APRIA HEALTHCARE GROUP INC
Form 10-K
February 25, 2011
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE FISCAL YEAR ENDED DECEMBER 31, 2010**

OR

¨ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
Commission file number: 333-168159

APRIA HEALTHCARE GROUP INC.

(Exact name of registrant as specified in its charter)

DELAWARE	**33-0488566**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
26220 Enterprise Court	
Lake Forest, CA	**92630**
(Address of principal executive offices)	**(Zip Code)**

Registrant s telephone number, including area code: (949) 639-2000

Securities registered pursuant to Section 12(b) of the Act: NONE

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of 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 ¨
Non-accelerated filer x Smaller reporting company ¨
(Do not check if a 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 voting common stock held by non affiliates of the registrant as of June 30, 2010, the last business day of the registrant s most recently completed second fiscal quarter was zero.

As of February 25, 2011, there were 100 shares of the registrant s common stock par value $0.01 per share, issued and outstanding.

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CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

This annual report on Form 10-K includes forward-looking statements regarding, among other things, our plans, strategies and prospects, both business and financial. These statements are based on the beliefs and assumptions of our management. Although we believe that our plans, intentions and expectations reflected in or suggested by these forward-looking statements are reasonable, we cannot assure you that we will achieve or realize these plans, intentions or expectations. Forward-looking statements are inherently subject to risks, uncertainties and assumptions. Generally, statements that are not historical facts, including statements concerning our possible or assumed future actions, business strategies, events or results of operations, are forward-looking statements. These statements may be preceded by, followed by or include the words believes , expects , anticipates , intends , plans , estimates or similar expressions.

Forward-looking statements are not guarantees of performance. You should not put undue reliance on these statements. You should understand that various important factors, in addition to those discussed elsewhere in this annual report on Form 10-K, could affect our future results and could cause those results or other outcomes to differ materially from those expressed or implied in our forward-looking statements:

- trends and developments affecting the collectability of accounts receivable;
- government legislative and budget developments that could continue to affect reimbursement levels;
- potential reductions in reimbursement rates by government and third-party payors;
- the effectiveness of our operating systems and controls;
- healthcare reform and the effect of federal and state healthcare regulations;
- economic and political events, international conflicts and natural disasters;
- acquisition-related risks; and
- the items discussed under Risk Factors in this annual report on Form 10-K.

All forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by the foregoing cautionary statements. We undertake no obligations to update or revise publicly any forward-looking statements, whether as a result of new information, future events or otherwise.

As used in this report, unless otherwise noted or the context otherwise requires, references to Company, we, us, and our are to Apria Healthca Group Inc., a Delaware corporation, and its subsidiaries; references to Apria and the Issuer are to Apria Healthcare Group Inc., exclusive of its subsidiaries; references to Merger Sub are to Sky Merger Sub Corporation, a Delaware corporation; references to Holdings are to Apria Holdings LLC, a Delaware limited liability company, exclusive of its subsidiaries; references to Sky Acquisition are to Sky Acquisition LLC , a Delaware limited liability company, exclusive of its subsidiaries; references to Blackstone and the Sponsor are to Blackstone Capital Partners V L.P.; references to the Investor Group are, collectively, to Blackstone and certain funds affiliated with Blackstone, Dr. Norman C. Payson and certain other members of our management; and references to home medical equipment, durable medical equipment and DME are used synonymously. On October 28, 2008, the Company was acquired by private investment funds affiliated with the Sponsor via a merger of the Merger Sub with and into Apria (the Merger), with Apria being the surviving corporation following the Merger. As a result of the Merger, the Investment Group beneficially owns all of Apria s issued and outstanding common stock. The Merger and the related financing and refinancing transactions, including, but not limited to, the equity investment by the Sponsor, the borrowings under the Company s senior secured bridge credit agreement dated October 28, 2008 (the senior secured bridge credit agreement) and the use of proceeds therefrom, the offerings of $700.0

million of the Company s 11.25% Senior Secured Notes due 2014 (Series A-1) (the Series A-1 Notes) and $317.5 million of the Company s 12.375% Senior Secured Notes due 2014 (Series A-2) (the Series A-2 Notes), the repayment of all outstanding borrowings under the Company s senior secured bridge credit agreement, and the payment of related fees and expenses, are collectively referred to in this Annual Report as the Transactions. The term Successor refers to the Company following the Merger and the term Predecessor refers to the Company prior to the Merger.

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PART I

ITEM 1. BUSINESS

We are a quality, cost-efficient provider of home healthcare products and services in the United States, offering a comprehensive range of home respiratory therapy, home infusion therapy and home medical equipment services to over two million patients annually in all 50 states through approximately 500 locations. We hold market-leading positions across all of our major service lines making us a leader in the homecare market. By targeting the managed care segment of the population, we are better positioned than many of our competitors to minimize risks associated with changes in Medicare/Medicaid reimbursement rates. We are focused on being the industry s highest-quality provider of homecare services, while maintaining our commitment to being a low-cost operator. Our integrated product and service offerings, combined with our national scale and strong reputation, provide us with a strategic advantage in attracting clients, which include almost all of the national and regional managed care and government payors in the United States, and in retaining our referral base of more than 70,000 physicians, discharge planners, hospitals and third-party payors. For the years ended December 31, 2010 and 2009 our net revenues were $2.08 billion and $2.09 billion, respectively.

We have two operating segments, (1) home respiratory therapy and home medical equipment and (2) home infusion therapy. Within the two operating segments there are three core service lines: home respiratory therapy, home medical equipment and home infusion therapy. Through these service lines we provide patients with a variety of clinical and administrative support services and related products and supplies, most of which are prescribed by a physician as part of a care plan. We provide substantial benefits to both patients and payors by allowing patients to receive necessary care and services in the comfort of their own home while reducing the cost of treatment. Our services include:

- providing in-home clinical respiratory care, infusion nursing and pharmaceutical management services;
- educating patients and caregivers about health conditions or illnesses and providing written instructions about home safety, self-care and the proper use of equipment;
- monitoring patients individualized treatment plans;
- reporting patient progress and status to the physician and/or managed care organization;
- providing in-home delivery, set-up and maintenance of equipment and/or supplies; and
- processing claims to third-party payors and billing/collecting patient co-pays and deductibles.

Home Respiratory Therapy and Home Medical Equipment ($1,083.2 million and $1,169.6 million, or 52.1% and 55.8%, of our net revenues for the years ended December 31, 2010 and 2009, respectively)

Home Respiratory Therapy

We are the largest provider of home respiratory therapies in the United States to the managed care market serving approximately 1.4 million patients annually through our nationwide distribution platform that includes approximately 410 respiratory/HME locations. We offer a full range of home respiratory therapy products and services, from the simplest nebulizer and oxygen concentrator to the most complex ventilator. Our services offer a compelling relative cost advantage to our patients and payors. For example, in-home oxygen treatment costs for a Medicare patient are on average less than $7 per day. Patients utilize our products to treat a variety of conditions, including:

chronic obstructive pulmonary diseases (COPD), such as emphysema and chronic bronchitis (the fourth leading cause of death in the U.S.);

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respiratory conditions associated with nervous system disorders or injuries, such as Lou Gehrig s disease and quadriplegia;

congestive heart failure; and

lung cancer.

By focusing our efforts primarily on the managed care population, we limit our exposure to the highly-regulated Medicare respiratory business, which is subject to changes in coverage, payment and pricing guidelines. As an example, Medicare oxygen accounted for less than 10% of our total net revenues for each of the years ended December 31, 2010 and 2009.

We employ a nationwide clinical staff of more than 850 respiratory care professionals, including home respiratory therapists who provide direct patient care, monitoring and 24-hour support services under physician-directed treatment plans and in accordance with our proprietary acuity program. We derive revenues from the provision of oxygen systems, ventilators, respiratory assist devices, and Continuous Positive Airway Pressure (CPAP) and bi-level devices, as well as from the provision of infant apnea monitors, nebulizers, home-delivered respiratory medications and related services.

