 31, 2014, December 31, 2013 and December 31, 2012:

	December 31, 2014				
	0-90 Days	91-180 Days	181-365 Days	Over 365 Days	Total
	(Amounts In Thousands, Except Percentages)				
Continuing Operations					
Illinois governmental based programs	$ 37,406	$ 5,298	$ 670	$ 762	$ 44,136
Other state, local and other governmental programs	12,951	1,815	1,284	60	16,110
Managed care organizations	6,524	1,167	919	258	8,868
Private duty and commercial	2,658	299	173	(30)	3,100
	59,539	8,579	3,046	1,050	72,214
Aging % continuing operations	82.4%	11.9%	4.2%	1.5%	
Discontinued Operations					
Medicare					
Other state, local and other governmental programs					
Private duty and commercial					
Illinois governmental based programs					
Total	$ 59,539	$ 8,579	$ 3,046	$ 1,050	$ 72,214
Aging % of total	82.4%	11.9%	4.2%	1.5%	
Allowance for doubtful accounts					$ 3,881
Reserve as % of gross accounts receivable					5.4%

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	December 31, 2013				
	0-90 Days	91-180 Days	181-365 Days	Over 365 Days	Total
	(Amounts In Thousands, Except Percentages)				
Continuing Operations					
Illinois governmental based programs	$ 40,584	$ 2,912	$ 430	$ 483	$ 44,409
Other state, local and other governmental programs	14,551	1,659	914	116	17,240
Private duty and commercial	2,586	380	142	112	3,220
	57,721	4,951	1,486	711	64,869
Aging % continuing operations	89.0%	7.6%	2.3%	1.1%	
Discontinued Operations					
Medicare			744		744
Other state, local and other governmental programs					
Private duty and commercial			(119)		(119)
Illinois governmental based programs					
			625		625
Total	$ 57,721	$ 4,951	$ 2,111	$ 711	$ 65,494
Aging % of total	88.1%	7.6%	3.2%	1.1%	
Allowance for doubtful accounts					$ 4,140
Reserve as % of gross accounts receivable					6.3%

	December 31, 2012				
	0-90 Days	91-180 Days	181-365 Days	Over 365 Days	Total
	(Amounts In Thousands, Except Percentages)				
Continuing Operations					
Illinois governmental based programs	$ 38,339	$ 13,374	$ 1,076	$ 126	$ 52,915
Other state, local and other governmental programs	10,248	845	610	329	12,032
Private duty and commercial	1,936	360	127	401	2,824
	50,523	14,579	1,813	856	67,771
Aging % continuing operations	74.5%	21.5%	2.7%	1.3%	
Medicare	4,751	955	188		5,894
Other state, local and other governmental programs	340	109	58		507
Private duty and commercial	965	211	164	30	1,370
Illinois governmental based programs	128	19	35	45	227
	6,184	1,294	445	75	7,998
Total	$ 56,707	$ 15,873	$ 2,258	$ 931	$ 75,769
Aging % of total	74.9%	20.9%	3%	1.2%	
Allowance for doubtful accounts					$ 4,466
Reserve as % of gross accounts receivable					5.9%

We calculate our continuing operations days sales outstanding (DSO) by taking the accounts receivable outstanding net of the allowance for doubtful accounts divided by the total net service revenues for the last quarter, multiplied by the number of days in that quarter. Our DSOs from continuing operations were 80, 85 and 86 days at December 31, 2014, December 31, 2013 and December 31, 2012, respectively. The DSOs for our largest payor, the Illinois Department on Aging, at December 31, 2014, December 31, 2013 and December 31, 2012 were 85, 97 and 122 days, respectively. We may not receive payments on a consistent basis in the near term and our DSOs and the DSO for our largest payor may increase. The change in the reserve as percentage of gross accounts receivable to 5.4% in 2014 from 6.3% in 2013 is attributable to the improvement in DSOs outstanding

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at the end of the respective years. The change to 6.3% in 2013 from 5.9% in 2012 is attributable to the Medicare receivables in the 2012 balances which have a historically higher collection rate and accordingly a lower reserve rate.

Dividend Notes

Prior to the completion of our IPO, we had 37,750 shares of series A preferred stock issued and outstanding, all of which were converted into shares of our common stock on November 2, 2009. Shares of our series A preferred stock accumulated dividends each quarter at a rate of 10%, compounded annually. We accrued these undeclared dividends because the holders had the option to convert their shares of series A preferred stock into common stock at any time with the accumulated dividends payable in cash or a note payable. Our series A preferred stock was converted into 4,077,000 shares of common stock in connection with the completion of our IPO on November 2, 2009. We paid $173,000 of the $13,109,000 outstanding accumulated dividends as of November 2, 2009 with the remaining $12,936,000 being converted into 10% junior subordinated promissory notes, which we refer to as the dividend notes. The dividends notes were subordinated and junior to all obligations under our credit facility. Our dividend notes were repaid in full during the fourth quarter of 2012.

Off-Balance Sheet Arrangements

As of December 31, 2014, 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

The majority of our revenues for 2014, 2013 and 2012 from continuing operations 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.

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, managed care organizations, commercial insurance companies and private consumers. While our accounts receivable are uncollateralized, our credit risk is somewhat limited due to the significance of governmental payors to our results of operations. Laws and regulations governing the governmental programs in which we participate 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 income. We received no prompt payment interest in 2014 and approximately $185,000 and $155,000 in prompt payment interest in 2013 and 2012, respectively. While we may be owed additional prompt payment interest, the amount and timing of receipt of such payments remains uncertain and we have determined that we will continue to recognize prompt payment interest income when received.

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 ASC Topic 350, *Goodwill and Other Intangible Assets*, goodwill and intangible assets with indefinite useful lives are not amortized. We test goodwill for impairment at the reporting unit level on an annual basis, as of October 1, or whenever potential impairment triggers occur, such as a significant change in business climate or regulatory changes that would indicate that an impairment may have occurred. We may use a qualitative test, known as Step 0, or a two-step quantitative method to determine whether impairment has occurred. We can elect to perform Step 0, an optional qualitative analysis, and based on the results skip the remaining two steps. In 2014, 2013 and 2012, we elected to implement Step 0. The results of our Step 0 assessment indicated that it was more likely than not that the fair value of our reporting unit exceeded its carrying value and therefore we concluded that there were no impairments for the years ended December 31, 2014 , 2013 or 2012.

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. No impairment charge was recorded for the years ended December 31, 2014, 2013 or 2012.

Indefinite-lived Assets

We also have indefinite-lived assets that are not subject to amortization expense such as licenses and in certain states certificates of need to conduct specific operations within geographic markets. Our management has concluded that these assets 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 the licenses indefinitely. The licenses and certificates of need are tested annually for impairment. No impairment was recorded for the years ended December 31, 2014, 2013 or 2012.

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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 operations. 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 were the responsibility of the selling shareholders in the acquisition, subject to certain limitations. The responsibility of the selling shareholders for these claims was terminated on December 29, 2014. 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 December 31, 2014, December 31, 2013 and December 31, 2012 we recorded $1,457,000, $821,000 and $953,000, respectively, in workers compensation insurance recovery receivables and a corresponding increase in its workers compensation liability. The workers compensation insurance recovery receivable is included in our prepaid expenses and other current assets on the balance sheet.

Interest Income

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 statement of operations caption, interest income. We received no prompt payment interest in 2014 and approximately $185,000 and $155,000 in prompt payment interest in 2014, 2013 and 2012, respectively. While we may be owed additional prompt payment interest, the amount and timing of receipt of such payments remains uncertain and we have determined that we will continue to recognize prompt payment interest income when received.

New Accounting Pronouncements

On April 10, 2014, the FASB issued Accounting Standards Update (ASU) No. 2014-08, Presentation of Financial Statements (Topic 205) and Property, Plant, and Equipment (Topic 360): Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity. The new guidance changes the requirements for reporting a discontinued operation. Only a disposal representing a strategic shift that has a major effect on the entity s operations and financial results will have to be reported as a discontinued operation. Examples of strategic shifts meeting the new criteria include a disposal of a major geographical area, a major line of business, or a major equity-method investment. Under this new guidance, many disposals that might be routine and not a change in an entity s strategy no longer will be reported as discontinued operations. For each comparative period, an entity s statement of financial position must present separately the assets and liabilities of a disposal group qualifying as a discontinued operation. The ASU requires additional disclosures about the assets, liabilities, revenues, expenses, and cash flows of a discontinued operation. An entity also will be required to disclose the pretax income or loss attributable to a disposal of a significant component that does not qualify for discontinued operations presentation. ASU 2014-08 is effective for public companies for annual and interim periods beginning on or after December 15, 2014.

In May 2014, the FASB issued Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09), which supersedes nearly all existing revenue recognition guidance under GAAP. The core principle of ASU 2014-09 is to recognize revenues when promised goods or services are transferred to customers in an amount that reflects the consideration to which an entity expects to be entitled for those goods or services. ASU 2014-09 defines a five step process to achieve this core principle and, in doing so, more judgment and estimates may be required within the revenue recognition process than are required under existing GAAP. The standard is effective for annual periods beginning after December 15, 2016, and interim periods therein,

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using either of the following transition methods: (i) a full retrospective approach reflecting the application of the standard in each prior reporting period with the option to elect certain practical expedients, or (ii) a retrospective approach with the cumulative effect of initially adopting ASU 2014-09 recognized at the date of adoption (which includes additional footnote disclosures). We are currently evaluating the impact of our pending adoption of ASU 2014-09 on our consolidated financial statements and have not yet determined the method by which we will adopt the standard in 2017.

Contractual Obligations and Commitments

We had outstanding letters of credit of $15,464,000 at December 31, 2014. These standby letters of credit benefit our third party insurer for our high deductible workers compensation insurance program. The amount of the letters of credit is negotiated annually in conjunction with the insurance renewals. We anticipate our commitment will increase as we continue to grow our business and more years become our responsibility as responsibility shifts from the former owners of Addus HealthCare to us.

The following table summarizes our cash contractual obligations as of December 31, 2014:

Contractual Obligations	Total	Less than 1 Year	1-2 Years	3-4 Years	More than 5 Years
		(Amounts in Thousands)			
Capital leases	3,944	1,105	2,210	629	
Operating leases	16,884	3,528	4,968	2,804	5,584
Total Contractual Obligations	$ 20,828	$ 4,633	$ 7,178	$ 3,433	$ 5,584

As described in Note 4 to the Condensed Consolidated Financial Statements, the acquisition agreements for Aid & Assist at Home, LLC and Coordinated Home Health Care, LLC contained contingent earn-out obligations. At December 31, 2014, we determined the combined value of these liabilities is $2,120,000.

Impact of Inflation

We do not believe that inflation has had a material effect on our business, financial condition or results of operations. If our costs were to become subject to significant inflationary pressures, we may not be able to fully offset such higher costs through price increases. Our inability or failure to do so could harm our business, financial condition and results of operation.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Quantitative and Qualitative Disclosures about Market Risk

Historically, we have been exposed to market risk due to fluctuations in interest rates. As of December 31, 2014, we had no outstanding indebtedness with variable interest rates and therefore no current exposure.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Our consolidated financial statements together with the related notes and the report of our independent registered public accounting firm, are set forth on the pages indicated in Item 15.

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

None.

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ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of December 31, 2014. 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.

