ALANCO TECHNOLOGIES INC
Form 8-K
July 05, 2016

SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 8-K

CURRENT REPORT

Pursuant to Section 13 or 15(d) of
The Securities Exchange Act of 1934

July 5, 2016

(Date of Report)

ALANCO TECHNOLOGIES, INC.

(Exact name of Registrant as specified in its charter)

0-9437

(Commission File No.)

ARIZONA	86-0220694
(State or other jurisdiction)	(IRS Employer Identification No.)

7950 E. ACOMA DRIVE, SUITE 111, SCOTTSDALE, ARIZONA 85260

(Address of Principal Executive Office) (Zip Code)

(480) 607-1010

(Registrant's telephone number, including area code)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions (see General Instruction A.2. below):

( ) Written communication pursuant to Rule 425 under the Securities Act

(17 CFR 230.425)

( ) Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

( ) Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

( ) Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Item 1.01 Entry into a Material Definitive Agreement
Item 2.03 Creation of a Direct Financial Obligation

On June 28, 2016, the Company executed a Loan Agreement with a $500,000 credit limit with the Anderson Family Trust, an entity controlled by Mr. Donald Anderson, a former director and longtime support of the Company.

Item 9.01 Financial Statement and Exhibits

99.1 Press Release dated July 5, 2016
99.2 Loan Agreement

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

Alanco Technologies, Inc.

By: /s/ John A. Carlson
Name: John A. Carlson
Title: Director, President & Chief Executive Officer

Date: July 5, 2016

man" SIZE="2">

our compliance with health care laws and regulations;

our compliance with Securities and Exchange Commission laws and regulations and Sarbanes-Oxley requirements;

the impact of federal and state government regulation on our business; and

the impact of changes in our future interpretations of fraud, anti-kickback or other laws.

The forward-looking statements contained in this report reflect our current views about future events and are based on assumptions and are subject to known and unknown risks and uncertainties. Many important factors could cause actual results or achievements to differ materially from any future results or achievements expressed in or implied by our forward-looking statements. Many of the factors that will determine future events or achievements are beyond our ability to control or predict. Important factors that could cause actual results or achievements to differ materially from the results or achievements reflected in our forward-looking statements include, among other things, the factors discussed in the Part II, Item 1A. Risk Factors, included in this report and in other of our filings with the SEC, including our annual report on Form 10-K for the year ended December 31, 2011. This report should be read in conjunction with that annual report on Form 10-K, and all our other filings, including quarterly reports on Form 10-Q and current reports on Form 8-K made with the SEC through the date of this report.

You should read this report, the information incorporated by reference into this report and the documents filed as exhibits to this report completely and with the understanding that our actual future results or achievements may be materially different from what we expect or anticipate.

Table of Contents

The forward-looking statements contained in this report reflect our views and assumptions only as of the date this report is signed. Except as required by law, we assume no responsibility for updating any forward-looking statements.

We qualify all of our forward-looking statements by these cautionary statements. In addition, with respect to all of our forward-looking statements, we claim the protection of the safe harbor for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995.

Unless the context otherwise requires, we, us, our, and the Company refer to LHC Group, Inc. and its consolidated subsidiaries.

OVERVIEW

We provide post-acute health care services by providing quality cost-effective health care services to our patients. As of March 31, 2012, we had 298 service providers in 19 states: Alabama, Arkansas, Georgia, Florida, Idaho, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia, Washington and West Virginia. Our services are classified into two segments: (1) home-based services offered through our home nursing agencies and hospices; and (2) facility-based services offered through our long-term acute care hospitals (LTACHs).

Through our home-based services segment we offer a wide range of services, including skilled nursing, private duty nursing, medically-oriented social services, hospice care and physical, occupational and speech therapy. As of March 31, 2012, the home-based services segment was comprised of the following:

Type of Service	Locations
Home Health	246
Hospice	32
Private Duty	4
Specialty Services	3
Management Companies	2
	287

Of our 287 home-based services locations, 152 are wholly-owned by us, 126 are majority-owned by us through joint ventures, 7 are license lease arrangements and we manage the operations of the remaining two locations. We intend to increase the number of home nursing agencies and hospice locations that we operate through continued acquisitions and development.

We provide facility-based services through our LTACHs. As of March 31, 2012, we owned and operated nine LTACH locations, of which all but one are located within host hospitals. We also owned and operated a health club and a pharmacy. Of these 11 facility-based services locations, six are wholly-owned by us and five are majority-owned through joint ventures.