We are also the largest provider of sleep apnea devices, including CPAP/bi-level devices, and patient support services in the United States. The incidence and diagnosis of Obstructive Sleep Apnea (OSA) continues to increase in the United States. We believe that the strength of our position in this market is partly due to our significant presence in the managed care market, since OSA largely affects adults between the ages of 35 and 55 rather than the population served by Medicare. To manage our significant new and recurring patient volumes in a cost-effective, clinically sound manner, we developed an innovative care model called the CPAP Center at Apria Healthcare. This branch-based model allows Apria s respiratory care practitioners to educate, on a timely and efficient basis, newly-diagnosed patients about their condition, the equipment and accessories their physician has prescribed for them, and the long-term importance of complying with the physician s order. In addition, we operate a comprehensive patient compliance model to ensure that Medicare patients in particular adhere to their therapy according to their physician s prescription. The model includes both one-on-one patient education and teaching performed in group settings, as well as remote monitoring technologies.

Home Medical Equipment

As the leading provider of home medical equipment in the United States, we supply a wide range of products to help improve the quality of life for patients with special needs. Our integrated service approach allows patients, hospital and physician referral sources and managed care organizations accessing either our home respiratory or home infusion therapy services to also access needed home medical equipment through a single source. The use of home medical equipment provides a significant relative cost advantage to our patients and payors. For example, on average, it costs $50 per day to create an in-home hospital room versus approximately $1,500 per day for in-patient hospital care, according to the Centers for Medicare and Medicaid Services (CMS). Basic categories of equipment are:

manual wheelchairs and ambulatory equipment, such as canes, crutches and walkers;

hospital room equipment, such as hospital beds and bedside commodes;

bathroom equipment, such as bath and shower benches, elevated toilet seats and toilet, tub or wall grab bars;

phototherapy systems, such as blankets, wraps or treatment beds for babies with jaundice; and

support surfaces, such as pressure pads and mattresses, for patients at risk for developing pressure sores or decubitus ulcers.

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Another example of our ability to serve patients nationally who have varying clinical needs is our negative pressure wound therapy program (NPWT). NPWT is a topical treatment intended to promote healing in acute and chronic wounds affected by conditions including diabetes, arterial insufficiency and venous insufficiency. This service is offered primarily to managed care organizations and integrates well with our home infusion therapy and home medical equipment service segments.

Home Infusion Therapy ($997.5 million and $925.0 million, or 47.9% and 44.2%, of our net revenues for the years ended December 31, 2010 and 2009, respectively)

We are the leading provider of home infusion therapy services in the United States serving approximately 120,000 patients annually through 72 infusion pharmacy locations nationwide. We provide patients with intravenous and injectable medications and clinical services at home or in one of our 62 ambulatory infusion suites nationwide. We employ nursing clinicians who assess patients before their discharge from the hospital whenever possible, and then develop, in conjunction with the physician, a plan of care. Our home infusion products and services offer a compelling relative cost advantage to our patients and payors. For example, we believe that a home intravenous antibiotic program in a Medicare managed care plan costs significantly less than the cost to provide that service in a hospital setting.

Home infusion therapy is used to administer drugs and other therapeutic agents directly into the body through various types of catheters or tubing. Our services are frequently used to treat patients with infectious diseases, cancer, gastrointestinal diseases, chronic or acute pain syndromes, immune deficiencies, cardiovascular disease or chronic genetic diseases, and those who require therapies associated with bone marrow or solid organ transplantation. We employ licensed pharmacists and registered nurses who specialize in the delivery of home infusion therapy. They are able to respond to emergencies and questions regarding therapy 24 hours a day, seven days a week and provide initial and ongoing training and education to the patient and caregiver. Other support services include supply replenishment, pump management, preventive maintenance, assistance with insurance questions and outcome reporting.

We believe we are also a leading provider of enteral nutrition in the United States. Enteral nutrition, or tube feeding, is prescribed to patients whose gastrointestinal system is malfunctioning or who suffer from neurological conditions, swallowing disorders or malnutrition attributable to stroke, cancer or other conditions. We employ licensed dieticians who specialize in the provision of enteral nutrition service. In recent years, advances in enteral nutrition have enabled more adults and children to have their nutritional and caloric needs met by tube feeding, as opposed to more invasive and expensive therapies.

Recent Events

Acquisition of Praxair U.S. Home Healthcare Business On February 2, 2011, we, along with Praxair, Inc. and Praxair Healthcare Services, Inc. (collectively, Praxair), jointly announced that our wholly owned subsidiary, Apria Healthcare, Inc. (AHI) and Praxair have entered into a definitive asset purchase agreement whereby AHI will acquire the assets of Praxair s home healthcare services division in the United States. The transaction is expected to close during the first quarter of 2011. Assuming a March 31, 2011 closing date, this business is expected to contribute approximately $85 to $95 million to our revenue in 2011. This estimate and the acquired business s contribution in future periods will be subject to decreases as a result of the impact of Medicare competitive bidding and other factors.

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Industry Overview

The home healthcare market, which is estimated to generate revenues of approximately $72 billion in the United States in 2010, comprises a broad range of products and services including respiratory therapy, home infusion therapy, home medical equipment, home healthcare nursing, orthotics and prosthetics and general medical supplies and is expected to grow at a compounded annual growth rate of 5.5% from 2010 through 2015 according to 2010 IBISWorld Industry Report. Our industry is highly-fragmented and is served by more than 10,000 competitors.

We benefit from the following trends within the home healthcare market:

Favorable industry dynamics. Favorable demographic trends and the continued shift to in-home healthcare have resulted in patient volume growth in the United States and are expected to continue to drive growth. The CMS Office of the Actuary projects that the number of Medicare beneficiaries will, on average for the years 2011-2013, grow by 3.2% annually. As the baby boomer population ages and life expectancy increases, the elderly who comprise the vast majority of our patients will represent a higher percentage of the overall population. According to a 2008 U.S. Census Bureau projection, the U.S. population aged 55 and over is expected to grow at approximately twice the average rate of population growth from 76.5 million, or 25% of the population, in 2010 to 112 million, or 30% of the population, by 2030. An aging population, the continued prevalence of smoking, increasing obesity rates and higher diagnosis rates have collectively driven growth in the industry, despite certain per-unit payment reductions.

Compelling in-home economics. By 2017, the nation s healthcare spending is projected to increase to $4.3 trillion, growing at an average annual rate of 6.7%, according to CMS. The rising cost of healthcare has caused many payors to look for ways to contain costs and home healthcare is increasingly sought out as an attractive, cost-effective, clinically appropriate alternative to expensive facility-based care. For example, in-home oxygen treatment costs for a Medicare patient are on average less than $7 per day.

Increased prevalence of in-home treatments. Improved technology has resulted in a wider variety of treatments being administered in patients homes. These improvements have allowed for earlier patient discharge and have lengthened the portion of the recuperation period spent outside of an institutional setting. In addition, medical advancements have also made medical equipment more simple, adaptable and cost-effective for use in the home.

Preference for in-home care. Many patients prefer the convenience and typical cost advantages of home healthcare over institutional care as it provides patients with greater independence, increased responsibility and improved responsiveness to treatment. A December 2007 national telephone survey conducted by Harris Interactive found that over 82% of the respondents expressed a preference for homecare over institutional care, and that preference is even more prevalent among the age 55+ population (91%). The same poll found that 74% of adults surveyed agreed that homecare is part of the solution to the problem of rapidly increasing Medicare spending for seniors in the United States.

Development of new infused and injectable drugs. There is a significant number of new infusion or injectable drugs in the development pipeline. We believe this proliferation of medications, many of which are for chronic conditions that require long-term treatment, will drive further increases in home infusion therapy utilization and referrals to our ambulatory infusion suites.

Our Competitive Strengths

Leading Market Positions with a Compelling Value Proposition

With approximately 12,300 employees and a national distribution footprint of approximately 500 locations that serve patients in all 50 states, we are the largest provider of home healthcare services in the United States. We are the market leader in infusion therapy and sleep apnea services, the leading respiratory provider to the managed care market and the leading provider of home medical equipment. We believe that our national platform, comprehensive product line and leading reputation provide us with a greater opportunity than our competitors to attract more

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customers as our industry continues to grow. Our national presence and scale enables us to frequently obtain preferred provider status from other national and regional managed care payors, negotiate better terms with vendors and leverage our fixed overhead costs. For example, we are a preferred provider for a comprehensive list of home respiratory and medical equipment products and services to many managed care organizations and, for some of these payors, we are the exclusive provider. We believe we are better suited to service large managed care accounts due to our extensive branch network, state of the art logistics systems, respiratory and infusion clinical expertise, national coverage of payors members, competitive pricing, comprehensive product line, accreditation from The Joint Commission (the Commission), and our ability to connect electronically with payors systems. We have leveraged this competitive advantage to gain share in the managed care market.