Based on the evaluation of our disclosure controls and procedures, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective as of December 31, 2014.

Management s Annual Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over our financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) promulgated under the Exchange Act. Under the supervision and with the participation of our management, including our Chief Executive Officer and our Chief Financial Officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in Internal Control Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in Internal Control Integrated Framework (2013), our management concluded our internal control over financial reporting was effective as of December 31, 2014.

Our internal control system is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. All internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

BDO USA, LLP, the independent registered public accounting firm that audited our consolidated financial statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which is included herein.

Changes in Internal Controls Over Financial Reporting

The Company implemented changes in its internal control over financial reporting in response to the material weaknesses identified in 2013. Material weaknesses identified in 2013 in information technology controls were remediated as the Company re-organized the structure of the Information Technology Department to properly segregate duties, implemented a formal change management process, and conducted detail user reviews of access to key systems. Deficiencies in payroll processes were remediated as the Company implemented and enhanced its review and monitoring of existing controls and implemented additional controls over changes to employee payroll information. These improvements were fully implemented in the fourth quarter of 2014.

In accordance with SEC regulations, management excluded from its assessment the internal control over financial reporting at Aid & Assist at Home, LLC, which was acquired on June 1, 2014 and whose financial statements constitute 5.1% of total assets as of December 31, 2014 and 2.4% of revenues for the year ended December 31, 2014.

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Report of Independent Registered Public Accounting Firm

Board of Directors and Stockholders

Addus HomeCare Corporation

Downers Grove, IL

We have audited Addus HomeCare Corporation s internal control over financial reporting as of December 31, 2014, based on criteria established in *Internal Control Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). Addus HomeCare Corporation s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Item 9A, Management s Annual Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company s internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company s internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company s assets that could have a material effect on the financial statements.

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

As indicated in the accompanying Item 9A, Management s Annual Report on Internal Control over Financial Reporting, management s assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Aid & Assist at Home, LLC, which was acquired on June 1, 2014, and which is included in the consolidated balance sheets of Addus HomeCare Corporation as of December 31, 2014, and the related consolidated statements of income, stockholders equity, and cash flows for the year then ended. Aid & Assist at Home, LLC constituted 5.1% of total assets as of December 31, 2014, and 2.4% of revenues for the year then ended. Management did not assess the effectiveness of internal control over financial reporting of Aid & Assist at Home, LLC because of the timing of the acquisition which was completed on June 1, 2014. Our audit of internal control over financial reporting of Addus HomeCare Corporation also did not include an evaluation of the internal control over financial reporting of Aid & Assist at Home, LLC.

In our opinion, Addus HomeCare Corporation maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on the COSO criteria.

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We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Addus HomeCare Corporation as of December 31, 2014 and 2013, and the related consolidated statements of income, stockholders equity, and cash flows for each of the three years in the period ended December 31, 2014 and our report dated March 16, 2015 expressed an unqualified opinion thereon.

/s/ BDO USA, LLP

Chicago, IL

March 16, 2015

ITEM 9B. OTHER INFORMATION

None.

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PART III

Certain information required by Part III is omitted from this Annual Report on Form 10-K as we intend to file our definitive Proxy Statement for the 2014 Annual Meeting of Stockholders pursuant to Regulation 14A of the Exchange Act not later than 120 days after the end of the fiscal year covered by this Annual Report, and certain information included in the Proxy Statement is incorporated herein by reference.

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information required by this item is incorporated by reference to the 2015 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2014.

Independent Director Compensation

On March 13, 2015, our board of directors adopted changes to our director compensation policy, effective March 1, 2015. The new policy provides that (i) our independent directors shall receive an increase in their annual retainer to $35,000, (ii) the annual retainers payable to the chairmen of the audit committee, compensation committee and nominating and corporate governance committee will be increased to $15,000, $10,000 and $7,500, respectively, and (iii) the amount of annual restricted stock awards granted to independent directors will be increased to $40,000 per year, vesting on the first anniversary of the date of issuance. Grants of such restricted stock shall be made following our annual meeting each year beginning with our 2015 annual meeting. A copy of the updated Independent Director Compensation Policy is attached hereto as Exhibit 10.31.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this item is incorporated by reference to the 2015 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2014.

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

The information required by this item is incorporated by reference to the 2015 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2014.

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

The information required by this item is incorporated by reference to the 2015 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2014.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this item is incorporated by reference to the 2015 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2014.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) Consolidated Financial Statements

1. Consolidated Financial Statements. The consolidated financial statements as listed in the accompanying Index to Consolidated Financial Information in page F-1 are filed as part of this Annual Report.

Schedule II Valuation and Qualifying Accounts

Schedules have been omitted because they are not applicable or are not required or the information required to be set forth in those schedules is included in the consolidated financial statements or related notes. All other schedules not listed in the accompanying index have been omitted as they are either not required or not applicable, or the required information is included in the consolidated financial statements or the notes thereto.

(b) Exhibits

Exhibit Number	Description of Document
3.1	Amended and Restated Certificate of Incorporation of Addus HomeCare Corporation dated as of November 2, 2009 (filed on November 20, 2009 as Exhibit 3.1 to Addus HomeCare Corporation s Quarterly Report on Form 10-Q and incorporated by reference herein)
3.2	Amended and Restated Bylaws of Addus HomeCare Corporation (filed on September 21, 2009 as Exhibit 3.5 to Amendment No. 2 to Addus HomeCare Corporation 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 Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
4.2	Registration Rights Agreement, dated September 19, 2006, by and among Addus HomeCare Corporation, Eos Capital Partners III, L.P., Eos Partners SBIC III, L.P., Freeport Loan Fund LLC, W. Andrew Wright, III, Addus Term Trust, W. Andrew Wright Grantor Retained Annuity Trust, Mark S. Heaney, James A. Wright and Courtney E. Panzer (filed on July 17, 2009 as Exhibit 4.2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.1	Separation and General Release Agreement, dated as of September 20, 2009, between Addus HealthCare, Inc. and W. Andrew Wright, III (filed on September 21, 2009 as Exhibit 10.1(b) to Amendment No. 2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.2	Amended and Restated Employment and Non-Competition Agreement, dated May 6, 2008, between Addus HealthCare, Inc. and Mark S. Heaney (filed on July 17, 2009 as Exhibit 10.2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.3	Amendment to the Amended and Restated Employment and Non-Competition Agreement, dated September 30, 2009, between Addus HealthCare, Inc. and Mark S. Heaney (filed on October 2, 2009 as Exhibit 10.2(a) to Amendment No. 4 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.4	Employment Agreement, dated November 29, 2010, by and between Addus HealthCare, Inc. and Dennis Meulemans (filed on December 1, 2010 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)

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Exhibit Number	Description of Document
10.5	Amended and Restated Employment and Non-Competition Agreement, dated August 27, 2007, between Addus HealthCare, Inc. and Darby Anderson (filed on July 17, 2009 as Exhibit 10.4 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.6	Amendment to the Amended and Restated Employment and Non-Competition Agreement, dated September 30, 2009, between Addus HealthCare, Inc. and Darby Anderson (filed on October 2, 2009 as Exhibit 10.4(a) to Amendment No. 4 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.7	Addus HealthCare, Inc. Home Health and Home Care Division Vice President and Regional Director Bonus Plan(filed on July 17, 2009 as Exhibit 10.10 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.8	Addus HealthCare, Inc. Support Center Vice President and Department Director Bonus Plan (filed on July 17, 2009 as Exhibit 1011 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.9	Addus Holding Corporation 2006 Stock Incentive Plan (filed on July 17, 2009 as Exhibit 10.12 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.10	Director Form of Option Award Agreement under the 2006 Stock Incentive Plan (filed on July 17, 2009 as Exhibit 10.13 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.11	Executive Form of Option Award Agreement under the 2006 Stock Incentive Plan (filed on July 17, 2009 as Exhibit 10.14 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.12	Form of Indemnification Agreement (filed on July 17, 2009 as Exhibit 10.16 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.13	License Agreement, dated March 24, 2006, between McKesson Information Solutions, LLC and Addus HealthCare, Inc. (filed on August 26, 2009 as Exhibit 10.17 to Amendment No. 1 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.14	Contract Supplement to the License Agreement, dated March 24, 2006 (filed on August 26, 2009 as Exhibit 10.17(a) to Amendment No. 1 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.15	Contract Supplement to the License Agreement, dated March 28, 2006 (filed on August 26, 2009 as Exhibit 10.17(b) to Amendment No. 1 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.16	Amendment to License Agreement, dated March 28, 2006, between McKesson Information Solutions, LLC and Addus HealthCare, Inc. (filed on August 26, 2009 as Exhibit 10.17(c) to Amendment No. 1 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.17	Lease, dated April 1, 1999, between W. Andrew Wright, III and Addus HealthCare, Inc. (filed on July 17, 2009 as Exhibit 10.18 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.18	First Amendment to Lease, dated as of April 1, 2002, between W. Andrew Wright, III and Addus HealthCare, Inc. (filed on July 17, 2009 as Exhibit 10.18(a) to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)

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Exhibit Number	Description of Document
10.19	Second Amendment to Lease, dated as of September 19, 2006, between W. Andrew Wright, III and Addus HealthCare, Inc. (filed on July 17, 2009 as Exhibit 10.18(b) to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.20	Third Amendment to Lease, dated as of September 1, 2008, between W. Andrew Wright, III and Addus HealthCare, Inc. (filed on July 17, 2009 as Exhibit 10.18(c) to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.21	Addus HomeCare Corporation 2009 Stock Incentive Plan (filed on September 21, 2009 as Exhibit 10.20 to Amendment No. 2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.22	Form of Incentive Stock Option Award Agreement under the 2009 Stock Incentive Plan (filed on September 21, 2009 as Exhibit 10.20(a) to Amendment No. 2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.23	Form of Restricted Stock Award Agreement under the 2009 Stock Incentive Plan (filed on September 21, 2009 as Exhibit 10.20(b) to Amendment No. 2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.24	Loan and Security Agreement, dated as of November 2, 2009, 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., 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 November 5, 2009 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)
10.25	Consent and Amendment No. 1 to the Loan and Security Agreement, dated as of March 18, 2010, 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., 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 March 18, 2010 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)
10.26	Joinder, Consent and Amendment No. 2 to Loan and Security Agreement, dated as of July 26, 2010, by and among Addus HealthCare, Inc., Addus HealthCare (South Carolina), 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., 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 July 27, 2010 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)

Exhibit Number	Description of Document
10.27	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 Addus HomeCare Corporation s Current Report on Form 8-K and incorporated herein by reference)
10.28	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 Addus HomeCare Corporation s Current Report on Form 8-K and incorporated herein by reference)
10.29	Amendment No. 2 to Employment and Non-Competition Agreement, dated November 17, 2011, by and between Addus HealthCare, Inc. and Mark S. Heaney (filed on November 23, 2011 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated herein by reference)
10.30	Amendment No. 5 to Loan and Security Agreement, dated as of March 2, 2012, 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 March 16, 2012 as Exhibit 10.41 to Addus HomeCare Corporation s Annual Report on Form 10-K and incorporated herein by reference)
10.31	Summary of Independent Director Compensation Policy*
10.32	The Executive Nonqualified Excess Plan Adoption Agreement, by Addus HealthCare, Inc., dated April 1, 2012 (filed on April 5, 2012 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)
10.33	The Executive Nonqualified Excess Plan Document, dated April 1, 2012 (filed on April 5, 2012 as Exhibit 99.2 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated herein by reference)
10.34	Employment Agreement, effective June 18, 2012, by and between Addus Healthcare, Inc. and Inna Berkovich (filed on June 20, 2012 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated herein by reference)