The percentage of net service revenue contributed from each reporting segment for the three months ended March 31, 2012 and 2011 was as follows:

	Three Months Ended March 31,	
	2012	2011
Home-based services	87.9%	87.6%
Facility-based services	12.1%	12.4%
	100.0%	100.0%

19

Table of Contents

Recent Developments

Home-based services

Home Nursing. The base payment rate for Medicare home nursing in 2012 is $2,138.52 per 60-day episode.

In March 2010, the Patient Protection and Affordable Care Act was enacted and was amended shortly afterwards by the Health Care and Education Affordability Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). The Affordable Care Act makes a number of changes to Medicare payment rates, including the reinstatement of the 3% home health rural add-on, which began on April 1, 2010 (expiring January 1, 2016). Other changes from the Affordable Care Act that began on or after January 1, 2011 are:

- a reduction in the market basket adjustment to be determined by The Centers for Medicare & Medicaid Services (CMS) for the calendar years 2011, 2012 and 2013 by 1%;
- a full productivity adjustment beginning in 2015; and
- rebasing of the base payment rate for Medicare beginning in 2014 and phasing in over a four year period the amount of the rebasing is uncertain at this time.

On October 31, 2011, CMS issued the final rule covering payment rates for home health services in CY 2012. CMS set the base payment rate for Medicare home nursing at $2,138.52 per 60-day episode for CY 2012, a decrease of 2.4% from the CY 2011 base payment rate of $2,192.07. The decrease for CY 2012 includes the following adjustments to the base rate, as compared to the CY 2011 base rate, in accordance with the Affordable Care Act: a reduction of 1% to the 2.4% inflation update increase to the market basket; and a 3.79% case-mix weight adjustment decrease. These changes are effective for all episodes completed during 2012.

The case-mix coding adjustment reduced HH PPS rates 3.79 percent for CY 2012 and an additional 1.32 percent reduction for CY 2013.

This rule also finalizes structural changes to the HH PPS by removing two hypertension codes from the case-mix system, lowering payments for high therapy episodes, and recalibrating the HH PPS case-mix weights to ensure that these changes result in the same amount of total aggregate payments.

Under current Medicare policy, a certifying physician or an allowed non-physician practitioner must see a patient prior to certifying a patient as eligible for the home health benefit. The rule also finalizes added flexibility to allow physicians who cared for the patient in an acute or post-acute facility to inform the certifying physician of their encounters with the patient in order to satisfy the requirement.

Hospice. The following table shows the hospice Medicare payment rates for Fiscal Year (FY) 2012, which began on October 1, 2011 and ends September 30, 2012:

Description	Rate per patient day
Routine Home Care	$ 151.03
Continuous Home Care	$ 881.46
Full Rate = 24 hours of care $36.73 = hourly rate	
Inpatient Respite Care	$ 156.22
General Inpatient Care	$ 671.84

On July 29, 2011, CMS issued its final rule for hospice for FY 2012 which increases Medicare reimbursement payments by 2.5%. The 2.5% increase consists of a 3.0% inflationary market basket update offset by a 0.5% reduction for the third year of CMS seven-year phase-out of its wage index budget neutrality adjustment factor. The final rule also will:

Change the way CMS counts hospice patients for the 2012 cap accounting year and beyond. The final policy for counting the number of Medicare hospice beneficiaries in care for a given cap year calculates the cap based on the number of days of care the patient received in that cap year for each hospice. This rule also finalized that the new counting method be applied to past cap years in certain instances.

Table of Contents

Allow hospice providers who do not want a change in their patient counting method to elect to continue using the current method.

Allow any hospice physician to perform the face-to-face encounter regardless of whether that same physician recertifies the patient s terminal illness and composes the recertification narrative.

Implement a hospice quality reporting program, which includes a timeframe for reporting, as required by section 3004 of the Affordable Care Act. The measures that are being adopted in this final rule for the FY 2014 program are one measure endorsed by the National Quality Forum related to pain management and one structural measure that assesses whether a hospice administers a Quality Assessment and Performance Improvement (QAPI) program that contains at least three indicators related to patient care.

Facility-based services.

LTACHs. On August 1, 2011, CMS released its rule for LTACH Medicare reimbursement for FY 2012, which spans from October 1, 2011 through September 30, 2012. In aggregate, payments for FY 2012 will increase 2.5% from FY 2011. Included in the final regulations is (1) a 2.9% market basket increase to the standard payment rate; (2) an aggregate reduction in the standard payment rate of 1.1% mandated by the Affordable Care Act; and (3) a reduction in the high cost outlier threshold per discharge from $18,785 in FY 2011 to $17,931 in FY 2012. The final rule would result in a 1.8% increase in average Medicare payments to LTACHs. Some of the other changes in the final rule include:

Three quality measures to begin reporting October 1, 2012 and will affect payment in FY 2014.