The significant number of new infusion drugs in the pipeline and an increasing use of specialty infusion treatments will contribute to increased growth in the specialty infusion market over the next few years. We are well-positioned in the specialty infusion services market, and have aggressively established relationships with pharmaceutical and biotech companies to obtain early access to drugs in various stages of clinical trials. We believe there are other cross-selling opportunities and synergies to be achieved by offering a diverse mix of services. We also believe that an integrated approach allows us to offer patients, hospital and physician referral sources and managed care organizations a highly-valued single source for respiratory therapy, specialty home infusion and home medical equipment.

Diversified Product and Customer Mix

We have one of the most comprehensive product lines and diversified customer mixes among our peers. Our broad product offering has affirmed our status as a leading provider in each market and has made us a more attractive partner to referral sources and payors, as we provide a one-stop solution for homecare products and services.

We contract with a substantial majority of the national managed care organizations including United HealthCare Services, Aetna Health Management, Humana Health Plans and Kaiser Foundation Health Plan, as well as a large number of regional and local payors. All of our contracted managed care organizations combined service over 217 million people.

The Coram acquisition in December 2007 enabled us to simultaneously expand our product offering in specialty infused drugs and rebalance our payor mix by reducing our reliance on government payors such as Medicare and Medicaid while expanding relationships with managed care organizations. Managed care payors contributed approximately 70% and 72% of our net revenues for the years ended December 31, 2010 and 2009, respectively, with no single contract accounting for more than 8% of net revenues during the same periods.

Proven Ability to Execute Cost Savings

We have successfully implemented a number of operational efficiency initiatives historically, which have helped to reduce our costs and significantly offset ongoing Medicare reimbursement changes. In late 2007, we launched a substantial multi-year cost reduction plan across a number of identified initiatives presently targeting approximately $168 million in expected annual savings, of which we have cumulatively realized approximately $153 million through December 31, 2010.

Scalable and Diversified Platform for Home Healthcare Delivery

We currently provide service to more than two million patients through a national infrastructure that enables us to deliver services to patients in their homes. Through approximately 500 locations, we are able to deliver a wide variety of cost-effective products and services to various patient groups. We have successfully leveraged this distribution platform across a number of product and service offerings including CPAP/bi-level, enteral nutrition and NPWT devices, and we are using our nursing capacity to provide infusion services through our growing network of ambulatory infusion suites.

We historically supplied CPAP/bi-level devices to a large number of patients, but provided related accessories and supplies primarily on an as-needed basis. Patients who rely on CPAP and bi-level devices periodically require

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replacement accessories to ensure that they remain compliant to the therapy prescribed by their physician. These accessories include masks, tubing and supplies. Now in operation for over six years, a centralized customer care center for CPAP and bi-level patients provides support and information to patients so that they know what their payors cover in terms of replacement accessories and understand the health value of remaining compliant to their therapy over the long-term. Accessory net revenues were $142.0 million and $155.9 million and represented 47% and 47% of our total CPAP/bi-level net revenues for the years ended December 31, 2010 and 2009, respectively.

Our NPWT program is another example of our ability to leverage our infrastructure and expertise. Coordination of care is provided using the same service and systems platform as is used for the CPAP/bi-level direct marketing service program. The program has expanded geographically since its inception, primarily based on strong interest from managed care customers who would like to add our NPWT service to existing contracts we operate with them.

Experienced Management Team

We have a strong and experienced senior management team with over 200 years of combined experience spanning nearly every segment of the healthcare industry, including managed care, manufacturing, supply chain, procurement, home healthcare, acute care, skilled nursing and long-term care. With an average tenure of 22 years within the healthcare industry, this team possesses in-depth knowledge of our industry and the regulatory environment in which we operate, as well as our portfolio of home healthcare services.

Our Business Strategy

Our business strategy is to position ourselves in the marketplace as a high-quality provider of a broad range of healthcare services and patient care management programs to our customers. The specific elements of our strategy are to:

Grow profitable revenue and market share. We are focused on growing profitable revenues and increasing market share in our core home infusion therapy and home respiratory therapy service lines. We have undertaken a series of steps towards this end. Since our acquisition of Coram in December 2007, we have grown our revenue and patient census in this segment and expanded our platform for further cross-selling opportunities. Since January 1, 2007, we have expanded our home respiratory therapy and home medical equipment sales force by 51%. This focus has allowed us to more efficiently cover each market served by promoting our products and services to physicians, hospital discharge planners and managed care organizations.

Continue to participate in the managed care market. We participate in the managed care market as a long-term strategic customer group because we believe that our scale, expertise, nationwide presence and array of home healthcare products and services will enable us to sign preferred provider agreements with managed care organizations. Managed care represented approximately 70% of our total net revenues for the year ended December 31, 2010.

Leverage our national distribution infrastructure. With approximately 500 locations and a robust platform supporting shared national services, we believe that we can efficiently add products, services and patients to our systems to grow our revenues and leverage our cost structure. For example, we have successfully leveraged this distribution platform across a number of product and service offerings, including a continuous positive airway pressure (CPAP)/ bi-level supply replenishment program, enteral nutrition and negative pressure wound therapy (NPWT) services, and we are using our nursing capacity to provide infusion services through our growing network of ambulatory infusion suites. We seek to achieve margin improvements through operational initiatives focused on the continual reduction of costs and delivery of incremental efficiencies. At the same time, we believe that it is essential to consistently deliver superior customer service in order to increase referrals and retain existing patients. Performance improvement initiatives are underway in all aspects of our operations including customer service, patient satisfaction, logistics, supply chain, clinical services and billing/collections. We believe that by being responsive to the needs of our patients and payors we can provide ourselves with opportunities to take market share from our competitors.

Continue to lead the industry in accreditation. The Medicare Improvement for Patients Act of 2008 (MIPPA) made accreditation mandatory for Medicare providers of durable medical equipment,

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prosthetics, orthotics and supplies (DMEPOS), effective October 1, 2009, per Centers for Medicare and Medicaid Services (CMS) regulation. We were the first durable medical equipment provider to seek and obtain voluntary accreditation from The Joint Commission. In June 2010, we completed a nationwide independent triennial accreditation renewal process conducted by The Joint Commission and, the Commission renewed our accreditation for another three years. The Joint Commission accreditation encompasses our full complement of services including home health, home medical equipment, clinical respiratory, ambulatory infusion services, pharmacy dispensing, and clinical consultant pharmacist services. We have more than 19 years of continuous accreditation by The Joint Commission longer than any other homecare provider.

Execute our strategic initiatives to drive profitability. For the past several years, we have successfully engaged in a range of cost savings initiatives to ease pressure on our revenue that has been and continues to be caused by Medicare and Medicaid reimbursement changes. These initiatives are designed to improve customer service, delivery and vehicle routing services, streamline the billing and payment process, effectively manage purchasing costs and improve the overall experience of the patients we serve. We launched a substantial multi-year cost reduction plan in late 2007. To date, we have made significant progress across a number of the identified initiatives targeting expected annual savings of approximately $168 million, of which we realized approximately $153 million through December 31, 2010.

Service Lines

We have two operating segments, (1) home respiratory therapy and home medical equipment and (2) home infusion therapy. Within the two operating segments there are three core service lines: home respiratory therapy, home medical equipment and home infusion therapy. Through these service lines we provide patients with a variety of clinical and administrative support services and related products and supplies, most of which are prescribed by a physician as part of a care plan. We provide substantial benefits to both patients and payors by allowing patients to receive necessary care and services in the comfort of their own home while reducing the cost of treatment. Our services include:

providing in-home clinical respiratory care, infusion nursing and pharmaceutical management services;

educating patients and caregivers about health conditions or illnesses and providing written instructions about home safety, self-care and the proper use of equipment;

monitoring patients individualized treatment plans;

reporting patient progress and status to the physician and/or managed care organization;

providing in-home delivery, set-up and maintenance of equipment and/or supplies; and

processing claims to third-party payors and billing/collecting patient co-pays and deductibles.