Exhibit Number	Description of Document
10.35	Asset Purchase Agreement, dated as of February 7, 2013, by and among Addus HealthCare, Inc., its subsidiaries identified therein, LHC Group, Inc. and its subsidiaries identified therein (filed on March 6, 2013 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)
10.36	Amended and Restated Credit and Guaranty Agreement, dated as of August 11, 2014, 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 (Delaware), Inc. and Cura Partners, LLC, as borrowers, Addus HomeCare Corporation, the other credit parties from time to a time a party thereto, the various institutions from time to time a party thereto, as lenders, and Fifth Third Bank as agent and L/C issuer (filed on August 11, 2014 as Exhibit 10.1 to Addus HomeCare Corporation s Quarterly Report on Form 10-Q and incorporated by reference herein).
10.37	Amendment No 1. to Amended and Restated Credit and Guaranty Agreement, dated as of November 6, 2014 and effective as of September 30, 2014, 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., PHC Acquisition Corporation, Professional Reliable Nursing Service, Inc., Addus HealthCare (South Carolina), Inc., Addus HealthCare (Delaware), Inc. and Cura Partners, LLC, as borrowers, Addus HomeCare Corporation, the other credit parties from time to time a party thereto, the various institutions from time to time a party thereto, as lenders, and Fifth Third Bank as agent and L/C issuer (filed on November 7, 2014 as Exhibit 10.2 to Addus HomeCare Corporation s Quarterly Report on Form 10-Q and incorporated by reference herein).
10.38	Employment and Non-Competition Agreement, effective December 15, 2014, by and between Addus HealthCare, Inc. and Maxine Hochhauser (filed on December 15, 2014 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein).
10.39	Amendment to Employment and Non-Competition Agreement, effective December 15, 2014, by and between Addus HealthCare, Inc. and Darby Anderson (filed on December 15, 2014 as Exhibit 99.2 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein).
21.1	Subsidiaries of Addus HomeCare Corporation*
23.1	Consent of BDO USA, LLP, Independent Registered Public Accounting Firm*
31.1	Certification of Chief Executive Officer Pursuant to Rule 13-14(a) of the Securities Exchange Act of 1934 as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
31.2	Certification of Chief Financial Officer Pursuant to Rule 13-14(a) of the Securities Exchange Act of 1934 as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
32.1	Certification of Chief Executive Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002**
32.2	Certification of Chief Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002**

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Exhibit Number	Description of Document
101	The following materials from Addus HomeCare Corporation s Annual Report on Form 10-K for the years ended December 31, 2014, formatted in Extensive Business Reporting Language (XBRL), (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Income, (iii) Consolidated Statements of Stockholders Equity, (iv) Consolidated Statements of Cash Flows, and (v) the Notes to the Consolidated Financial Statements.*

* Filed herewith
** Furnished herewith

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SIGNATURES

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

Addus HomeCare Corporation

By: /s/ MARK S. HEANEY
Mark S. Heaney,

President and Chief Executive Officer
Date: March 16, 2015

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

Signature	Title	Date
/s/ MARK S. HEANEY **Mark S. Heaney**	President and Chief Executive Officer (Principal Executive Officer) and Director	March 16, 2015
/s/ DENNIS B. MEULEMANS **Dennis B. Meulemans**	Chief Financial Officer (Principal Financial and Accounting Officer)	March 16, 2015
/s/ MARK L. FIRST **Mark L. First**	Director	March 16, 2015
/s/ SIMON A. BACHLEDA **Simon A. Bachleda**	Director	March 16, 2015
/s/ STEVEN I. GERINGER **Steven I. Geringer**	Director	March 16, 2015
/s/ R. DIRK ALLISON **R. Dirk Allison**	Director	March 16, 2015

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INDEX TO CONSOLIDATED FINANCIAL INFORMATION

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Report of Independent Registered Public Accounting Firm

Board of Directors and Stockholders

Addus HomeCare Corporation

Downers Grove, Illinois

We have audited the accompanying consolidated balance sheets of Addus HomeCare Corporation as of December 31, 2014 and 2013 and the related consolidated statements of income, stockholders equity, and cash flows for each of the three years in the period ended December 31, 2014. In connection with our audits of the consolidated financial statements, we have also audited the financial statement schedule listed in the accompanying index. These financial statements and schedule are the responsibility of the Company s management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements and schedule. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Addus HomeCare Corporation at December 31, 2014 and 2013, and the results of its operations and its cash flow for each of the three years in the period ended December 31, 2014, in conformity with accounting principles generally accepted in the United States of America.

Also, in our opinion, the financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Addus HomeCare Corporation s internal control over financial reporting as of December 31, 2014, based on criteria established in *Internal Control Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) and our report dated March 16, 2015 expressed an unqualified opinion thereon.

/s/ BDO USA, LLP

Chicago, IL

March 16, 2015

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ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

As of December 31, 2014 and 2013

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

	2014	2013
Assets		
Current assets		
Cash	$ 13,363	$ 15,565
Accounts receivable, net of allowances of $3,881 and $4,140 at December 31, 2014 and 2013, respectively	68,333	61,354
Prepaid expenses and other current assets	7,168	6,235
Deferred tax assets	8,508	8,326
Total current assets	97,372	91,480
Property and equipment, net of accumulated depreciation and amortization	7,695	2,634
Other assets		
Goodwill	64,220	60,026
Intangibles, net of accumulated amortization	10,347	8,762
Investments in joint ventures	900	900
Other assets	269	132
Total other assets	75,736	69,820
Total assets	$ 180,803	$ 163,934
Liabilities and stockholders equity		
Current liabilities		
Accounts payable	$ 3,951	$ 4,633
Current portion of capital lease obligations	986	
Current portion of contingent earn-out obligation	1,000	
Accrued expenses	37,268	40,904
Total current liabilities	43,205	45,537
Long-term liabilities		
Deferred tax liabilities	5,845	3,441
Capital lease obligations, less current portion	2,677	
Contingent earn-out obligation, less current portion	1,120	1,100
Total long-term liabilities	9,642	4,541
Total liabilities	52,847	50,078
Stockholders equity		
	11	11

Common stock $.001 par value; 40,000 authorized and 11,010 and 10,913 shares issued and outstanding as of December 31, 2014 and 2013, respectively		
Additional paid-in capital	84,929	83,072
Retained earnings	43,016	30,773
Total stockholders equity	127,956	113,856
Total liabilities and stockholders equity	$ 180,803	$ 163,934

See accompanying Notes to Consolidated Financial Statements

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ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

For the years ended December 31, 2014, 2013 and 2012

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

	For the Year Ended December 31,		
	2014	2013	2012
Net service revenues	$ 312,942	$ 265,941	$ 244,315
Cost of service revenues	229,207	198,202	180,264
Gross profit	83,735	67,739	64,051
General and administrative expenses	61,834	50,118	46,362
Gain on sale of agency			(495)
Depreciation and amortization	3,830	2,160	2,521
Total operating expenses	65,664	52,278	48,388
Operating income from continuing operations	18,071	15,461	15,663
Interest income	(18)	(188)	(155)
Interest expense	698	674	1,723
Total interest expense, net	680	486	1,568
Income from continuing operations before income taxes	17,391	14,975	14,095
Income tax expense	5,428	3,812	4,807
Net income from continuing operations	11,963	11,163	9,288
Discontinued operations:			
Income (loss) from Home Health Business, net of tax	280	(980)	(1,653)
Gain on sale of Home Health Business, net of tax		8,962	
Earnings (losses) from discontinued operations	280	7,982	(1,653)
Net income	$ 12,243	$ 19,145	$ 7,635
Net income per common share			
Basic income per share			
Continuing operations	$ 1.10	$ 1.03	$ 0.86
Discontinued operations	0.02	0.74	(0.15)
Basic income per share	$ 1.12	$ 1.77	$ 0.71
Diluted income per share			
Continuing operations	$ 1.08	$ 1.01	$ 0.86
Discontinued operations	0.02	0.72	(0.15)

Diluted income per share	$ 1.10	$ 1.73	$ 0.71
Weighted average number of common shares and potential common shares outstanding:			
Basic	10,900	10,826	10,764
Diluted	11,114	11,075	10,784

See accompanying Notes to Consolidated Financial Statements

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ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS EQUITY

For the years ended December 31, 2014, 2013 and 2012

(amounts and shares in thousands)

	Common Stock		Additional Paid in Capital	Retained Earnings	Total Stockholders Equity
	Shares	Amount			
Balance at December 31, 2011	10,775	11	82,437	3,993	86,441
Issuance of shares of common stock under restricted stock award agreements	43				
Stock-based compensation			341		341
Shares issued	5				
Net income				7,635	7,635
Balance at December 31, 2012	10,823	$ 11	$ 82,778	$ 11,628	$ 94,417
Issuance of shares of common stock under restricted stock award agreements	63				
Stock-based compensation			515		515
Common shares withheld for witholding taxes on exercise of options	(67)		(221)		(221)
Shares issued	94				
Net income				19,145	19,145
Balance at December 31, 2013	10,913	$ 11	$ 83,072	$ 30,773	$ 113,856
Issuance of shares of common stock under restricted stock award agreements	36				
Stock-based compensation			827		827
Excess tax benefit from exercise of stock options			816		816
Shares issued	61		214		214
Net income				12,243	12,243
Balance at December 31, 2014	11,010	$ 11	$ 84,929	$ 43,016	$ 127,956

See accompanying Notes to Consolidated Financial Statements

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ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

For the years ended December 31, 2014, 2013 and 2012

(amounts in thousands)

	For the Year Ended December 31,		
	2014	**2013**	**2012**
Cash flows from operating activities:			
Net income	$ 12,243	$ 19,145	$ 7,635
Adjustments to reconcile net income to net cash provided by operating activities, net of acquisitions:			
Depreciation and amortization	3,830	2,160	2,544
Deferred income taxes	2,221	4,701	839
Stock-based compensation	827	515	341
Amortization of debt issuance costs	154	166	215
Provision for doubtful accounts	2,818	3,019	2,877
Gain on sale of Home Health Business		(15,284)	
Gain on sale of agency			(495)
Changes in operating assets and liabilities, net of acquisitions:			
Accounts receivable	(9,276)	7,818	(1,812)
Prepaid expenses and other current assets	(873)	1,061	(18)
Accounts payable	(850)	435	(1,149)
Accrued expenses	(4,066)	3,657	4,428
Net cash provided by operating activities	7,028	27,393	15,405
Cash flows from investing activities:			
Acquisitions of businesses	(7,172)	(12,325)	
Acquisition of customer list	(50)		
Net proceeds from sale of Home Health Business		16,105	
Net proceeds from sale of agency			495
Purchases of property and equipment	(6,411)	(887)	(1,114)
Net cash provided by (used in) investing activities	(13,633)	2,893	(619)
Cash flows from financing activities:			
Net repayments on term loan		(208)	(2,500)
Net payments on revolving credit loan		(16,250)	(8,500)
Payments on subordinated dividend notes			(4,069)
Excess tax benefit from exercise of stock options	816		
Cash received from exercise of stock options	214		
Borrowings on capital lease obligations	4,033		
Payments for debt issuance costs	(290)		
Payments on capital lease obligations	(370)		
Net cash provided by (used in) financing activities	4,403	(16,458)	(15,069)
Net change in cash	(2,202)	13,828	(283)

Cash, at beginning of period	15,565	1,737	2,020
Cash, at end of period	$ 13,363	$ 15,565	$ 1,737
Supplemental disclosures of cash flow information:			
Cash paid for interest	$ 698	$ 725	$ 1,557
Cash paid for income taxes	4,465	5,689	1,758
Supplemental disclosures of non-cash investing and financing activities			
Contingent and deferred consideration accrued for acquisitions	$ 1,020	$ 1,100	$
Tax benefit related to the amortization of tax goodwill in excess of book basis	123	160	159

See accompanying Notes to Consolidated Financial Statements

ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Basis of Presentation and Description of Business

The consolidated financial statements include the accounts of Addus HomeCare Corporation (Holdings) and its subsidiaries (together with Holdings, the Company). The Company is a provider of comprehensive home and community based services, which are provided primarily in the home, and focused on the dual eligible (Medicare/Medicaid) population. The Company s services include personal care and assistance with activities of daily living, and adult day care. The Company s consumers are primarily persons who are at risk of hospitalization or institutionalization, such as the elderly, chronically ill and disabled. The Company s payor clients include federal, state and local governmental agencies, managed care organizations, commercial insurers and private individuals. The Company currently provides home and community based services to over 31,000 consumers through 129 locations across 22 states, including 5 adult day centers in Illinois.