Clarification that the 25-day ALOS calculation includes both traditional Medicare Fee-For-Service and Medicare Advantage stays but this calculation will begin January 1, 2012.

On April 24, 2012 CMS released its proposed rule for LTACH Medicare reimbursement for FY 2013 which spans from October 1, 2012 through September 30, 2013. In aggregate, payments for FY 2013 will increase by 1.9 percent in under the proposed rule. CMS is proposing an annual update to LTACH payment rates of 2.1 percent. In addition to this update for inflation (adjusted as required by the statute), the 2.1 percent update to LTACH payment rates will be reduced by approximately 1.3 percent to 0.8 percent for the one-time budget neutrality adjustment for discharges on or after December 29, 2012.

In the Medicare, Medicaid, and SCHIP Extension Act of 2007, Congress imposed a three-year moratorium that prevented CMS from implementing certain payment policies affecting LTACHs. At the same time, the law imposed a moratorium on establishing new LTACHs and LTACH satellite facilities and on increasing the number of patient beds in existing LTACHs, unless an exception applied. The moratorium was extended for two years in the Affordable Care Act of 2010. The moratorium will, therefore, expire at various times in 2012.

In the FY 2013 rule, CMS is proposing:

* A one-year extension of the existing moratorium on the 25 percent threshold policy, pending results of an on-going research initiative to re-define the role of LTACHs in the Medicare program.

* To apply an approximate 1.3 percent reduction (first year of a proposed three-year phase-in) for a one-time prospective budget neutrality adjustment. The proposed reduction would not apply to discharges occurring on or before December 28, 2012, because the law prohibits its application before that date. The budget neutrality adjustment reduces the update from 2.1 percent to 0.8 percent for discharges on or after December 29, 2012.

* To reduce Medicare payments for very short stay cases in LTACHs to the IPPS comparable per diem amount payment option for discharges occurring on or after December 29, 2012. The law prohibits application of this policy prior to that date.

The legislative moratorium on new LTACHs and satellite facilities will expire at the end of 2012.

Table of Contents

RESULTS OF OPERATIONS

Three months ended March 31, 2012

Consolidated financial statements

The following table summarizes our consolidated results of operations for the three months ended March 31, 2012 and 2011 (amounts in thousands) except percents which are percents of consolidated net service revenue unless indicated otherwise:

	2012		2011		Increase (Decrease)	Percentage Change
Net service revenue	$ 158,761		$ 161,783		(3,022)	(1.9%)
Cost of service revenue	89,859	56.6%	88,956	55.0%	903	1.0%
General and administrative expenses	50,882	32.0%	55,040	34.0%	(4,158)	(7.6%)
Provision for bad debt	2,761	1.7%	2,562	1.6%	199	7.8%
Income tax expense	5,226	40.3%(1)	5,161	40.1%(1)	65	1.3%
Noncontrolling interest	1,998		2,448		(450)	
Total non-operating income (loss)	(294)		78		(372)	
Net income attributable to LHC Group, Inc.	$ 7,741		$ 7,694		47	

(1) Percentage of income from continuing operations attributable to LHC Group, Inc.

Home-based services segment operating results

The following table summarizes our home-based results of operations for the three months ended March 31, 2012 and 2011 (amounts in thousands) expect percents which are percentages of home-based net service revenue:

	2012		2011		Increase (Decrease)	Percentage Change
Net service revenue	$ 139,595		$ 141,801		(2,206)	(1.6%)
Cost of service revenue	79,061	56.6%	77,089	54.4%	1,972	2.6%
General and administrative expenses	45,226	32.4%	50,063	35.3%	(4,837)	(9.7%)
Provision for bad debt	2,623	1.9%	2,408	1.7%	215	8.9%
Operating income	$ 12,685		$ 12,241			

Net service revenue

The following table sets forth as of March 31, 2012 home-based services revenue growth and home health agencies percentages for organic and total growth and the related change from the same period in 2011 (in thousands except census and episode data).