The following table sets forth a summary of total net revenues by service line and segment, expressed as percentages of total net revenues:

	Year Ended December 31, 2010 (Successor)	Year Ended December 31, 2009 (Successor)	Period October 29, 2008 to December 31, 2008 (Successor)	Period January 1, 2008 to October 28, 2008 (Predecessor)
Home respiratory therapy	45%	48%	52%	52%

Home medical equipment	7	8	7	9
Total home respiratory and home medical equipment segment	52	56	59	61
Home infusion therapy segment	48	44	41	39
Total net revenues	100%	100%	100%	100%

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Organization and Operations

Organization. Our approximately 500 locations deliver home healthcare products and services to patients in their homes and to other care sites through our delivery fleet and our qualified delivery professionals and clinical employees. Our home respiratory therapy, home medical equipment and home infusion therapy service lines are organized into geographic divisions that provide management oversight.

Corporate Compliance. As a leader in the home healthcare industry, we have implemented a compliance program to further our commitment to providing quality home healthcare services and products while maintaining high standards of ethical and legal conduct. We believe that it is essential to operate our business with integrity and in full compliance with applicable regulations. Our Corporate Compliance Program includes a written Code of Ethical Business Conduct that employees receive as part of their initial orientation process. The program is designed to accomplish the goals described above through employee education, a confidential disclosure program, written policy guidelines, periodic reviews, frequent reinforcement, compliance audits, a formal disciplinary component and other programs. Compliance oversight is provided by the Corporate Compliance Committee, which meets quarterly and consists of senior and mid-level management personnel from various functional disciplines. In addition to updates provided to the Board of Directors during its regular meetings, a written Compliance Program Report is submitted annually to the Board for review and discussion.

Pursuant to the merger agreement to acquire Coram, we assumed Coram s obligations under its Certification of Compliance Agreement (the Compliance Agreement) with the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS). The Compliance Agreement, which became effective on August 22, 2007, obligated Coram to maintain a compliance program to monitor and ensure compliance with federal healthcare program requirements. Under the Compliance Agreement, Coram s compliance program was required to include maintenance of specified funding levels for the compliance program for at least three years following the date of the Compliance Agreement, prompt refunding of any overpayments, and implementation of various compliance program elements such as training, auditing and disclosure programs, development of a code of conduct and appointment of a compliance officer and compliance committee. Additionally, the Compliance Agreement required notification to the OIG of certain events and imposed an annual certification requirement on Coram. The Compliance Agreement provided for stipulated penalties for failure to comply with its provisions. After submitting our final report to the OIG (as required under the Compliance Agreement), the OIG issued a closure letter to us dated September 21, 2010 that stated that the Compliance Agreement has concluded to the satisfaction of the OIG. The Company, including its Coram division, will continue to implement an enterprise-wide corporate compliance program which is grounded in existing laws, rules and regulations and guidelines for healthcare organizations issued by the OIG.

Internal Audit. Our internal audit function reports directly to the Audit Committee of the Board of Directors and provides ongoing assessments of our system of disclosure controls and procedures, and internal control over financial reporting. Our internal audit function is responsible for both operational and financial reviews of our operations, for monitoring compliance with policies and procedures, for the identification and development of best practices within the organization.

Operating Systems and Controls. Our business is dependent, to a substantial degree, upon the quality of our operating and field information policies and procedures for proper contract administration, accurate order entry and pricing, billing and collections, and inventory and patient service equipment management. These policies and procedures also provide reporting that enables us to monitor and evaluate contract profitability. Our information services department works closely with all of the operating areas of our business to ensure that our policies and procedures are compliant with government regulations and payor requirements and to support their business improvement initiatives with technological solutions. See *Risk Factors Risks Relating to Our Business Our Failure to Successfully Design, Modify, and Implement Computer and Other Process Changes to Maximize Productivity and Ensure Compliance Could Ultimately Have a Significant Negative Impact on Our Results of Operations and Financial Condition*.

We have established performance indicators which measure operating results against expected thresholds for the purpose of allowing all levels of management to identify and modify areas requiring improvement and to monitor the resulting progress. We have also developed mechanisms for measuring and reporting patient and customer

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satisfaction. Operating models with strategic targets have been developed to move us toward more effective management of the sales, customer service, accounts receivable, clinical and distribution areas of our business. Our management team is compensated using performance-based incentives focused on certain specified criteria such as Adjusted EBITDA and adjusted free cash flow. See *Executive Compensation*.

Payors. We derive substantially all our revenues from third-party payors, including private insurers, managed care organizations, Medicare and Medicaid. For the year ended December 31, 2010, approximately 24% of our total net revenues were derived from Medicare and 6% from Medicaid. Generally, each third-party payor has specific requirements which must be met before claim submission will result in payment. Certain payor-related functions are now being administered by Intelenet Global Services Private Limited (Intelenet), an Indian company affiliated with the Sponsor. We have policies and procedures in place to manage the claims submission process, including verification procedures to facilitate complete and accurate documentation. Notwithstanding these measures, violations of these requirements may still occur and could result in the termination of a contract with a payor, the repayment of amounts previously received or other potentially significant liability. When the third party payor is a governmental entity, violations of these requirements could subject us to civil, administrative and criminal enforcement actions. From time to time, we engage in renegotiation, sometimes precipitated by a written or verbal termination notice, with payors with which we are contracted to provide our various products and services. See *Risk Factors Risks Relating to Our Business Continued Reductions in Medicare and Medicaid Reimbursement Rates and the Comprehensive Healthcare Reform Law Could Have a Material Adverse Effect on Our Results of Operations and Financial Condition, Risk Factors Risks Relating to Our Business Non-Compliance With Laws and Regulations Applicable to Our Business and Future Changes in Those Laws and Regulations Could Have a Material Adverse Effect on Us, Risk Factors Risks Relating to Our Business Our Outsourcing and Offshoring Activities Subject Us to Risks That Could Have a Significant Negative Impact on Our Results of Operations and Financial Condition, Risk Factors Risks Relating to Our Business Our Payor Contracts are Subject to Renegotiation or Termination Which Could Result in a Decrease in Our Revenue and Profits and Certain Relationships and Related Party Transactions Intelenet Agreement*.

Receivables Management. We operate in an environment with complex requirements governing billing and reimbursement for our products and services. We have initiatives focused specifically on receivables management such as system enhancements, process refinements and organizational changes have resulted in improvement and consistency in key accounts receivable indicators.

We are expanding our use of technology in areas such as electronic claims submission and electronic funds transfer with managed care organizations to more efficiently process business transactions. This use of technology can expedite claims processing and reduce the administrative cost associated with this activity for both us and our customers/payors. We now submit approximately 94% of our home respiratory and home medical equipment claims and approximately 75% of our home infusion therapy claims electronically. We are also focusing our resources on developing internal expertise with the unique reimbursement requirements of certain large third-party payors, which may help to reduce subsequent denials and shorten related collection periods. Our policy is to collect co-payments from the patient or applicable secondary payor. In the absence of a secondary payor, we generally require the co-payment at the time the patient is initially established with the product/service. Subsequent months co-payments are billed to the patient. We are also seeking to streamline related processes in order to improve the co-payment collection rate. Certain accounts receivable administrative functions are now being administered by Intelenet. We have established policies and procedures for Intelenet to perform effectively on our behalf. See *Risk Factors Risks Relating to Our Business Our Outsourcing and Offshoring Activities Subject Us to Risks That Could Have a Significant Negative Impact on Our Results of Operations and Financial Condition, Risk Factors Risks Relating to Our Business Our Failure to Maintain Controls and Processes Over Billing and Collections or the Deterioration of the Financial Condition of Our Payors Could Have a Significant Negative Impact on Our Results of Operations and Financial Condition and Certain Relationships and Related Party Transactions Intelenet Agreement*.

Marketing

Through our field sales force, we market our services primarily to physicians, managed care organizations, hospitals, medical groups, home health agencies and case managers. We have developed and put into practice several marketing initiatives, including but not limited to:

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Automated Call Routing Through Toll-Free Numbers. This allows select managed care organizations to reach any of our locations and to access the full range of our services through toll-free telephone numbers.