Discontinued Operations

On February 7, 2013, subsidiaries of Holdings entered into an Asset Purchase Agreement with LHC Group, Inc. and certain of its subsidiaries (the Home Health Purchase Agreement). Pursuant to the Home Health Purchase Agreement, effective March 1, 2013, the purchasers acquired substantially all the assets of the Company s home health business in Arkansas, Nevada and South Carolina and 90% of its home health business in California and Illinois, with the Company retaining 10% ownership in such locations, for cash consideration of $20,000,000.

The Company s home health services were operated through licensed and Medicare certified offices that provided physical, occupational and speech therapy, as well as skilled nursing services to pediatric, adult infirm and elderly patients. Home health services were reimbursed from Medicare, Medicaid and Medicaid-waiver programs, commercial insurance and private payors (see note 2).

Principles of Consolidation

All intercompany balances and transactions have been eliminated in consolidation. The Company s investment in entities with less than 20% ownership or in which the Company does not have the ability to influence the operations of the investee are being accounted for using the cost method and are included in investments in joint ventures.

Revenue Recognition

The Company generates net service revenues by providing services directly to consumers. The Company receives payments for providing services from federal, state and local governmental agencies, commercial insurers and private consumers. The Company s continuing operations, which include the results of operations previously included in its home and community segment and agencies in three states previously included in its home health segment, 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 and community based 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.

Laws and regulations governing the Medicaid and Medicare 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.

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ADDUS HOMECARE CORPORATION

AND SUBSIDIARIES

Notes to Consolidated Financial Statements (Continued)

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 that the Company s management believes is sufficient to cover potential losses. However, actual collections could differ from the Company s estimates.

Property and Equipment

Property and equipment are recorded at cost and depreciated over the estimated useful lives of the related assets by use of the straight-line method except for internally developed software which is amortized by the sum-of-years digits method. Maintenance and repairs are charged to expense as incurred. The estimated useful lives of the property and equipment are as follows:

Computer equipment	3 5 years
Furniture and equipment	5 7 years
Transportation equipment	5 years
Computer software	5 10 years
Leasehold improvements	Lesser of useful life or lease term, unless probability of lease renewal is likely

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 ASC Topic 350, *Goodwill and Other Intangible Assets*, goodwill and intangible assets with indefinite useful lives are not amortized. The Company tests goodwill for impairment at the reporting unit level on an annual basis, as of October 1, or whenever potential impairment triggers occur, such as a significant change in business climate or regulatory changes that would indicate that an impairment may have occurred. The Company may use a qualitative test, known as Step 0, or a two-step quantitative method to determine whether impairment has occurred. In Step 0, the Company can elect to perform an optional qualitative analysis and based on the results skip the two step analysis. In 2014, 2013 and 2012, the Company elected to implement Step 0 and was not required to conduct the remaining two step analysis. The results of the Company s Step 0 assessments indicated that it was more likely than not that the fair value of its reporting unit exceeded its carrying value and therefore the Company concluded that there was no impairments for the years ended December 31, 2014, 2013 or 2012.

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 twenty-five years.

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Intangible assets with finite lives are amortized using the estimated economic benefit method over the useful life and assessed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. The Company would recognize an impairment loss when the estimated future non-discounted cash flows associated with the intangible asset is less than the carrying value. An impairment change would then be recorded for the excess of the carrying value over the fair value. The Company estimates the fair value of these intangible assets using the income approach. No impairment charge was recorded for the years ended December 31, 2014, 2013 or 2012.

The income approach, which the Company uses to estimate the fair value of its intangible assets (other than goodwill), is dependent on a number of factors including estimates of future market growth and trends, forecasted revenue and costs, expected periods the assets will be utilized, appropriate discount rates and other variables. The Company bases its fair value estimates on assumptions the Company believes to be reasonable but which are unpredictable and inherently uncertain. Actual future results may differ from those estimates.

The Company also has indefinite-lived intangible assets that are not subject to amortization expense such as certificates of need and licenses to conduct specific operations within geographic markets. The Company s 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 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. No impairment was recorded for the years ended December 31, 2014, 2013 or 2012.

Debt Issuance Costs

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

Workers Compensation Program

The Company s workers compensation program has a $350,000 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.

Interest Income

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 statement of operations as interest income. The Company received no prompt payment interest in 2014 and $185,000 and $155,000 in prompt payment interest in 2013 and 2012, respectively. While the Company may be owed additional prompt payment interest, the amount and timing of receipt of such payments remains uncertain and the Company has determined that it will continue to recognize prompt payment interest income when received.

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Notes to Consolidated Financial Statements (Continued)

Interest Expense

The Company s interest expense consists of interest costs on its credit facility, capital lease obligations and other debt instruments.

Income Tax Expenses

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 and restricted stock awards. 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.

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 year ended December 31, 2014 were 684,000 stock options of which 146,000 were out-of-the money and 80,000 restricted stock awards with 14,000 included in the weighted diluted shares outstanding for 2014.

Included in the Company s calculation for the year ended December 31, 2013 were 647,000 stock options of which none were out-of-the money and 96,000 restricted stock awards with 44,000 included in the weighted diluted shares outstanding for 2013.

Included in the Company s calculation for the year ended December 31, 2012 were 596,000 stock options of which 501,000 were out-of-the money and therefore anti-dilutive and 57,000 restricted stock awards with 12,000 included in the weighted diluted shares outstanding for 2012.

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Estimates

The financial statements are prepared by management in conformity with U.S. Generally Accepted Accounting Principles (GAAP) and include estimated amounts and certain disclosures based on assumptions about future events. 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 carrying value of the Company s long-term debt with variable interest rates approximates fair value based on instruments with similar terms.

The Company applies fair value techniques on a non-recurring basis associated with valuing potential impairment losses related to goodwill and indefinite-lived intangible assets and also when determining the fair value of contingent considerations. To determine the fair value in these situations, the Company uses Level 3 inputs, such as discounted cash flows, or if available, what a market participant would pay on the measurement date.

The Company utilizes the income approach to estimate the fair value of its intangible assets derived from acquisitions. In addition, discounted cash flows were used to estimate the fair value of the Company s investment in joint ventures.

New Accounting Pronouncements

On April 10, 2014, the FASB issued Accounting Standards Update (ASU) No. 2014-08, Presentation of Financial Statements (Topic 205) and Property, Plant, and Equipment (Topic 360): Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity. The new guidance changes the requirements for reporting a discontinued operation. Only a disposal representing a strategic shift that has a major effect on the entity s operations and financial results will have to be reported as a discontinued operation. Examples of strategic shifts meeting the new criteria include a disposal of a major geographical area, a major line of business, or a major equity-method investment. Under this new guidance, many disposals that might be routine and not a change in an entity s strategy no longer will be reported as discontinued operations. For each comparative period, an entity s statement of financial position must present separately the assets and liabilities of a disposal group qualifying as a discontinued operation. The ASU requires additional disclosures about the assets, liabilities, revenues, expenses, and cash flows of a discontinued operation. An entity also will be required to disclose the pretax income or loss attributable to a disposal of a significant component that does not qualify for discontinued operations presentation. ASU 2014-08 is effective for public companies for annual and interim periods beginning on or after December 15, 2014.

In May 2014, the FASB issued Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers* (ASU 2014-09), which supersedes nearly all existing revenue recognition guidance under GAAP. The core principle of ASU 2014-09 is to recognize revenues when promised goods or services are transferred to customers in an amount that reflects the consideration to which an entity expects to be entitled for those goods or services. ASU 2014-09 defines a five step process to achieve this core principle and, in doing so, more judgment and estimates may be required within the revenue recognition process than are required under existing GAAP. The standard is effective for annual periods beginning after December 15, 2016, and interim periods therein, using either of the following transition methods: (i) a full retrospective approach reflecting the application of the

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standard in each prior reporting period with the option to elect certain practical expedients, or (ii) a retrospective approach with the cumulative effect of initially adopting ASU 2014-09 recognized at the date of adoption (which includes additional footnote disclosures). The Company is currently evaluating the impact of its pending adoption of ASU 2014-09 on its consolidated financial statements and has not yet determined the method by which it will adopt the standard in 2017.

Reclassification of Prior Period Balances

Certain reclassifications have been made to prior period amounts to conform to the current-year presentation. Previously, the contingent earn-out obligation for the Coordinated Home Health Care, LLC acquisition described in Note 4 had been classified as an Accrued expense on the Company s Consolidated Balance Sheets. The Company revised the classification in the current year s report to Contingent earn-out obligation, less current portion, a long-term liability. In addition, in the current year s report, deferred revenue has been included in Accrued expenses. Previously, this amount was separately listed on the Consolidated Balance Sheets.

2. Discontinued Operations

During December 2012, in anticipation of the sale of substantially all of the assets used in its home health business (the Home Health Business), the Company reported the operating results of the Home Health Business as discontinued operations in accordance with ASC 360-10-45, *Impairment or Disposal of Long-Lived Assets.* On February 7, 2013, the Company entered into the Home Health Purchase Agreement, pursuant to which subsidiaries of LHC Group, Inc. agreed to acquire substantially all the assets of the Home Health Business in Arkansas, Nevada and South Carolina and 90% of the Home Health Business in California and Illinois, with the Company retaining 10% ownership in such locations, for cash consideration of $20,000,000. The transaction was consummated effective March 1, 2013. In addition, the results of operations for an agency in Pennsylvania that was sold on December 30, 2013 and an agency in Idaho that was closed on November 30, 2012 are included in discontinued operations.

The Company has included the financial results of the Home Health Business in discontinued operations for all periods presented. In connection with the discontinued operations presentation, certain financial statement footnotes have also been updated to reflect the impact of discontinued operations.