	Same Store(1)	De Novo(2)	Organic(3)	Organic Growth (Loss) %	Acquired(4)	Total	Total Growth (Loss) %
Revenue	$ 137,811	$ 217	$ 138,028	(2.4)%	$ 1,567	$ 139,595	(1.6)%
Medicare Revenue	$ 107,943	$ 158	$ 108,101	(5.2)%	$ 1,462	$ 109,563	(4.1)%
New Admissions	27,430	20	27,450	5.6%	246	27,696	5.7%

New Medicare Admissions	18,856	18	18,874	2.1%	172	19,046	2.5%
Average Census	32,250	31	32,281	(6.0)%	327	32,608	(5.4)%
Average Medicare Census	24,414	17	24,431	(7.7)%	258	24,689	(7.1)%
Episodes	40,990	10	41,000	(2.4)%	287	41,287	(1.9)%

(1) Same store location that has been in service with the Company for greater than 12 months.
(2) De Novo internally developed location that has been in service with the Company for 12 months or less.

Table of Contents

(3) Organic combination of same store and de novo.
(4) Acquired purchased location that has been in service with the Company for 12 months or less.
Total organic home-based revenue for the three months ended March 31, 2012 decreased 2.4% compared to the three months ended March 31, 2011, while organic Medicare revenue decreased 5.2%. The primary cause for the decrease in organic revenue in the home-based segment was the decrease in census and episodes.

Although new admissions and new Medicare admissions increased in the first quarter of 2012 compared to last year, they occurred later in the quarter. As a result, average home health patient census for the three months ended March 31, 2012 was 5.4% lower than the March quarter last year, which resulted in lower revenue in the segment.

Total home health admissions increased 5.7% to 27,696 during the current period, compared to 26,194 for the same period in 2011.

Organic growth is generated by population growth in areas covered by mature agencies, agencies five years old or older, and by increased market share in acquired and developing agencies. Historically, acquired agencies have the highest growth in admissions and average census in the first 24 months after acquisition, and have the highest contribution to organic growth, measured as a percentage, in the second full year of operation after the acquisition.

Cost of service revenue

The following table summarizes home-based services cost of service revenue (amounts in thousands):

	Three Months Ended March 31,			
	2012		**2011**	
Salaries, wages and benefits	$ 68,660	49.2%(1)	$ 67,029	47.3%(1)
Transportation	5,909	4.2%	5,480	3.9%
Supplies and services	4,492	3.2%	4,580	3.2%
	$ 79,061	56.6%	$ 77,089	54.4%

(1) Percentage of home-based net service revenue
Salaries, wages and benefits increased during the three months ended March 31, 2012 compared to the same period last year. The increase was primarily due to an increase in employee positions, an increase in incentives related to productivity and an increase in related payroll tax benefits. Transportation increased during the three months ended March 31, 2012 compared to the same period last year due to the increase in mileage reimbursement rates.

General and administrative expenses

General and administrative expenses decreased during the three months ended March 31, 2012 compared to the same period last year. The decrease was primarily due to elimination of salaries and benefits, consulting, travel and hotel costs incurred last year related to the conversion of our point of care platform. We accelerated this transition in order to replace the legacy billing systems which remained from previous acquisitions. The accelerated transition was completed in the first quarter last year. In addition, there were fewer acquisitions and lower acquisition related costs in the March 2012 quarter. Finally, cost reduction initiatives begun last year reduced personnel costs and other corporate costs in the March 2012 quarter compared to last year.

Table of Contents

Facility-based Services Segment Operating Results

The following table summarizes our facility-based results of operations for the three months ended March 31, 2012 and 2011 (amounts in thousands):

	2012		2011		Increase (Decrease)	Percentage Change
Net service revenue	$ 19,166		$ 19,982		(816)	(4.1%)
Cost of service revenue	10,798	56.3%(1)	11,867	59.4%(1)	(1,069)	(9.0%)
General and administrative expenses	5,656	29.5%(1)	4,977	24.9%(1)	679	13.6%
Provision for bad debt	138	0.7%(1)	154	0.8%(1)	(16)	(10.4%)
Operating income	$ 2,574		$ 2,984			

(1) Percentage of facility-based net service revenue

Net service revenue decreased during the three months ended March 31, 2012 compared to the same period last year. The decrease was primarily due to a reduction in pharmacy revenue related to a third party contract.

Cost of service revenue

The following table summarizes facility-based services cost of service revenue (amounts in thousands):

	Three Months Ended March 31,			
	2012		2011	
Salaries, wages and benefits	$ 6,879	35.9%(1)	$ 6,782	33.9%(1)
Transportation	55	0.3%	37	0.2%
Supplies and services	3,864	20.1%	5,048	25.3%
	$ 10,798	56.3%	$ 11,867	59.4%

(1) Percentage of facility-based net service revenue

Salaries, wages and benefits increased during the three months ended March 31, 2012 compared to the same period last year. This increase was primarily due to an increase in contract labor. In addition, net service revenue was reduced by the loss of a third party contract causing cost of service revenue as a percentage of net service revenue to increase.