Nationwide Accreditation. All of our branch locations are accredited by The Joint Commission. The Joint Commission is a nationally recognized organization that develops standards for various healthcare industry segments and monitors compliance with those standards through voluntary surveys of participating providers. As the home healthcare industry has grown and accreditation has become a mandatory requirement for Medicare DMEPOS providers, the need for objective quality measurements has increased. Accreditation by the Commission entails a lengthy voluntary review process that is conducted every three years. Accreditation is also widely considered a prerequisite for entering into contracts with managed care organizations at every level and is required for Medicare competitive bidding. Because accreditation is expensive and time consuming, not all providers choose to undergo the process.

Essential Care Model. We have developed the Essential Care Model, a proprietary model that defines the services, supplies and products delivered in conjunction with prescribed homecare equipment and therapies. The Essential Care Model is used to establish consistent and clear expectations for referral sources, payors and patients.

Patient/Referral Satisfaction and Complaint Resolution Process. We have a centralized patient and referral source satisfaction survey function that periodically conducts customer surveys and targeted member satisfaction studies for key managed care organizations as specified by various contractual arrangements. The same centralized group manages a complaint resolution process through which service improvements are identified and implemented at the field level. We believe that both centralized processes afford us visibility to centralized performance improvement data and trends that enable us to amend policies and procedures as necessary to meet the needs of patients and referral sources.

Apria Great Escapes® Travel Program. Our more than 500 location network facilitates travel for patients who require oxygen, alternate site infusion or other products, services and therapies. We coordinate equipment and service needs for thousands of traveling patients annually, which enhances their mobility and quality of life.

Comprehensive, Patient-Centric Clinical and Therapy Management Programs. We offer a number of clinical management programs designed to help physicians and managed care customers better manage patients through the use of homecare and ambulatory infusion suites to achieve substantial healthcare savings through the careful and appropriate oversight and management of medical equipment services and biotherapies. Our COPD Care Management, Sleep Management, RespiratoryAssist , SatAssist , Nourish and Tube Feeding Programs provide feedback to physicians regarding changes in patients clinical status, thus preventing unnecessary hospital or emergency admissions. Our proprietary EyeOn® infusion therapy management programs for Hemophilia and IVIG support hundreds of patients each year. Our extensive experience and clinical expertise have enabled our development of proprietary, proven therapy management programs designed specifically for these high cost and highly complex biotherapies. The EyeOn® program creates proven cost savings through careful risk assessment, management, and appropriate utilization management techniques.

Sales

As of December 31, 2010, we employed approximately 1,200 sales professionals whose primary responsibility is to generate new referrals and to maintain existing relationships for all of our service lines. Key customers include physicians and their staffs, hospital-based healthcare professionals and managed care organizations, among others. We provide our sales professionals with the necessary clinical and technical training to represent our major service offerings.

An integral component of our overall sales strategy is to increase volume through managed care referral sources and traditional physician referral channels. Specific growth initiatives designed to increase customer awareness of our clinical and operational programs are in place with the goal of securing a greater share of the traditional market. The ultimate decision makers for healthcare services vary greatly, from closed model managed care organizations to

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preferred provider networks, which are controlled by more traditional means. Our selling structure and strategies are designed to adapt to changing market factors and will continue to adjust as further changes in the industry occur. Managed care organizations continue to represent a significant portion of our business in several of our primary metropolitan markets. No third-party managed care payor group, however, represented more than 8% of our total net revenues for the year ended December 31, 2010. Among our more significant managed care customers during 2010 were Aetna Health Management, CIGNA Health Corporation, Kaiser Foundation Health Plan and United HealthCare Services. We also offer various fee-for-service arrangements to hospitals or hospital systems whose patients have home healthcare needs. See *Risk Factors Risks Relating to Our Business We Believe That Continued Pressure to Reduce Healthcare Costs Could Have a Material Adverse Effect on Us* and *Management s Discussion and Analysis of Financial Condition and Results of Operations.*

Competition

The segment of the healthcare market in which we operate is highly competitive. In each of our service lines there are a limited number of national providers and numerous regional and local providers. The competitive factors most important in the regional and local markets are:

- reputation with referral sources, including local physicians and hospital-based professionals;
- accessibility and an efficient, responsive referral process;
- price of services;
- overall ease of doing business;
- quality of patient care and associated services; and
- range of home healthcare services and products.

In addition to the foregoing, the most important competitive factors in the larger, national markets are:

- ability to service a wide geographic area;
- ability to develop and maintain contractual relationships with managed care organizations;
- access to capital;
- information systems capabilities; and
- accreditation by The Joint Commission or a similar accrediting body.

In each of our service lines there are a number of national providers and numerous regional and local providers with which we directly compete. Among these national providers are American HomePatient, Inc., Medco/Critical Care Systems, Lincare Holdings, Inc., Walgreen s Option Care and Rotech Healthcare Inc. Other types of healthcare providers, including industrial gas manufacturers, individual hospitals and hospital systems, home health agencies and health maintenance organizations, have entered and may continue to enter the market to compete with our

various service lines. Depending on their business strategies and financial position, it is possible that our competitors may have access to significantly greater financial and marketing resources than we do. This may increase pricing pressure and limit our ability to maintain or increase our market share. See *Risk Factors Risks Relating to Our Business We Believe That Continued Pressure to Reduce Healthcare Costs Could Have a Material Adverse Effect on Us* and *Risk Factors Risks Relating to Our Business We Experience Competition From Numerous Other Home Respiratory Therapy/Home Medical Equipment and Home Infusion Therapy Service Providers, and This Competition Could Adversely Affect Our Revenues and Our Business.*

Acquisition and Development Activities

In order to take advantage of our core competencies, expand our service offerings and enhance our value proposition for our customers, we may elect to make selective acquisitions of businesses with complementary

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products and services, or with operations in additional markets. We evaluate acquisition opportunities to determine those that have potential for growth and profitability under our operating structure.

Outsourced Activities

We have an outsourcing strategy with respect to certain billing, collections, administrative and information systems functions and have engaged two business process outsourcing firms, Intelenet and Dell Services (formerly Perot Systems Corporation), to perform select services.

Intelenet Agreement

In May 2009, we entered into the Master Service Agreement (Intelenet Agreement) with Intelenet, an Indian company affiliated with the Sponsor, regarding the outsourcing of certain functions relating to billing, collections and other administrative and clerical services. We presently expect to make payments to Intelenet of approximately $100 million over a seven-year period that began in the second quarter of 2009. One of the members of our Board of Directors, Mr. Patrick Bourke, is an employee of the Sponsor and also serves on the Board of Directors of Intelenet. During the year ended December 31, 2010, we paid approximately $20.9 million under the Intelenet Agreement.

Perot Systems Agreement

In April 2009, we entered into an Information Technology Services Agreement (the Perot Agreement) with Perot Systems Corporation (Perot Systems) to outsource certain information technology functions to Perot Systems. Dell Inc. acquired Perot Systems in November 2009 and created a new business unit called Dell Services, which provides the services covered by the Perot Agreement. We expect to pay approximately $241.0 million to Dell Services over the ten-year term of the Perot Agreement. During the year ended December 31, 2010, we paid approximately $29.3 million under the Perot Agreement. In addition to amounts under the ten-year term of the agreement, we expect to pay approximately $15.0 million over the first 60 months of the contract for services rendered primarily in support of the cost savings initiatives described earlier relating to operations and revenue management functions.