The following table presents the net service revenues and earnings attributable to discontinued operations, which include the financial results for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
		(Amounts in Thousands)	
Net service revenues	$	$ 6,462	$ 38,822
Income (loss) before income taxes	470	(1,672)	(2,752)
Income tax expense (benefit)	190	(692)	(1,099)
Earnings (loss) from discontinued operations	$ 280	$ (980)	$ (1,653)

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The following table presents the net gain on the sale of the Home Health Business which was recorded in the year ended December 31, 2013:

	Gain (Amounts in Thousands)
Gain before income taxes	$ 15,284
Income tax expense	(6,322)
Net income from discontinued operations	8,962

Pursuant to the Home Health Purchase Agreement, the Company retained $625,000 of accounts receivable, net as of December 31, 2013. In addition, the Company retained the related accrued expenses and accounts payable associated with the Home Health Business as of December 31, 2013.

3. Sale of Agency

During February 2012, the Company completed its sale of a home health agency located in Portland, Oregon for approximately $525,000 with net proceeds of approximately $495,000 after the payment of closing related expenses. The Company recorded a $495,000 pre-tax gain on the sale of the agency as part of continuing operations.

4. Acquisitions

Effective June 1, 2014, the Company acquired Cura Partners, LLC, which conducts business under the name Aid & Assist at Home, LLC (Aid & Assist), in order to further expand the Company s presence in the State of Tennessee. The total consideration for the transaction was $8,192,000, comprised of $7,172,000 in cash and $1,020,000, which has not yet been paid, representing the estimated fair value, subject to the achievement of certain performance targets set forth in an earn-out agreement. The related acquisition costs were $508,000 and were expensed as incurred. The results of operations from this acquired entity are included in the Company s statement of operations from the date of the acquisition.

The Company s acquisition of Aid & Assist has been accounted for in accordance with ASC Top 805, *Business Combinations,* and the resultant goodwill and other intangible assets will be accounted for under ASC Topic 350 *Goodwill and Other Intangible Assets* . The acquisition was recorded at its fair value as of June 1, 2014. The total purchase price is $8,192,000 and is comprised of:

	Total (Amounts in Thousands)
Cash	$ 7,172
Contingent earn-out obligation	1,020
Total purchase price	$ 8,192

The contingent earn-out obligation has been recorded at its fair value of $1,020,000, which is the present value of the Company s obligation to pay up to $1,168,000 based on probability-weighted estimates of the achievement of certain performance targets, as defined in the earn-out agreement between the parties. As of December 31, 2014, the Company revalued this liability at $200,000.

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Under business combination accounting, the total purchase price will be allocated to Aid & Assist s net tangible and identifiable intangible assets based on their estimated fair values. Based upon management s preliminary valuation, the total purchase price has been allocated as follows:

	Total (Amounts in Thousands)
Goodwill	$ 4,317
Identifiable intangible assets	3,950
Accounts receivable (net)	521
Furniture, fixtures and equipment	65
Other current assets	60
Accrued liabilities	(553)
Accounts payable	(168)
Total purchase price allocation	$ 8,192

Management s assessment of qualitative factors affecting goodwill for Aid & Assist includes: estimates of market share at the date of purchase, ability to grow in the market, synergy with existing Company operations and the presence of managed care payors in the market.

Identifiable intangible assets acquired consist of trade names and trademarks, customer relationships and non-compete agreements. The estimated fair value of identifiable intangible assets was determined by the Company s management. It is anticipated that the net intangible and identifiable intangible assets, including goodwill, are deductible for tax purposes. These estimates are provisional and are subject to change.

The Aid & Assist acquisition accounted for $7,536,000 of net service revenues from continuing operations for the year ended December 31, 2014.

The Company entered into two definitive acquisition agreements to acquire home and community based businesses during 2013 to further its presence in both existing states and to expand into new states. On October 17, 2013 the Company entered into an asset purchase agreement to acquire the entire home and community based business of Medi Home Private Care Division of Medical Services of America, Inc. The acquisition included two agencies located in South Carolina which were closed effective November 1, 2013; four agencies located in Tennessee and two agencies located in Ohio which closed in January 2014. The Company also entered into an asset purchase agreement to acquire the assets of Coordinated Home Health Care, LLC a personal care business located in New Mexico on November 7, 2013. The combined purchase price for these two acquisitions was $12,325,000 at the close and a maximum of $2,250,000 in future cash based on certain performance. The purchase included sixteen offices located in Southern New Mexico. The transaction closed effective December 1, 2013. The related acquisitions costs were $735,000 for the Medi Home Private Care Division of Medical Services of America, Inc. and Coordinated Home Health Care, LLC deals, and were expensed as incurred. The results of operations from these acquired entities are included in our statement of operations from the dates of the respective acquisitions.

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The Company s acquisition of the assets of Coordinated Home Health Care, LLC (CHHC) has been accounted for in accordance with ASC Top 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 as of December 1, 2013. The total purchase price is $12,825,000 and is comprised of:

	Total (Amounts in Thousands)
Cash	$ 11,725
Contingent earn-out obligation	1,100
Total purchase price	$ 12,825

The contingent earn-out obligation was recorded at its fair value of $1,100,000, which is the present value of the Company s obligation to up to $2,250,000 based on probability-weighted estimates of the achievement of certain performance targets, as defined in the earn-out agreement between the parties. As of December 31, 2014, the Company recorded $1,000,000 as the current portion of contingent earn out obligation payable in 2015 and revalued the remaining liability at $920,000.

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

	Total (Amounts in Thousands)
Goodwill	$ 9,488
Identifiable intangible assets	3,300
Accounts receivable	888
Prepaid expenses	35
Furniture, fixtures and equipment	58
Deposits	15
Accounts payable	(81)
Accrued liabilities	(864)
Other liabilities	(14)
Total purchase price allocation	$ 12,825

Management s assessment of qualitative factors affecting goodwill for CHHC includes: estimates of market share at the date of purchase, ability to grow in the market, synergy with existing Company operations and the presence of managed care payors in the market.

Identifiable intangible assets acquired consist of trade names and trademarks, customer relationships and non-compete agreements. The estimated fair value of identifiable intangible assets was determined by management. It is anticipated that the net intangible and identifiable intangible assets, including goodwill, are deductible for tax purposes.

Acquisitions completed during the fourth quarter 2013 accounted for $21,945,000 and $1,692,000 of net service revenues from continuing operations for the years ended December 31, 2014 and 2013, respectively.

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The following table contains unaudited pro forma consolidated income statement information assuming the Aid & Assist and CHHC acquisitions closed on January 1, 2013:

	For The Year Ended December 31, 2014	2013
	(Amounts in Thousands)	
Net service revenues	$ 318,352	$ 298,395
Operating income from continuing operations	18,080	15,890
Net income from continuing operations	12,022	10,050
Earnings from discontinued operations	280	7,982
Net income	$ 12,302	$ 18,032
Net income per common share		
Basic income per share		
Continuing operations	$ 1.05	$ 0.99
Discontinued operations	0.02	0.74
Basic income per share	$ 1.07	$ 1.72
Diluted income per share		
Continuing operations	$ 1.03	$ 0.96
Discontinued operations	0.02	0.72
Diluted income per share	$ 1.05	$ 1.68

The pro forma disclosures in the table above include adjustments for, amortization of intangible assets and tax expense and acquisition costs to reflect results that are more representative of the combined results of the transactions as if they had occurred on January 1, 2013. 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. The unaudited pro forma financial information does not reflect the impact of future events that may occur after the acquisition, such as anticipated cost savings from operating synergies.

5. Property and Equipment

Property and equipment consisted of the following:

	December 31, 2014	2013
	(Amounts in Thousands)	
Computer equipment	$ 2,537	$ 2,110
Furniture and equipment	2,224	1,099
Transportation equipment	673	588

Leasehold improvements	4,609	1,628
Computer software	5,105	3,749
	15,148	9,174
Less accumulated depreciation and amortization	(7,453)	(6,540)
	$ 7,695	$ 2,634

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Computer software includes $3,109,000 of internally developed software. Depreciation and amortization expense predominantly related to computer equipment and software and leasehold improvements is reflected in general and administrative expenses and totaled $1,416,000, $814,000 and $870,000 for the years ended December 31, 2014, 2013 and 2012, respectively.

6. Goodwill and Intangible Assets

The Company s carrying value of goodwill is the residual of the purchase price over the fair value of the net assets acquired from various acquisitions including the acquisition of Addus HealthCare. In accordance with 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 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 impairment may have occurred.

Goodwill is required to be tested for impairment at least annually. The Company can elect to perform Step-0 an optional qualitative analysis and based on the results skip the remaining two steps. In 2014, 2013 and 2012, the Company elected to implement Step 0 and was not required to conduct the remaining two step analysis. In performing its goodwill assessment for 2014, 2013 and 2012, the Company evaluated the following factors that affect future business performance: macroeconomic conditions, industry and market considerations, cost factors, overall financial performance, entity-specific events, reporting unit factors and company stock price. As a result of the assessment of these qualitative factors, the Company has concluded that it is more likely than not that the fair values of the reporting unit goodwill as of December 31, 2014, 2013 and 2012 exceed the carrying values of the unit. Accordingly, the first and second steps of the goodwill impairment test as described in FASB ASC 350-20-35, which includes estimating the fair values of the Company, are not considered necessary.

The goodwill for the Company s continuing operations was $64,220,000 and $60,026,000 as of December 31, 2014 and 2013, respectively.

A summary of goodwill and related adjustments for continuing operations is provided below:

	Goodwill (Amounts in Thousands)
Goodwill, at December 31, 2012	$ 50,536
Additions for acquisitions	9,650
Adjustments to previously recorded goodwill	(160)
Goodwill, at December 31, 2013	$ 60,026
Additions for acquisitions	4,317
Adjustments to previously recorded goodwill	(123)
Goodwill, at December 31, 2014	$ 64,220

Adjustments to the previously recorded goodwill are primarily credits related to amortization of tax goodwill in excess of book basis.

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 twenty-five years.

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The Company also has indefinite-lived assets that are not subject to amortization expense such as licenses and in certain states certificates of need to conduct specific operations within geographic markets. The Company has concluded these assets 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 the licenses indefinitely. The licenses and certificates of need 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 years ended December 31, 2014, 2013 or 2012.

The carrying amount and accumulated amortization of each identifiable intangible asset category consisted of the following for continuing operations at December 31, 2014 and 2013:

	Customer and referral relationships	Trade names and trademarks	State Licenses	Non-competition agreements	Total
			(Amounts in Thousands)		
Gross balance at January 1, 2013	$ 24,908	$ 4,081	$ 150	$ 408	$ 29,547
Additions for acquisitions	1,438	1,200		1,100	3,738
Accumulated amortization	(21,138)	(2,995)		(390)	(24,523)
Net Balance at December 31, 2013	5,208	2,286	150	1,118	8,762
Gross balance at January 1, 2014	26,346	5,281	150	1,508	33,285
Additions	50				50
Additions for acquisitions	1,500	1,900		550	3,950
Accumulated amortization	(22,497)	(3,619)		(822)	(26,938)
Net Balance at December 31, 2014	$ 5,399	$ 3,562	$ 150	$ 1,236	$ 10,347

Amortization expense for continuing and discontinued operations related to the identifiable intangible assets amounted to $2,414,000, $1,346,000 and $1,674,000 for the years ended December 31, 2014, 2013 and 2012, respectively. Goodwill and state licenses are not amortized pursuant to ASC Topic 350.