Supplies and services decreased during the three months ended March 31, 2012 compared to the same period last year. This decrease was primarily due to the decrease in pharmaceutical supplies related to patient care.

LIQUIDITY AND CAPITAL RESOURCES

Liquidity

Our principal source of liquidity for operating activities is the collection of patient accounts receivable, most of which are collected from governmental and third party commercial payors. We also have the ability to obtain additional liquidity, if necessary, through our revolving credit facility, which provides for aggregate borrowings up to $75.0 million.

24

Table of Contents

Our reported cash flows from operating activities are affected by various external and internal factors, including the following:

Operating Results Our net income has a significant effect on our operating cash flows. Any significant increase or decrease in our net income could have a material effect on our operating cash flows.

Timing of Acquisitions We use our operating cash flows for acquisitions. When the acquisitions occur at or near the end of a period, our cash outflows significantly increase.

Timing of Payroll Our employees are paid bi-weekly on Fridays; therefore, operating cash flows decline in reporting periods that end on a Friday.

Medical Insurance Plan Funding We are self-funded for medical insurance purposes. Any significant changes in the amount of insurance claims submitted could have a direct effect on our operating cash flows.

Medical Supplies A significant expense associated with our business is the cost of medical supplies. Any increase in the cost of medical supplies, or in the use of medical supplies by our patients, could have a material effect on our operating cash flows.

The following table summarizes changes in cash (amounts in thousands):

	Three Months Ended March 31,	
	2012	**2011**
Cash provided by operating activities	$ 25,585	$ 18,337
Cash (used in) investing activities	(2,860)	(14,385)
Cash (used in) financing activities	(22,640)	(3,852)
Change in cash	85	100
Cash and cash equivalents at beginning of period	256	288
Cash and cash equivalents at end of period	$ 341	$ 388

During the first quarter of 2012, we recovered federal income tax payments and utilized tax operating losses to provide $17.5 million cash from operations. This was offset in part by changes in other current assets and liabilities.

Cash used in investing activities in the first quarter of 2012 was lower than last year due to lower acquisition activity. Additionally, in the first quarter last year we paid approximately $3.0 million related to software conversion of our general ledger, purchasing and payable and point of care initiatives.

Cash used in financing activities was primarily the net repayment of our line of credit.

Accounts Receivable and Allowance for Uncollectible Accounts

At March 31, 2012, our allowance for uncollectible accounts, as a percentage of patient accounts receivable, was approximately 11.1%, or $11.5 million, compared to 10.5% or $10.7 million at December 31, 2011. Days sales outstanding as of March 31, 2012 and December 31, 2011 were each 53 days. Our calculation of days sales outstanding is derived by dividing our ending net patient accounts receivable (i.e., net of estimated revenue adjustments and allowance for doubtful accounts) at March 31, 2012 and December 31, 2011 by our average daily net patient revenues for the three month periods ended March 31, 2012 and December 31, 2011, respectively.

25

Table of Contents

The following table sets forth as of March 31, 2012, the aging of accounts receivable (based on the end of episode date) and the total allowance for uncollectible accounts expressed as a percentage of the related aged accounts receivable (amounts in thousands):

	0-90	91-180	181-365	Over 365	Total
Payor					
Medicare	$ 47,485	$ 9,896	$ 5,020	$ 1,125	$ 63,526
Medicaid	2,756	981	588	229	4,554
Other	21,046	7,113	5,516	1,679	35,354
Total	$ 71,287	$ 17,990	$ 11,124	$ 3,033	$ 103,434
Allowance as a percentage of receivables	3.4%	7.5%	24.1%	100.0%	11.1%

For home-based services, we calculate the allowance for uncollectible accounts as a percentage of total patient receivables. The percentage changes depending on the payor and increases as the patient receivables age. For facility-based services, we calculate the allowance for uncollectible accounts based on a claim by claim review. As a result, the allowance percentages presented in the table above vary between the aging categories because of the mix of claims in each category.