Government Regulation

We are subject to extensive government regulation, including numerous laws directed at regulating reimbursement of our products and services under various government programs and preventing fraud and abuse, as more fully described below. We maintain certain safeguards intended to reduce the likelihood that we will engage in conduct or enter into arrangements in violation of these restrictions. Corporate contract services and legal department personnel review and approve written contracts subject to these laws. We also maintain various educational and audit programs designed to keep our managers updated and informed regarding developments on these topics and to reinforce to employees our policy of strict compliance in this area. Federal and state laws require that we obtain facility and other regulatory licenses and that we enroll as a supplier with federal and state health programs. Under various federal and state laws, we are required to make filings or submit notices in connection with transactions that might be defined as a change of control of the Company. We are aware of these requirements and routinely make such filings with, and seek such approvals from, the applicable regulatory agencies. Notwithstanding these measures, due to changes in and new interpretations of such laws and regulations, and changes in our business, violations of these laws and regulations may still occur, which could subject us to civil and criminal enforcement actions; licensure revocation, suspension or non-renewal; severe fines and penalties; the repayment of amounts previously paid to us and even the termination of our ability to provide services, including those provided under certain government programs such as Medicare and Medicaid. See *Risk Factors Risks Relating to Our Business Continued Reductions in Medicare and Medicaid Reimbursement Rates and the Comprehensive Healthcare Reform Law Could Have a Material Adverse Effect on Our Results of Operations and Financial Condition* and *Risk Factors Risks Relating to Our Business Our Failure To Maintain Required Licenses Could Impact Our Operations.*

Medicare and Medicaid Revenues. In the year ended December 31, 2010 approximately 24% and 6% of our net revenues were reimbursed by the Medicare and state Medicaid programs, respectively. No other third-party payor represented more than 8% of our total net revenues for the year ended December 31, 2010. The majority of our

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revenues are derived from rental income on equipment rented and related services provided to patients, sales of equipment, supplies and pharmaceuticals and other items we sell to patients for patient care under fee-for-service arrangements. Revenues derived from capitation arrangements represented 8% of total net revenues for the year ended December 31, 2010.

Medicare Reimbursement. There are a number of legislative and regulatory initiatives in Congress and at CMS that affect or may affect Medicare reimbursement policies for products and services we provide. Specifically, a number of important legislative changes that affect our business were included in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which was signed into law in December 2003; the Deficit Reduction Act of 2005 (DRA), which was signed into law in February 2006; MIPPA, which became law on July 15, 2008 and the comprehensive healthcare reform law signed in March 2010 (the Reform Package). These Acts and their implementing regulations and guidelines contain numerous provisions that were significant to us and continue to have an impact on our operations today, as described below.

DMEPOS Competitive Bidding. The MMA required implementation of a competitive bidding program for certain DMEPOS items. By statute, CMS was required to implement the DMEPOS competitive bidding program over time, with Round 1 of competition occurring in portions of 10 of the largest Metropolitan Statistical Areas (MSAs), in 2007, launch of the program in 2008 and in 70 additional markets in 2009, and in additional markets after 2009.

In 2007 and 2008, CMS sought and reviewed bids and developed a plan to implement Round 1 on July 1, 2008. CMS offered us contracts in several CBAs in Round 1; we accepted the contracts for certain product categories and declined others due to unacceptably low single payment amounts (SPAs) in certain markets, which would not adequately cover the cost of providing quality service to our patients in those areas. We, along with other winning contract suppliers, began providing services under Round 1 on July 1, 2008.

The bidding process for Round 1 was controversial and complex, which resulted in deadline extensions. Moreover, CMS was subject to numerous lawsuits seeking a delay of Round 1. Then on July 15, 2008, MIPPA was enacted which, among other provisions, delayed the DMEPOS competitive bidding program by requiring that Round 1 competition commence in 2009, and required a number of program reforms prior to CMS re-launching the program. As a result, contracts that were awarded under Round 1 were terminated. In January 2009, CMS released an interim final rule on the DMEPOS competitive bidding program implementing certain MIPPA provisions requiring CMS to conduct the Round 1 Rebid in 2009 and mandating certain changes for both the Round 1 Rebid and subsequent rounds of the program. Changes mandated by MIPPA include requirements for the government to administer the program more transparently, exemption of certain DMEPOS products from the program and a new implementation schedule.

In July 2010, CMS published a proposed rule containing several provisions related to the competitive bidding program according to the Reform Package. The proposed rule included the proposed list of 21 additional MSAs to be included in Round 2, as well as provisions relating to the diabetic supply category. Those provisions include a proposed definition of mail order and non-mail order items and a proposal for providers to supply a minimum level of product choices to patients. The final rule was published in November 2010. CMS adjusted certain aspects of the geographic boundaries of three large MSAs, but otherwise the Round 2 markets are now final. The new rates took effect on January 1, 2011 for the Round 1 Rebid markets.

Under MIPPA, the initial CBAs and product categories subject to rebidding are very similar to those of Round 1. MIPPA also excludes Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories as a competitive bidding product category in Round 1 and permanently excludes Group 3 Complex Rehabilitative Power Wheelchairs and Related Accessories as a competitive bidding product category. MIPPA also includes a new provision requiring bids for mail order diabetes testing supplies after Round 1 to include a certain percentage of all types of available diabetic testing strips.

The estimated annual total net revenues associated with the items that would have been subject to competitive bidding in Round 1 of what was to be the initial year of the program represented approximately 1.4% of our annual total net revenues. Based on 2008 data provided provided to bidders during the Round 1 Rebid process, we estimate that after the DRA and MIPPA reimbursement reductions of 2009 and a change in our business mix since 2007 are allocated for, the estimated annual total net revenues associated with items subject to competitive bidding in the

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Round 1 Rebid is approximately 1.0% of our annual total net revenues. In early July 2010, CMS announced the new SPAs for each of the product categories and each of the CBAs included in the Round 1 Rebid. The average price reduction for all products in all CBAs was 32%. CMS then began the contracting process with suppliers by issuing contract offer letters to qualified providers. We received contract offers for a substantial majority of the bids we submitted. We did not receive contract offers for certain product categories in certain CBAs, and we filed a formal request for CMS to reconsider certain of those bids. Approximately $21 million of our net revenues for the fiscal year ended December 31, 2009 was generated by the products and CBAs included in the Round 1 Rebid. We estimate that the initial results of the Round 1 Rebid will impact our net revenues in the fiscal year ending December 31, 2011 by approximately $8 million, assuming the current contracts and no changes in volume.

Notwithstanding the changes MIPPA requires, competitive bidding imposes a significant risk to DMEPOS suppliers. Under the rules governing the program, if a DMEPOS supplier operating in a CBA is not awarded a contract for that CBA, the supplier generally will not be able to bill and be reimbursed by Medicare for DMEPOS items supplied in that CBA for the time period covered by the competitive bidding program unless the supplier meets certain exceptions or acquires a winning bidder. Because the applicable statutes mandate financial savings from the competitive bidding program, a winning contract supplier will receive lower Medicare payment rates under competitive bidding than the otherwise applicable DMEPOS fee schedule rates. As competitive bidding is phased in across the country under the revised MIPPA implementation schedule, we will likely experience a reduction in reimbursement, as will most if not all other DMEPOS suppliers in the impacted areas. In addition, there is a risk that the new competitive bidding prices will become a benchmark for reimbursement from other payors. MIPPA does not prevent CMS from adjusting prices for DMEPOS items in non-bid areas; however, before using its authority to adjust prices in non-bid areas, MIPPA requires that CMS issue a regulation that specifies the methodology to be used and consider how prices through competitive bidding compare to costs for those items and services in the non-bid areas.

The Reform Package also includes changes to the Medicare DMEPOS competitive bidding program. Significantly, Round 2 of the competitive bidding program has been expanded from 70 to 91 of the largest MSAs. Additional details concerning products to be included and other aspects of implementing Round 2 will not be fully known until after CMS completes a rulemaking process, which is now scheduled for the spring or summer of 2011. Assuming that Round 2 would include the same product categories, bidding rules and markets currently being implemented and/or planned by CMS, we estimate that approximately $110 million of our net revenues for the fiscal year ending December 31, 2011 would be subject to competitive bidding. Although the bidding process for Round 2 is currently scheduled to commence in 2011, the new Round 2 rates and guidelines are scheduled to take effect no earlier than January 2013. Therefore, we cannot estimate the impact of potential Round 2 rate reductions on our business until more specific information is published by CMS and its contractors. The Reform Package also gives the Secretary of Health and Human Services additional authority to apply competitive bid pricing to non-bid areas rulemaking process and that could occur by 2016.