The estimated future intangible amortization expense is as follows:

For the year ended December 31,	Total (Amount in Thousands)
2015	$ 2,561
2016	2,396
2017	1,897
2018	1,771
2019	808
Thereafter	764

Total	$	10,197

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7. Details of Certain Balance Sheet Accounts

Prepaid expenses and other current assets consist of the following:

	December 31,	
	2014	2013
	(Amounts in Thousands)	
Prepaid health insurance	$ 2,762	$ 3,192
Prepaid workers compensation and liability insurance	1,326	1,173
Prepaid rent	595	455
Workers compensation insurance receivable	1,457	821
Other	1,028	594
	$ 7,168	$ 6,235

Accrued expenses consisted of the following:

	December 31,	
	2014	2013
	(Amounts in Thousands)	
Accrued payroll	$ 12,703	$ 12,932
Accrued workers compensation insurance	14,081	13,347
Accrued health insurance (3)	3,540	3,731
Indemnification reserve (1)	1,263	3,224
Accrued payroll taxes	3,287	1,755
Accrued professional fees	1,500	1,319
Amounts due to LHCG (2)		2,196
Other	894	2,400
	$ 37,268	$ 40,904

(1) As a condition of the sale of the Home Health Business to subsidiaries of LHC Group. Inc. (LHCG) the Company is responsible for any adjustments to Medicare and Medicaid billings prior to the closing of the sale. In connection with an internal evaluation of the Company s billing processes, it discovered documentation errors in a number of claims that it had submitted to Medicare. Consistent with applicable law, the Company voluntarily remitted $1,840,000 to the government in March 2014. The Company, using its best judgment, has estimated a total of $1,263,000 for billing adjustments remaining.

(2) Amounts due to LHCG pursuant to a billing services arrangement between the Company and LHCG.

(3) The Company provides health insurance coverage to qualified union employees providing home and community based services in Illinois through a Taft-Hartley multi-employer health and welfare plan under Section 302(c)(5) of the Labor Management Relations Act of 1947. The Company s insurance contributions equal the amount reimbursed by the State of Illinois. Contributions are due within five business days from the date the funds are received from the State. Amounts due of $2,404,000 and $3,163,000 for health insurance reimbursements and contributions were reflected in prepaid insurance and accrued insurance at December 31, 2014 and 2013, respectively.

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The Company s workers compensation program has a $350,000 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. These letters of credit totaled $15,464,000 and $12,411,000 at December 31, 2014 and 2013.

As part of the terms of the acquisition of Addus HealthCare in 2006, all 2005 and prior workers compensation claims were the obligation of the former stockholders of Addus HealthCare. During the fourth quarter of 2014, Addus entered into an agreement pursuant to which the responsibility of the selling shareholders for these claims was terminated. The outstanding loss reserves associated with the 2005 and prior workers compensation policies approximated $779,000 and $604,000 at December 31, 2014 and 2013, respectively. The Company received $841,000 in cash and escrow amounts in exchange for the termination of these liabilities.

8. Long-Term Debt

Capital Leases

On July 12, 2014 and September 11, 2014, the Company executed two 48-month capital lease agreements for $2,650,000 and $1,428,000, respectively, with First American Commercial Bancorp, Inc. The capital leases were entered into to finance property and equipment at the Company s new corporate headquarters in Downers Grove, IL. The underlying assets are included in Property and equipment, net of accumulated depreciation and amortization in the accompanying Consolidated Balance Sheets. These capital lease obligations require monthly payments through September 2018 and have implicit interest rates that range from 3.0% to 3.3%. At the end of the term, the Company has the option to purchase the assets for $1 per lease agreement.

An analysis of the leased property under capital leases by major classes is as follows.

Classes of Property	Asset Balances at December 31, 2014 (Amounts in Thousands)
Leasehold Improvements	$ 2,928
Furniture & Equipment	526
Computer Equipment	431
Computer Software	147
Less: Accumulated Depreciation	(239)
	$ 3,793

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The future minimum payments for capital leases as of December 31, 2014 are as follows:

	Capital Lease (Amounts In Thousands)
2015	$ 1,105
2016	1,105
2017	1,105
2018	629
Total minimum lease payments	3,944
Less: amount representing estimated executory costs (such as taxes, maintenance and insurance), including profit thereon, included in total minimum lease payments	(68)
Net minimum lease payments	3,876
Less: amount representing interest (1)	(213)
Present value of net minimum lease payments (2)	$ 3,663

(1) Amount necessary to reduce net minimum lease payments to present value calculated at the Company s incremental borrowing rate at lease inception.

(2) Reflected in the balance sheet as current and noncurrent obligations under capital leases of $986,000 and $2,677,000, respectively.

Senior Secured Credit Facility

On August 11, 2014, the Company renewed its credit facility. The Company s credit facility provides a $55,000,000 revolving line of credit expiring November 2, 2019 and includes a $27,500,000 sublimit for the issuance of letters of credit. On November 6, 2014, the Company amended its credit facility, with retroactive effect to September 30, 2014. The credit facility was amended to (i) reduce the floating interest rate from one-month LIBOR, plus a margin of 4.6% to one-month LIBOR, plus a margin of 3.5%, (ii) reduce the interest rate for loans based on term periods of one, two or three months from the LIBOR rate, plus a margin of 4.6% to the LIBOR rate, plus a margin of 3.5% and (iii) increase the allowed capital expenditures for the fiscal year ending 2014 from $5,000,000 to $7,000,000. 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 in the credit agreement, for the most recent 12-month period for which financial statements have been delivered under the credit agreement multiplied by the specified advance multiple, up to 3.25, less the outstanding senior indebtedness and letters of credit, and (ii) $55,000,000 less the outstanding revolving loans and letters of credit. Interest on the revolving line of credit may be payable at (i) a floating rate equal to the one-month LIBOR, plus a margin of 3.5%, (ii) the LIBOR rate for term periods of one, two or three months, plus a margin of 3.5% or (iii) the base rate, plus a margin of 1.6%, where the base rate is equal to the greatest of (a) the rate of interest last quoted by The Wall Street Journal as the prime rate, (b) the sum of the federal funds rate, plus a margin of 0.5% and (c) the sum of the adjusted LIBOR that would be applicable to a loan with a one month interest period advanced on such day, plus a margin of 3%. The Company

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pays 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 are charged at a rate of 2.0% per annum payable monthly. The Company did not have any amounts outstanding on the credit facility as of December 31, 2014, and the total availability under the revolving credit loan facility was $39,536,000 and $42,279,000, as of December 31, 2014 and December 31, 2013, respectively.

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 the Company s 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 $2,000,000, 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.

Subordinated Dividend Notes

On November 2, 2009, in conjunction with the IPO, all outstanding shares of Holdings series A preferred stock were converted into an aggregate 4,077,000 shares of common stock at a ratio of 1:108. Total accrued and unpaid dividends on the series A preferred stock were $13,109,000 as of November 2, 2009, at which time a dividend payment of $173,000 was made and the remaining $12,936,000 in unpaid preferred dividends were converted into dividend notes. The dividend notes are subordinated and junior to all obligations under the Company s credit facility. On November 2, 2009, the Company made a mandatory payment of $4,000,000 on the dividend notes. Interest on the outstanding dividend notes accrues at a rate of 10% per annum, compounded annually. The outstanding principal amount of the dividend notes was originally payable in eight equal consecutive quarterly installments which commenced on December 31, 2009 and each March 31, June 30, September 30 and December 31 of each year thereafter until paid in full. Interest on the unpaid principal balance of the dividend notes is due and payable quarterly in arrears together with each payment of principal.

On March 18, 2010, the Company amended its subordinated dividend notes. A balance of $7,819, 000 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 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 $4,468,000 to $1,250,000 in 2010; from $3,351,000 to $2,500,000 in 2011; and amended total payments in 2012 to $4,069,000, 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. The Company repaid the subordinated dividend notes in the fourth quarter of 2012.

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9. Income Taxes

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

	December 31,		
	2014	2013	2012
	(Amounts in Thousands)		
Current			
Federal	$ 2,231	$ 2,926	$ 3,745
State	976	435	792
Deferred			
Federal	1,915	393	196
State	306	58	74
Provision for income taxes	$ 5,428	$ 3,812	$ 4,807

The tax effects of certain temporary differences between the Company s book and tax bases of assets and liabilities give rise to significant portions of the deferred income tax assets at December 31, 2014 and 2013. The deferred tax assets consisted of the following:

	December 31,	
	2014	2013
	(Amounts in Thousands)	
Deferred tax assets		
Current		
Accounts receivable allowances	$ 1,568	$ 1,664
Accrued compensation	1,365	849
Accrued workers compensation	5,099	5,365
Other	899	923
Total current deferred tax assets	8,931	8,801
Deferred tax liabilities		
Current		
Prepaid insurance	(423)	(475)
Net deferred tax assets current	8,508	8,326
Deferred tax assets		
Long-term		
Transaction costs	612	
Property and equipment	(394)	52
Reserves	510	1,295
Stock-based compensation	713	861
Other	(218)	

Total long-term deferred tax assets	1,223	2,208
Deferred tax liability		
Long-term		
Goodwill and intangible assets	(7,068)	(5,649)
Total long-term deferred tax liabilities	(5,845)	(3,441)
Total net deferred tax assets	$ 2,663	$ 4,885

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Management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management considers projected future taxable income and tax-planning strategies in making this assessment. Based on this assessment, management believes it is more likely than not that the Company will realize its deferred income tax assets as of December 31, 2014.

A reconciliation of the statutory federal tax rate of 34.5%, 35.0% and 34.0% to the effective income tax rate, for continuing operations for the years ended December 31, 2014, 2013, and 2012, is summarized as follows:

	December 31,		
	2014	**2013**	**2012**
Federal income tax at statutory rate	34.5%	35.0%	34.0%
State and local taxes, net of federal benefit	5.9	5.2	5.9
Jobs tax credits, net (1)	(9.9)	(6.8)	(7.5)
Nondeductible meals and entertainment	0.5	0.4	(0.8)
Other	0.2	(8.3)	2.5
Effective income tax rate	31.2%	25.5%	34.1%

(1) Included in the jobs tax credit for the year ended December 31, 2012 was a one-time benefit of a 2.4% reduction from the Company s statutory tax rate for the jobs tax credits earned in 2012 but not recorded until 2013. The federal employment opportunity tax credits were reinstated in 2013 and were not an allowable deduction in 2012.

The Company is subject to taxation in the jurisdictions in which it operates. The Company continues to remain subject to examination by U.S. federal authorities for the years 2010 through 2014 and for various state authorities for the years 2010 through 2014. As part of the acquisition of Addus HealthCare in 2006, the selling stockholders agreed to assume and indemnify the successor for any federal or state tax liabilities prior to the acquisition date.

The total amount of unrecognized tax benefits under ASC Topic 740 at December 31, 2014 was $115,000. If recognized, the entire amount would favorably impact the effective tax rate in future periods. Interest and penalties related to income tax liabilities are recognized in interest expense and general and administrative expenses, respectively. The Company does not anticipate a material change in its liabilities for uncertain tax positions during the next 12 months.