The following table sets forth as of December 31, 2011, the aging of accounts receivable (based on the end of episode date) and the total allowance for uncollectible accounts expressed as a percentage of the related aged accounts receivable (amounts in thousands):

Payor	0-90	91-180	181-365	Over 365	Total
Medicare	$ 48,656	$ 10,358	$ 6,732	$ 1,110	$ 66,856
Medicaid	2,609	770	642	160	4,181
Other	18,346	5,425	5,860	1,240	30,871
Total	$ 69,611	$ 16,553	$ 13,234	$ 2,510	$ 101,908
Allowance as a percentage of receivables	3.7%	9.9%	30.0%	98.8%	10.5%

Indebtedness

As of March 31, 2012 we had $14.2 million drawn and a letter of credit totaling $5.7 million outstanding and $55.1 million available under our line of credit. At December 31, 2011, $34.8 million was drawn and a letter of credit totaling $3.8 million was outstanding on the line of credit.

Our Credit Facility with Capital One, National Association provides for a maximum aggregate principal borrowing of $75 million. The Credit Facility, which is scheduled to expire on October 12, 2013, is unsecured and has a letter of credit sublimit of $7.5 million. The commitment fee is 0.50% of the total availability. An additional fee of 0.375% is charged for any unused amounts. The interest rate for the borrowings under the Credit Agreement, at the election of us, shall be either at the Base Rate (as defined in the Credit Agreement) as a function of the prime rate or the Eurodollar Rate (as defined in the Credit Agreement). Borrowings accruing interest under the Credit Agreement at either the Base Rate or the Eurodollar Rate are subject to the applicable margins set forth below:

Leverage Ratio	Eurodollar Margin	Base Rate Margin
<1.00:1.00	2.25%	1.00%
≥1.00:1.00<1.50:1.00	2.50%	1.25%
≥1.50:1.00<2.00:1.00	2.75%	1.50%

Our Credit Facility contains customary affirmative, negative and financial covenants. For example, we are restricted in incurring additional debt, disposing of assets, making investments, allowing fundamental changes to our business or organization, and making certain payments in respect of stock or other ownership interests, such

26

Table of Contents

as dividends and stock repurchases, up to 2.0 million shares. Under the Credit Facility, we are also required to meet certain financial covenants with respect to minimum fixed charge coverage, consolidated net worth and leverage ratios.

Our Credit Facility also contains customary events of default. These include bankruptcy and other insolvency events, cross-defaults to other debt agreements, a change in control involving us or any subsidiary guarantor, and the failure to comply with certain covenants.

At March 31, 2012, we believe the Company was in compliance with all covenants.

Contingencies

For a discussion of contingencies, see Item 1, Notes to Condensed Consolidated Financial Statements Note 7 Commitments and Contingencies of this Form 10-Q.

Off-Balance Sheet Arrangements

We do not currently have any off-balance sheet arrangements with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. In addition, we do not engage in trading activities involving non-exchange traded contracts. As such, we are not materially exposed to any financing, liquidity, market or credit risk that could arise if we had engaged in these relationships.

Critical Accounting Policies

For a discussion of critical accounting policies, see Item 1, Notes to Condensed Consolidated Financial Statements Note 2 Significant Accounting Policies of this Form 10-Q.

Revenue Recognition

We report net service revenue at the estimated net realizable amount due from Medicare, Medicaid, commercial insurance, managed care payors, patients and others for services rendered.

Medicare

Home-Based Services

Home Nursing Services. We are reimbursed by Medicare for delivering care over a 60-day period referred to as an episode. We recognize revenue based on the number of days elapsed during an episode of care within the appropriate reporting period.

A portion of the estimated Medicare prospective payment system reimbursement from each submitted home nursing episode is received in the form of a request for anticipated payment (RAP). We submit a RAP for 60% of the estimated reimbursement for the initial episode at the start of care. The full amount of the episode is billed after the episode has been completed. Final payments from Medicare may reflect one of four retroactive adjustments to ensure the adequacy and effectiveness of the total reimbursement: (a) an outlier payment if the patient s care was unusually costly; (b) a low utilization adjustment if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider before completing the episode; or (d) a payment adjustment based upon the level of therapy services required in the population base. We estimate all potential adjustments to an episode based on the best information available as the services are provided and prior to recognizing revenue or presenting the final bill. Therefore, historically, we have recorded little or no adjustments at the time payment is received. Although our estimates are based on historical experience using the best information available at the time we provide service, final payments could differ from our estimates.

Table of Contents

Hospice Services. We are paid by Medicare under a per diem payment system. We receive one of four predetermined daily or hourly rates based upon the level of care we furnished. We record net service revenue less provision for bad debts from hospice services based on the daily or hourly rate and recognize revenue as these hospice services are provided.