With respect to the competitive bidding program generally, at a March 2010 Program Advisory and Oversight Committee (PAOC) meeting, CMS briefed the PAOC regarding Round 2 of the DMEPOS competitive bidding program. The briefing focused on certain aspects of Round 2, which is mandated by MIPPA to begin in 2011. CMS expects to make changes to the program through the rulemaking process and anticipates that another proposed rule will be published. CMS anticipates that it will announce the Round 2 bidding schedule and begin the bidding process, with bidder registration, in the winter of 2011. CMS plans to complete the bid evaluation process, announce the SPAs and begin the contract process for Round 2 in the spring of 2012. In addition, CMS plans to announce the Round 2 contract suppliers in the summer of 2012. We cannot quantify what negative impact, if any, the revised program, including the expansion of Round 2, will have upon our revenue or operations once the program is reinitiated, but it could be material.

Nevertheless, we believe that our geographic coverage, clinical marketing programs and purchasing strength provide competitive advantages to maintain and enhance market share under Medicare competitive bidding. However, there is no guarantee that we will be selected as a winning contract supplier in any future phases of the program and be awarded competitive bidding contracts by CMS or that we will garner additional market share. Under the current competitive bidding regulations, if we are not selected as a winning contract supplier for a particular CBA, we will generally not be allowed to supply Medicare beneficiaries in the CBA with products subject to competitive bidding, unless we elect to continue to service existing patients under the grandfathering provision of the most recent final rule or we acquire a winning supplier. Because of our combination of both managed care and

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traditional business, we believe we can nevertheless maintain a favorable overall market position in a particular CBA even if we are not selected as a contract supplier.

Medicare Fee Schedule for DMEPOS and Consumer Price Index-Urban (CPI-U) Adjustments. In addition to the adoption of the DMEPOS competitive bidding program, the MMA implemented a five-year freeze on annual Consumer Price Index (CPI) payment increases for most durable medical equipment from 2004 to 2008. In MIPPA, in order to offset the cost of delaying in the implementation of the DMEPOS competitive bidding program, Congress approved a nationwide average payment reduction of 9.5% in the DMEPOS fee schedule payments for those product categories included in Round 1, effective January 1, 2009. Product categories subject to competitive bidding but furnished in non-competitive bid areas were eligible to receive mandatory annual CPI-U updates beginning in 2010. Competitively bid items and services in metropolitan areas with contracts in place are not eligible to receive a CPI-U payment update during a contract period, which is currently a three-year period.

The DMEPOS items and services that were not in a product category subject to competitive bidding in Round 1 received a 5.0% CPI-U payment update in 2009. For 2010, the CPI-U was -1.4%. However, annual DMEPOS payment updates were not permitted to be negative according to statute. Therefore, the CPI update in 2010 was 0%. The Reform Package makes changes to Medicare DMEPOS fee schedule payments for 2011 and subsequent years. The CPI-U payment update will now be adjusted annually by a new multi-factor productivity adjustment measurement which may result in negative DMEPOS payment updates. While CPI-U for 2011 is +1.1%, the multi-factor productivity adjustment is -1.2%, so the net result is a 0.1% decrease in DMEPOS fee schedule payments in 2011 for items and services not included in an area subject to competitive bidding.

Capped Rentals and Oxygen Equipment. Under the DRA, beginning with Medicare beneficiaries who received DMEPOS products and services as of January 2006, ownership of certain durable medical equipment categorized by CMS in the capped rental category (e.g., hospital beds, wheelchairs, nebulizers, patient lifts and CPAP devices) automatically transfers to the Medicare beneficiary at the end of a maximum rental period. As of January 1, 2006, the maximum rental period for this category became 13 months. Therefore, the first month in which the new policy had an impact on our revenue was February 2007. In addition, the service and maintenance fee, which had been paid to suppliers twice yearly after the rental period ended in order to cover various non-equipment service costs for patients who require use of the equipment, was eliminated for those patients who commenced service on or after January 1, 2006. However, the DRA provides for additional payments for maintenance and service of the item for repair parts and labor not covered by a supplier s or manufacturer s warranty. Implementing regulations also imposed other repair and replacement obligations on suppliers with respect to equipment that does not last the useful lifetime of the equipment, which CMS has generally defined as being five years.

With respect to oxygen equipment, the DRA converted Medicare reimbursement for oxygen equipment from an ongoing rental method to a capped rental and rent-to-purchase methodology and limited reimbursement for rental of oxygen equipment to the current 36-month maximum. The DRA mandated that, after the 36-month rental period, the ownership of the equipment would transfer to the Medicare beneficiary, who would assume primary responsibility for identifying when repairs or preventive maintenance are needed. However, MIPPA repealed the mandatory title transfer for oxygen equipment. The existing implementing regulations to the DRA and MIPPA provisions also limit supplier replacement of oxygen equipment during the rental period, and require suppliers to replace equipment that does not last the useful lifetime of the equipment, which CMS has generally defined as being five years. As a result, the equipment will continue to be owned by the home oxygen provider for as long as the patient s medical need exists, after which time it will be returned to the home oxygen provider.

The 36-month rental period was retroactively applied to January 1, 2006 for all beneficiaries requiring oxygen as of December 31, 2005. Accordingly, Medicare services provided on or after January 1, 2009 were the first Medicare claims in which the rental cap impacted us. DRA regulations, which remain intact despite the repeal of mandatory title transfer, established new payment classes for oxygen equipment, including transfilling and portable equipment, new monthly rental reimbursement rates, and new reimbursement rates for the delivery of oxygen contents, if applicable. On November 19, 2008, CMS published revised regulations implementing DRA and MIPPA. Under the revised regulations, suppliers must continue furnishing oxygen equipment after the 36-month rental cap period during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, with certain limited exceptions. CMS also specified that a new period of continuous use will not begin following the 36-month rental cap period until the end of the equipment s reasonable useful lifetime, unless the equipment is replaced because it is lost, stolen, irreparably damaged, or is replaced after the reasonable useful life expires. CMS has

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provided that the reasonable useful lifetime of oxygen equipment is five years (60 months). Therefore, a new oxygen capped rental period (36 months) may begin after the five year (60 months) useful lifetime of the oxygen equipment. However, at least one Durable Medical Equipment Medicare Administrative Contractor (DMEMAC) has provided that a patient must request that the supplier provide the new oxygen equipment and the supplier may not arbitrarily issue new equipment. Among other provisions, CMS also stated that it would not reimburse suppliers for oxygen tubing, cannulas and supplies patients may need between the 37th and 60th months of oxygen therapy and requires that the initial supplier of oxygen therapy make arrangements with another supplier if a patient relocates temporarily or permanently outside of the initial supplier s service area. In addition, CMS stated that it would not establish any reimbursement rates for non-routine services patients may require after the 36-month rental period.

Regarding repairs and maintenance of oxygen equipment, CMS revised its regulations so that for services provided on or after January 1, 2009, the implementing regulations permitted payment in calendar year 2009 only to suppliers for general maintenance and servicing of certain oxygen equipment every six months, beginning after the first six-month period elapsed after the initial 36-month rental period. The final rule governing repairs and maintenance of oxygen equipment limits payment for general maintenance and servicing visits to 30 minutes of labor based on rates the Medicare contractors establish. With respect to equipment parts, CMS has stated that payments will not be made for equipment parts and that the supplier is responsible for replacing the parts on equipment from the supplier s inventory in order to meet the patient s medical need for oxygen. CMS issued guidance in November 2009 continuing the general maintenance and servicing payments for certain oxygen equipment.

In a proposed rule issued in June 2010, CMS proposed to change the threshold rental month from which the original oxygen supplier would continue to be responsible for serving a patient, regardless of his/her move outside of the supplier s service area, from the 36th to the 18th month. The agency sought public comments, and in a final rule published in November 2010, the agency indicated that it would not change its current policy but would continue to study the issue. We cannot speculate on any future changes CMS may make to its repair, maintenance and service, supply or other fee schedules related to oxygen. We may or may not continue to provide repair and maintenance service on oxygen equipment that has met the cap. We routinely evaluate the impact of the changes caused by all applicable legislation and regulations and adjust our operating policies accordingly.