A summary of the activities associated with the Company s reserve for unrecognized tax benefits is as follows:

	Unrecognized Tax Benefits (Amounts in Thousands)
Balance at December 31, 2012	$ 115
Increases related to current year tax positions	

Balance at December 31, 2013	$	115
Increases related to current year tax positions		
Balance at December 31, 2014	$	115

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10. Stock Options and Restricted Stock Awards

Stock Options

The 2006 Plan provides for the grant of non-qualified stock options to directors and eligible employees, as defined in the 2006 Plan. A total of 899,000 of Holdings shares of common stock were reserved for issuance under the 2006 Plan. The number of options to be granted and the terms thereof were approved by Holdings board of directors. The option price for each share of common stock subject to an option may be greater than or equal to the fair market value of the stock at the date of grant. The stock options generally vest ratably over a five year period and expire 10 years from the date of grant, if not previously exercised.

In September 2009, the Company s board of directors and stockholders adopted and approved the 2009 Plan. The 2009 Plan provides for the grant of 1,500,000 incentive stock options, nonqualified stock options, stock appreciation rights, restricted stock, deferred stock units, restricted stock units, other stock units and performance shares.

A summary of stock option activity and weighted average exercise price is as follows:

	For The Year Ended December 31,					
	2014		2013		2012	
	Options (Amounts in Thousands)	Weighted Average Exercise Price	Options (Amounts in Thousands)	Weighted Average Exercise Price	Options (Amounts in Thousands)	Weighted Average Exercise Price
Outstanding, beginning of period	647	$ 8.80	596	$ 8.11	775	$ 7.69
Granted	121	22.97	177	10.93	36	4.49
Exercised	(66)	6.90	(94)	9.09	(5)	4.53
Forfeited/Cancelled	(18)	9.26	(32)	7.89	(209)	6.02
Outstanding, end of period	684	$ 11.43	647	$ 8.80	596	$ 8.11

The following table summarizes stock options outstanding and exercisable at December 31, 2014:

Exercise Price	Options	Outstanding Weighted Average Remaining Contractual Life in Years	Weighted Average Exercise Price	Options	Exercisable Weighted Average Remaining Contractual Life in Years	Weighted Average Exercise Price
$4.06-$5.93	113,000	6.5	$ 4.73	78,000	6.4	$ 4.92
$8.91-$23.22	571,370	5.7	12.76	324,619	3.3	9.56
	684,370		$ 11.43	402,619		$ 8.66

The Company historically used the Black-Scholes option pricing model to estimate the fair value of its stock based payment awards under its 2006 Plan, 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. Holdings did not have a history of market prices of its common stock as it was not a public company prior to the IPO, and as such management estimates volatility based on the volatilities of a peer group of publicly traded companies. The

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expected term of options is based on the Company s estimate of when options will be exercised in the future. The risk-free interest rate assumption is based on observed interest rates appropriate for the terms of the Company s awards. The dividend assumption is based on the Company s history and expectation of not paying dividends. The expected turn-over rate represents the expected forfeitures due to employee turnover and is based on historical rates experienced by the Company. The expected exercise multiple represents the mean ratio of the stock price to the exercise price at which employees are expected to exercise their options.

The weighted-average estimated fair value of employee stock options granted as calculated using the Black-Scholes model and the Enhanced Hull-White Trinomial model and the related assumptions follow:

	For the Year Ended December 31,		
	2014	2013	2012
	Grants	Grants	Grants
Weighted average fair value	$10.69	$5.14	$2.09
Risk-free discount rate	2.12% 2.73%	2.07% 2.96%	1.59% 1.95%
Expected life	7.70 8.20 years	6.00 6.25 years	6.00 6.50 years
Dividend yield			
Volatility	47%	47%	42% 51%
Expected turn-over rate	5%	5%	5%
Expected exercise multiple	2.2	2.2	2.2

Stock option compensation expense, for continuing and discontinued operations, totaled $502,000, $276,000 and $181,000 for the years ended December 31, 2014, 2013 and 2012, respectively. As of December 31, 2014, there was $1,659,000 of total unrecognized compensation cost that is expected to be recognized over a period of five years.

The intrinsic value of vested and outstanding stock options was $6,286,000 and $8,785,000, respectively as of December 31, 2014. The intrinsic value of stock options exercised during the year ended December 31, 2014 was $1,025,000. There were 66,000 stock options exercised of which 26,000 shares of common stock were issued as part of a cashless exchange and 94,000 stock options exercised of which 67,000 shares of common stock were issued as part of a cashless exchange in 2014 and 2013, respectively.

Restricted Stock Awards

In 2014, management awarded 36,000 shares of restricted stock awards under the 2009 Plan with a weighted average grant date fair value of $22.75 per share. As of December 31, 2014, $939,000 of unearned compensation related to unvested awards of restricted stock will be recognized over the remaining vesting terms of the awards.

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The following table summarizes the status of unvested restricted stock awards outstanding at December 31, 2014, 2013 and 2012:

	For The Year Ended December 31,					
	2014		2013		2012	
	Restricted Stock Awards (Amounts in Thousands)	Weighted Average Grant Date Fair Value	Restricted Stock Awards (Amounts in Thousands)	Weighted Average Grant Date Fair Value	Restricted Stock Awards (Amounts in Thousands)	Weighted Average Grant Date Fair Value
Unvested restricted stock awards, beginning of period	70	$ 9.13	42	$ 4.80	21	$ 5.95
Awarded	36	22.75	63	9.61	44	4.48
Vested	(22)	10.34	(32)	4.65	(20)	5.14
Forfeited	(5)	6.66	(3)	5.32	(3)	5.93
Unvested restricted stock awards, end of period	79	$ 15.16	70	$ 9.13	42	$ 4.80

The fair market value of restricted stock awards that vested during the year ended December 31, 2014 was $598,000.

Restricted stock award compensation expense, for continuing and discontinued operations, totaled $325,000, $239,000 and $160,000 for the years ended December 31, 2014, 2013 and 2012, respectively.

Shares available under the 2006 Plan and the 2009 Plan were 564,000 and 826,000, respectively, as of December 31, 2014. The Company does not plan on issuing any further grants under the 2006 Plan.

11. Operating Leases and Related Party Transactions

The Company leases its branch office space under various operating leases that expire at various dates through 2024. In addition to rent, the Company is typically responsible for taxes, maintenance, insurance and common area costs. A number of the office leases also contain escalation and renewal option clauses. Total rent expense on these office leases was $2,707,000, $2,442,000 and $3,380,000 for continuing and discontinued operations for the years ended December 31, 2014, 2013, and 2012, respectively. In connection with the sale of the Home Health Business, the Company entered into subleases for all or a portion of 13 of the Company s leased properties and assigned nine leases to the purchasers. Assigned leases are not included in the schedule below.

The Company entered into a 132 month lease with a third party for approximately 59,000 square feet of office space in Downers Grove, IL for its corporate headquarters. The Company assumed occupancy in May 2014. Rental expense relating to this lease amounted to $503,000 for the year ended December 31, 2014. Previously, the Company leased its corporate office space from a former member of its board of directors, who is also a stockholder of the Company. Under the terms of an operating lease that expired in June 2013; this lease agreement operated on a month to month basis through May 2014. Rental expense relating to this lease amounted to $200,000, $483,000 and $486,000 for the years ended December 31, 2014, 2013 and 2012, respectively.

During 2011, the Company entered into a lease for its telecom system under a five year operating lease that expires in June 2016. Total expense on the telecom lease for continuing and discontinued operations was $366,000, $379,000 and $285,000 for the years ended December 31, 2014, 2013 and 2012, respectively.

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Notes to Consolidated Financial Statements (Continued)

The following is a schedule of the future minimum payments, exclusive of taxes and other operating expenses, required under the Company s operating leases. The payments owed with respect to the subleased properties have been included from the table below because the Company remains liable for payments in the event that the sublessee does not make the required payment to the landlord.

	Rent (Amount in Thousands)
2015	$ 3,528
2016	2,915
2017	2,053
2018	1,555
2019	1,249
Thereafter	5,584
Total	$ 16,884

12. Stockholders Equity

2009 Stock Incentive Plan

In September 2009, the Company s board of directors and stockholders adopted and approved the 2009 Plan. The 2009 Plan when established provided for the grant of 750,000 incentive stock options, nonqualified stock options, stock appreciation rights, restricted stock, deferred stock units, restricted stock units, other stock units and performance shares. In May 2013, the Company s Board of Directors and stockholders approved an increase in the number of incentive stock options to 1,500,000 which was approved by the stockholders at the 2013 Annual Meeting.

13. Segment Data

The Company historically segregated its results into two distinct reporting segments: the home & community segment and the home health segment. As a result of the sale of the Home Health Business, the Company has reported the operating results for the Home Health Business in discontinued operations. Therefore, all of the Company s operations are reported as one operating segment.

14. Employee Benefit Plans

The Company s 401(k) Retirement Plan covers all non-union employees. The 401(k) plan is a defined contribution plan that provides for matching contributions by the Company. Matching contributions are discretionary and subject to change by management. Under the provisions of the 401(k) plan, employees can contribute up to the maximum percentage and limits allowable under the Internal Revenue Code of 1986. The Company provided a matching contribution, equal to 6.0% of the employees contributions, totaling $30,000, $46,000 and $44,000 for continuing and discontinued operations for the year ended December 31, 2014, 2013, and 2012, respectively.

15. Commitments and Contingencies

Legal Proceedings

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

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Employment Agreements

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

16. 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. The Illinois Department on Aging accounted for 53.2%, 58.8% and 57.3% of the Company s net service revenues for 2014, 2013, and 2012, respectively.

The related receivables due from the Illinois Department on Aging represented 54.2% and 65.6% of the Company s accounts receivable at December 31, 2014 and 2013, respectively.

17. Concentration of Cash

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

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Notes to Consolidated Financial Statements (Continued)

18. Unaudited Summarized Quarterly Financial Information

The following is a summary of the Company s unaudited quarterly results of operations (amounts and shares in thousands, except per share data):

	Year Ended December 31, 2014				Year Ended December 31, 2013			
	Dec. 31	Sept. 30	Jun. 30	Mar. 31	Dec. 31	Sept. 30	Jun. 30	Mar. 31
Net service revenues	$ 82,636	$ 81,658	$ 76,965	$ 71,683	$ 69,882	$ 67,306	$ 65,755	$ 62,998
Gross profit	22,647	21,840	20,580	18,668	18,102	17,226	16,613	15,798
Operating income from continuing operations	5,242	4,961	4,098	3,770	3,476	4,263	3,980	3,742
Net income from continuing operations	3,643	3,237	2,729	2,354	3,124	2,770	2,582	2,687
Earnings (loss) from discontinued operations	280				(2,239)	(203)	(150)	10,574
Net income	$ 3,923	$ 3,237	$ 2,729	$ 2,354	$ 885	$ 2,567	$ 2,432	$ 13,261
Average shares outstanding:								
Basic	10,929	10,927	10,903	10,850	10,838	10,787	10,785	10,778
Diluted	11,143	11,154	11,138	11,110	11,154	11,071	11,016	10,845
Income (loss) per common share:								
Basic								
Continuing operations	$ 0.33	$ 0.30	$ 0.25	$ 0.22	$ 0.29	$ 0.26	$ 0.24	$ 0.25
Discontinued operations	0.03				(0.21)	(0.02)	(0.01)	0.98
Basic net income per share	$ 0.36	$ 0.30	$ 0.25	$ 0.22	$ 0.08	$ 0.24	$ 0.23	$ 1.23
Diluted net income per share								
Continuing operations	$ 0.33	$ 0.29	$ 0.25	$ 0.21	$ 0.28	$ 0.25	$ 0.23	$ 0.25
Discontinued operations	0.02				(0.20)	(0.02)	(0.01)	0.98
Diluted net income per share	$ 0.35	$ 0.29	$ 0.25	$ 0.21	$ 0.08	$ 0.23	$ 0.22	$ 1.23

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Notes to Consolidated Financial Statements (Continued)

19. Subsequent Event

Effective January 1, 2015, the Company acquired Priority Home Health Care, Inc. for approximately $4,250,000, in order to further expand the Company s presence in the State of Ohio. Priority Home Health Care, Inc. is a company headquartered in Cleveland, Ohio that operates six offices in the Cleveland, Akron and Columbus areas. The related acquisition costs were $421,000, and such costs were expensed as incurred and are included in the Company s results for 2014.