Hospice payments are also subject to an inpatient cap and an overall payment cap. The inpatient cap relates to individual programs receiving more than 20% of its total Medicare reimbursement from inpatient care services. The overall payment cap relates to individual programs receiving reimbursements in excess of a cap amount, which is calculated by multiplying the number of beneficiaries receiving services during the period by a statutory amount that is indexed for inflation. The determination for each cap is made annually based on the 12-month period ending on October 31 of each year. We monitor our limits on a provider-by-provider basis. While historically we have not exceeded these caps, our revenue could be affected if we exceed the cap limits in the future.

Facility-Based Services

Long-Term Acute Care Services. We are reimbursed by Medicare for services provided at our LTACHs based on a predetermined fixed amount intended to reflect the average cost of treating a Medicare patient. The actual amount reimbursed can be adjusted based on length of stay and facility-specific costs, as well as in instances where a patient is discharged and subsequently re-admitted. Similar to the home health Medicare reimbursement, we estimate the adjustment based on a historical average and record revenue considering such adjustment. Similar to other Medicare prospective payment systems, the rate is also adjusted for geographic wage differences. Revenue is recognized for our LTACHs as services are provided. Although our estimates are based on historical experience using the best information available at the time we provide service, final payments could differ from our estimates.

Medicaid, managed care and other payors

Medicaid reimbursement is based on a predetermined fee schedule applied to each service provided. Therefore, revenue is recognized for Medicaid services as the services are provided based on this fee schedule. Managed care payors reimburse us in a manner similar to either Medicare or Medicaid. Accordingly, we recognize revenue from managed care payors in the same manner as we recognize revenue from Medicare or Medicaid.

Accounts Receivable and Allowances for Uncollectible Accounts

We report accounts receivable net of estimated allowances for uncollectible accounts and adjustments. Accounts receivable are uncollateralized and primarily consist of amounts due from Medicare, other third-party payors, and patients. To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for uncollectible accounts to reduce the carrying amount of such receivables to their estimated net realizable value.

The collection of outstanding receivables is our primary source of cash collections and is critical to our operating performance. Because Medicare is our primary payor, the credit risk associated with receivables from other payors is limited. We believe the credit risk associated with our Medicare accounts, which represent 61.4% and 65.6% of our patient accounts receivable at March 31, 2012 and December 31, 2011, respectively, is limited due to (i) the historical collections from Medicare and (ii) the fact that Medicare is a U.S. government payor. We do not believe that there are any other significant concentrations of receivables from any particular payor that would subject it to any significant credit risk in the collection of accounts receivable.

The amount of the provision for bad debts is based upon our assessment of historical and expected net collections, business and economic conditions and trends in government reimbursement. Quarterly, we perform a detailed review of historical writeoffs and recoveries as well as recent collection trends. Uncollectible accounts are written off when we have exhausted collection efforts and concluded the account will not be collected.

Table of Contents

Although our estimated reserves for uncollectible accounts are based on historical experience and the most current collection trends, this process requires significant judgment and interpretation of the observed trends and the actual collections could differ from our estimates.

Insurance

We retain significant exposure for our employee health insurance, workers compensation, employment practices and professional liability insurance programs. Our insurance programs require us to estimate potential payments on filed claims and/or claims incurred but not reported. Our estimates are based on information provided by the third-party plan administrators, historical claim experience, expected costs of claims incurred but not paid and expected costs associated with settling claims. Each month we review the insurance-related recoveries and liabilities to determine if any adjustments are required.

Our employee health insurance program is self funded, with stop-loss coverage on claims that exceed $150,000 for any individual covered employee or employee family member. We are responsible for workers compensation claims up to $350,000 per individual incident.

Malpractice, employment practices and general patient liability claims for incidents which may give rise to litigation have been asserted against us by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. We are aware of incidents that have occurred through March 31, 2012 that may result in the assertion of additional claims. We currently carry professional, general liability and employment practices insurance coverage (on a claims made basis) for this exposure. We also carry D&O coverage (also on a claims made basis) for potential claims against our directors and officers, including securities actions, with a deductible of $500,000 per claim.

We estimate our liabilities related to these programs using the most current information available. As claims develop, we may need to change the recorded liabilities and change our estimates. These changes and adjustments could be material to our financial statements, results of operations and financial condition.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK.

As of March 31, 2012, we had cash of $341,000. The FDIC reinstated coverage on all non interest bearing checking accounts through December 31, 2012. All non interest bearing accounts are fully insured, regardless of the balance of the account.