VALUATION AND QUALIFYING ACCOUNTS

SCHEDULE II

(Amounts In Thousands)

Allowance for doubtful accounts	**Balance at beginning of period**	**Additions/ charges**	**Deductions***	**Balance at end of period**
Year ended December 31, 2014				
Allowance for doubtful accounts	$ 4,140	2,818	3,077	$ 3,881
Year ended December 31, 2013				
Allowance for doubtful accounts	$ 4,466	3,020	3,346	$ 4,140
Year ended December 31, 2012				
Allowance for doubtful accounts	$ 7,189	2,877	5,600	$ 4,466

* Write-offs, net of recoveries

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EXHIBIT INDEX

Exhibit Number	Description of Document
3.1	Amended and Restated Certificate of Incorporation of Addus HomeCare Corporation dated as of November 2, 2009 (filed on November 20, 2009 as Exhibit 3.1 to Addus HomeCare Corporation s Quarterly Report on Form 10-Q and incorporated by reference herein)
3.2	Amended and Restated Bylaws of Addus HomeCare Corporation (filed on September 21, 2009 as Exhibit 3.5 to Amendment No. 2 to Addus HomeCare Corporation 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 Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
4.2	Registration Rights Agreement, dated September 19, 2006, by and among Addus HomeCare Corporation, Eos Capital Partners III, L.P., Eos Partners SBIC III, L.P., Freeport Loan Fund LLC, W. Andrew Wright, III, Addus Term Trust, W. Andrew Wright Grantor Retained Annuity Trust, Mark S. Heaney, James A. Wright and Courtney E. Panzer (filed on July 17, 2009 as Exhibit 4.2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.1	Separation and General Release Agreement, dated as of September 20, 2009, between Addus HealthCare, Inc. and W. Andrew Wright, III (filed on September 21, 2009 as Exhibit 10.1(b) to Amendment No. 2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.2	Amended and Restated Employment and Non-Competition Agreement, dated May 6, 2008, between Addus HealthCare, Inc. and Mark S. Heaney (filed on July 17, 2009 as Exhibit 10.2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.3	Amendment to the Amended and Restated Employment and Non-Competition Agreement, dated September 30, 2009, between Addus HealthCare, Inc. and Mark S. Heaney (filed on October 2, 2009 as Exhibit 10.2(a) to Amendment No. 4 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.4	Employment Agreement, dated November 29, 2010, by and between Addus HealthCare, Inc. and Dennis Meulemans (filed on December 1, 2010 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)
10.5	Amended and Restated Employment and Non-Competition Agreement, dated August 27, 2007, between Addus HealthCare, Inc. and Darby Anderson (filed on July 17, 2009 as Exhibit 10.4 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.6	Amendment to the Amended and Restated Employment and Non-Competition Agreement, dated September 30, 2009, between Addus HealthCare, Inc. and Darby Anderson (filed on October 2, 2009 as Exhibit 10.4(a) to Amendment No. 4 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.7	Addus HealthCare, Inc. Home Health and Home Care Division Vice President and Regional Director Bonus Plan (filed on July 17, 2009 as Exhibit 10.10 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.8	Addus HealthCare, Inc. Support Center Vice President and Department Director Bonus Plan (filed on July 17, 2009 as Exhibit 10.11 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)

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Exhibit Number	Description of Document
10.9	Addus Holding Corporation 2006 Stock Incentive Plan (filed on July 17, 2009 as Exhibit 10.12 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.10	Director Form of Option Award Agreement under the 2006 Stock Incentive Plan (filed on July 17, 2009 as Exhibit 10.13 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.11	Executive Form of Option Award Agreement under the 2006 Stock Incentive Plan (filed on July 17, 2009 as Exhibit 10.14 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.12	Form of Indemnification Agreement (filed on July 17, 2009 as Exhibit 10.16 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.13	License Agreement, dated March 24, 2006, between McKesson Information Solutions, LLC and Addus HealthCare, Inc. (filed on August 26, 2009 as Exhibit 10.17 to Amendment No. 1 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.14	Contract Supplement to the License Agreement, dated March 24, 2006 (filed on August 26, 2009 as Exhibit 10.17(a) to Amendment No. 1 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.15	Contract Supplement to the License Agreement, dated March 28, 2006 (filed on August 26, 2009 as Exhibit 10.17(b) to Amendment No. 1 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.16	Amendment to License Agreement, dated March 28, 2006, between McKesson Information Solutions, LLC and Addus HealthCare, Inc. (filed on August 26, 2009 as Exhibit 10.17(c) to Amendment No. 1 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.17	Lease, dated April 1, 1999, between W. Andrew Wright, III and Addus HealthCare, Inc. (filed on July 17, 2009 as Exhibit 10.18 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.18	First Amendment to Lease, dated as of April 1, 2002, between W. Andrew Wright, III and Addus HealthCare, Inc. (filed on July 17, 2009 as Exhibit 10.18(a) to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.19	Second Amendment to Lease, dated as of September 19, 2006, between W. Andrew Wright, III and Addus HealthCare, Inc. (filed on July 17, 2009 as Exhibit 10.18(b) to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.20	Third Amendment to Lease, dated as of September 1, 2008, between W. Andrew Wright, III and Addus HealthCare, Inc. (filed on July 17, 2009 as Exhibit 10.18(c) to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.21	Addus HomeCare Corporation 2009 Stock Incentive Plan (filed on September 21, 2009 as Exhibit 10.20 to Amendment No. 2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.22	Form of Incentive Stock Option Award Agreement under the 2009 Stock Incentive Plan (filed on September 21, 2009 as Exhibit 10.20(a) to Amendment No. 2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)
10.23	Form of Restricted Stock Award Agreement under the 2009 Stock Incentive Plan (filed on September 21, 2009 as Exhibit 10.20(b) to Amendment No. 2 to Addus HomeCare Corporation s Registration Statement on Form S-1 and incorporated by reference herein)

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Exhibit Number	Description of Document
10.24	Loan and Security Agreement, dated as of November 2, 2009, 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., 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 November 5, 2009 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)
10.25	Consent and Amendment No. 1 to the Loan and Security Agreement, dated as of March 18, 2010, 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., 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 March 18, 2010 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)
10.26	Joinder, Consent and Amendment No. 2 to Loan and Security Agreement, dated as of July 26, 2010, by and among Addus HealthCare, Inc., Addus HealthCare (South Carolina), 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., 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 July 27, 2010 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)
10.27	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 Addus HomeCare Corporation s Current Report on Form 8-K and incorporated herein by reference)
10.28	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 Addus HomeCare Corporation s Current Report on Form 8-K and incorporated herein by reference)

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Exhibit Number	Description of Document
10.29	Amendment No. 2 to Employment and Non-Competition Agreement, dated November 17, 2011, by and between Addus HealthCare, Inc. and Mark S. Heaney (filed on November 23, 2011 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated herein by reference)
10.30	Amendment No. 5 to Loan and Security Agreement, dated as of March 2, 2012, 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 March 16, 2012 as Exhibit 10.41 to Addus HomeCare Corporation s Annual Report on Form 10-K and incorporated herein by reference)
10.31	Summary of Independent Director Compensation Policy*
10.32	The Executive Nonqualified Excess Plan Adoption Agreement, by Addus HealthCare, Inc., dated April 1, 2012 (filed on April 5, 2012 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)
10.33	The Executive Nonqualified Excess Plan Document, dated April 1, 2012 (filed on April 5, 2012 as Exhibit 99.2 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated herein by reference)
10.34	Employment Agreement, effective June 18, 2012, by and between Addus Healthcare, Inc. and Inna Berkovich (filed on June 20, 2012 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated herein by reference)
10.35	Asset Purchase Agreement, dated as of February 7, 2013, by and among Addus HealthCare, Inc., its subsidiaries identified therein, LHC Group, Inc. and its subsidiaries identified therein (filed on March 6, 2013 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein)
10.36	Amended and Restated Credit and Guaranty Agreement, dated as of August 11, 2014, 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 (Delaware), Inc. and Cura Partners, LLC, as borrowers, Addus HomeCare Corporation, the other credit parties from time to a time a party thereto, the various institutions from time to time a party thereto, as lenders, and Fifth Third Bank as agent and L/C issuer (filed on August 11, 2014 as Exhibit 10.1 to Addus HomeCare Corporation s Quarterly Report on Form 10-Q and incorporated by reference herein).
10.37	Amendment No 1. to Amended and Restated Credit and Guaranty Agreement, dated as of November 6, 2014 and effective as of September 30, 2014, 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., PHC Acquisition Corporation, Professional Reliable Nursing Service, Inc., Addus HealthCare (South Carolina), Inc., Addus HealthCare (Delaware), Inc. and Cura Partners, LLC, as borrowers, Addus HomeCare Corporation, the other credit parties from time to time a party thereto, the various institutions from time to time a party thereto, as lenders, and Fifth Third Bank as agent and L/C issuer (filed on November 7, 2014 as Exhibit 10.2 to Addus HomeCare Corporation s Quarterly Report on Form 10-Q and incorporated by reference herein).

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Exhibit Number	Description of Document
10.38	Employment and Non-Competition Agreement, effective December 15, 2014, by and between Addus HealthCare, Inc. and Maxine Hochhauser (filed on December 15, 2014 as Exhibit 99.1 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein).
10.39	Amendment to Employment and Non-Competition Agreement, effective December 15, 2014, by and between Addus HealthCare, Inc. and Darby Anderson (filed on December 15, 2014 as Exhibit 99.2 to Addus HomeCare Corporation s Current Report on Form 8-K and incorporated by reference herein).
21.1	Subsidiaries of Addus HomeCare Corporation*
23.1	Consent of BDO USA, LLP, Independent Registered Public Accounting Firm*
31.1	Certification of Chief Executive Officer Pursuant to Rule 13-14(a) of the Securities Exchange Act of 1934 as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
31.2	Certification of Chief Financial Officer Pursuant to Rule 13-14(a) of the Securities Exchange Act of 1934 as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
32.1	Certification of Chief Executive Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002**
32.2	Certification of Chief Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002**
101	The following materials from Addus HomeCare Corporation s Annual Report on Form 10-K for the years ended December 31, 2014, formatted in Extensive Business Reporting Language (XBRL), (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Income, (iii) Consolidated Statements of Stockholders Equity, (iv) Consolidated Statements of Cash Flows, and (v) the Notes to the Consolidated Financial Statements.*

* Filed herewith
** Furnished herewith