Our exposure to market risk relates to changes in interest rates for borrowings under our Credit Facility. The Credit Facility is a revolving credit facility and, as such, we borrow, repay and re-borrow amounts as needed, changing the average daily balance outstanding under the facility. A hypothetical 100 basis point increase in interest rates on the average daily amounts outstanding under the Credit Facility would have increased interest expense $49,000 for the three months ended March 31, 2012.

ITEM 4. CONTROLS AND PROCEDURES.

Evaluation of Disclosure Controls and Procedures

We maintain disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) promulgated under the Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed in our reports filed under the Exchange Act, is recorded, processed, summarized and reported within the time periods specified in the SEC s rules and forms. Such information is also accumulated and communicated to management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure. Management of the Company, under the supervision and with the participation of the Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of the design and operation of the Company s disclosure controls and procedures as of the end of the period covered by this report.

Table of Contents

The Company s Chief Executive Officer and Chief Financial Officer concluded that the Company maintained effective disclosure controls and procedures at the reasonable assurance level as of March 31, 2012.

Changes in Internal Controls Over Financial Reporting

There have not been any changes in the Company s internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act, during the period ending March 31, 2012 that have materially affected, or are reasonably likely to materially affect, the Company s internal control over financial reporting.

Table of Contents

PART II OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS.
For a discussion of legal proceedings, see Item 1, Notes to Condensed Consolidated Financial Statements Note 7 Commitments and Contingencies of this Form 10-Q.

ITEM 1A. RISK FACTORS.
None

ITEM 2. UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS.
In October 2010, the Company s Board of Directors authorized a share repurchase program to repurchase shares of the Company s common stock, par value $0.01 per share, from time to time, in an amount not to exceed $50.0 million (Stock Repurchase Program). The Company anticipates that it will finance the Stock Repurchase Program with cash from general corporate funds, or draws under the Company s Credit Facility. The Company may repurchase shares of common stock in open market purchases or in privately negotiated transactions in accordance with applicable securities laws, rules and regulations. The timing and extent to which the Company repurchases its shares will depend upon market conditions and other corporate considerations. During the three months ended March 31, 2012, no amounts have been repurchased. The remaining dollar value of shares authorized to be purchased under the share repurchase program is $49.4 million at March 31, 2012.

ITEM 3. DEFAULTS UPON SENIOR SECURITIES.
None

ITEM 4. MINE SAFETY DISCLOSURES.
None

ITEM 5. OTHER INFORMATION.
None

Table of Contents

ITEM 6. EXHIBITS.

3.1	Certificate of Incorporation of LHC Group, Inc. (previously filed as an exhibit to the Form S-1/A (File No. 333-120792) on February 14, 2005).
3.2	Bylaws of LHC Group, Inc. as amended on December 31, 2007 (previously filed as Exhibit 3.1 to the Form 8-K on January 4, 2008).
4.1	Specimen Stock Certificate of LHC s Common Stock, par value $0.01 per share (previously filed as an exhibit to the Form S-1/A (File No. 333-120792) on February 14, 2005).
31.1	Certification of Keith G. Myers, Chief Executive Officer pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Peter J. Roman, Chief Financial Officer pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1*	Certification of Chief Executive Officer and Chief Financial Officer of LHC Group, Inc. pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Instance Document
101.SCH	XBRL Schema Document
101.CAL	XBRL Calculation Linkbase Document
101.DEF	XBRL Definition Linkbase Document
101.LAB	XBRL Label Linkbase Document
101.PRE	XBRL Presentation Linkbase Document

Attached as Exhibit 101 to this report are documents formatted in XBRL (Extensible Business Reporting Language). Users of this data are advised pursuant to Rule 406T of Regulation S-T that the interactive data file is deemed not filed or part of a registration statement or prospectus for purposes of section 11 or 12 of the Securities Act of 1933, is deemed not filed for purposes of section 18 of the Securities Exchange Act of 1934, and otherwise not subject to liability under these sections. The financial information contained in the XBRL-related documents is unaudited and unreviewed.

* This exhibit is furnished to the SEC as an accompanying document and is not deemed to be filed for purposes of Section 18 of the Securities Exchange Act of 1934 or otherwise subject to the liabilities of that Section, and the document will not be deemed incorporated by reference into any filing under the Securities Act of 1933.

Table of Contents

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

LHC GROUP, INC.

Date: May 10, 2012

/s/ Peter J. Roman
Peter J. Roman
Executive Vice President and Chief Financial Officer

(Principal financial officer)