In recent years, there have been several legislative and executive branch efforts to further reduce the maximum rental period for oxygen therapy, equipment and related services. Former President Bush s 2007, 2008 and 2009 healthcare budget proposals sought to reduce the maximum rental period for oxygen equipment from the DRA-mandated 36 months to 13 months, which was recommended by the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) in a limited study of the oxygen benefit published in 2006 entitled Medicare Home Oxygen: Equipment Cost and Servicing. Neither President Obama s 2010 or 2011 budget proposals nor the Reform Package included a reduction in the oxygen rental period. However, it is premature to know whether future budgets or proposals will contain such a provision or any other provisions based on these or future studies released by one or more government agencies.

Over the course of 2008, CMS and the DMEMACs issued coverage determinations for positive airway pressure (PAP) devices, including CPAP and bi-level devices. Among other changes, the Medicare DMEMAC local coverage determinations (LCDs) require additional documentation of clinical benefit of the PAP devices for continued coverage of the device beyond the first three months of therapy. Specifically, for PAP devices with initial dates of service on or after November 1, 2008, documentation of clinical benefit must be demonstrated by: (1) a face-to-face clinical re-evaluation by the treating physician (between the 31st and 90th day) with documentation that symptoms of obstructive sleep apnea are improved; and (2) objective evidence of adherence to use of the PAP device, reviewed by the treating physician. The LCDs define adherence to therapy as the use of the PAP device greater than or equal to 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three months of initial usage. If the clinical benefit requirements are not met, then continued coverage of the PAP device and related accessories are denied by Medicare as not medically necessary. We believe these requirements effectively require suppliers to supply PAP devices that monitor patient compliance and record hours of use, which adds to our expense structure without a corresponding increase in payments from Medicare. Beginning in late 2008 and continuing into 2010, we have adjusted our operational model, patient care and payment policies to comply with these Medicare requirements. These requirements only apply to Medicare Part B fee-for-service patients, not to those patients enrolled in Medicare Advantage or commercial health plans, and Medicare Part B fee-for-service represents a smaller portion of the overall PAP patient market. However, some commercial

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payors are now attempting to implement the Medicare rules. Despite our intensive efforts to educate patients about the importance of complying with their physician-prescribed therapy, some of our Medicare Part B patients do not meet the threshold for compliance. In order to reduce the impact of the LCDs, we are continuing to educate patients and referral sources concerning the importance of compliance with the patient s prescribed therapy. However, these and similar LCDs are likely to continue to impact the PAP industry.

Reimbursement for Inhalation and Infusion Therapy Drugs. As a result of the MMA, beginning January 2005, Medicare Part B reimbursement for most drugs, including inhalation drugs, became based upon the manufacturer-reported ASP (subject to adjustment each quarter), plus 6%, plus a separate dispensing fee per patient episode. CMS publishes the ASP plus 6% payment levels in the month that precedes the first day of each quarter, and we have no way of knowing if the quarterly average sales prices (ASPs) will increase or decrease since manufacturers report applicable ASP information directly to CMS. Since 2006, dispensing fees have remained at $57.00 for a 30-day supply for a new patient, $33.00 for each 30-day supply thereafter, and $66.00 for each 90-day supply.

The Medicare reimbursement methodology for non-compounded, infused drugs administered through durable medical equipment, such as infusion pumps, was not affected by this MMA change. It remains based upon either 95% of the October 1, 2003 Average Wholesale Price (AWP) or, for those drugs whose AWPs were not published in the applicable 2003 compendia, at 95% of the first published AWP. Also, coding and reimbursement changes pertaining to compounded medications, issued in 2007, did not have a material impact on us due to the extremely low volume of patient-specific, physician-prescribed compounding that was performed by our inhalation pharmacies.

Although CMS had considered issuing a National Coverage Decision (NCD) for certain inhalation drug therapies, in the third quarter of 2007, CMS issued a NCD that stated that no national coverage policy was appropriate at that time. Rather, CMS stated that it would continue to defer decisions about the medical necessity of individual respiratory drugs to the local contractors. Thereafter, in April of 2008, the DMEMACs finalized proposed LCD policies for several respiratory drugs, including Xopenex® and DuoNeb®[1]. Each of these two drugs was subjected to a separate least costly alternative (LCA) policy which would have changed the reimbursement methodology in a way that would effectively have eliminated Medicare beneficiary access to these drugs which are frequently used to treat COPD. After complaints were filed by Medicare beneficiaries in the Federal District Court for the District of Columbia, CMS announced that it planned to withdraw the LCA for Xopenex. On November 5, 2008, the plaintiffs in the Xopenex case filed a Motion to Voluntarily Dismiss all claims in the litigation. Subsequent to the filing of the complaint in the DuoNeb case, CMS postponed the LCA for DuoNeb until November 1, 2008. In November 2008, the Federal District Court for the District of Columbia enjoined CMS s LCA for DuoNeb, saying that the Medicare program s policy of paying for only the least costly alternative was not permitted under the Medicare law and finding that Medicare and some of its contractors had unlawfully limited payments for DuoNeb. The court made two distinct findings on the merits, in summary: (1) with limited exceptions (e.g., a public health emergency) CMS does not have the authority to deviate from the 106% ASP calculation for a covered Part B drug, and (2) the reasonable and necessary language in Section 1862 refers to coverage only and cannot be applied to reimbursement determinations. The court reasoned that CMS s position would have given the Secretary of HHS significant discretion to determine the amount paid for every item and service covered by Medicare, without reference to the detailed formulas established in the laws enacted by Congress. This decision was appealed by the government in the U.S. Court of Appeals for the District of Columbia. In December 2009, the U.S. Court of Appeals for the District of Columbia upheld the District Court s ruling in all regards and confirmed the distinction between Medicare coverage and reimbursement by ruling that the Medicare statute precludes the Secretary from issuing a coverage determination that sets the reimbursement rate for a covered drug based on the least costly alternative . This decision has national implications for the coverage of inhalation drugs. The time period for the government to file an appeal of the Court of Appeals decision has expired, and the government did not appeal.

In 2007 and 2008, there were other changes to the reimbursement methodology for the inhalation drugs Xopenex and albuterol. Beginning in the third quarter of 2007, CMS began reimbursing providers of Xopenex and albuterol a blended ASP for these two inhalation drugs. On December 29, 2007, the President signed into law the Medicare,

[1] Xopenex is a registered trademark of Sepracor, Inc., and DuoNeb is a registered trademark of Dey Labs, LLC.

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Medicaid, and State Children s Health Insurance Program Extension Act of 2007, which partially reversed the CMS regulatory decision regarding Xopenex and albuterol. Beginning on April 1, 2008, Medicare began to reimburse providers for Xopenex by blending the average sales prices of Xopenex and albuterol, but it no longer reimbursed providers for albuterol at the blended price. Rather, albuterol is reimbursed using an albuterol-only ASP.

We estimate that the combined effect of these changes to inhalation drug reimbursement resulted in a $7.9 million decline in revenue for the year ended December 31, 2009 from the same period in 2008. However, we implemented strategies intended to partially mitigate these negative impacts in subsequent periods, including the discontinuation of the inhalation drug Xopenex from our inhalation pharmacies drug formulary and other formulary changes.

A limited number of infusion therapies, supplies and equipment are covered by Medicare Part B. The MMA, through the new Medicare Part D program, provided expanded coverage for certain home infusion therapy drugs, but excluded coverage for the corresponding supplies and clinical services needed to safely and effectively administer these drugs. We have contracted with a limited number of Medicare Part D prescription drug plans in order to provide continuity of care for certain patients.

Due to ongoing Part D and Part B coverage and payment issues associated with home infusion therapy, the industry is continuing to work with CMS and Congress to rectify the Medicare coverage and payment limitations that restrict Medicare beneficiary and referral source access to quality home infusion therapy services. Bills were introduced in the 110th and 111th Congresses to consolidate home infusion therapy coverage under Part B and we expect similar legislation to be introduced in the 112th Congress. The Medicare Home Infusion Therapy Coverage Act would provide for Medicare infusion benefit coverage in a more comprehensive manner that is analogous to how the therapy is covered by the managed care sector, including Medicare Advantage plans. Industry representatives continue to present the cost-saving and patient care advantages of home infusion therapy to CMS, members of Congress and the Obama Administration in an effort to, at a minimum, include a formal demonstration project in either CMS work plan or future legislation. In addition to a June 2010 report issued by the Government Accountability Office (GAO) in 2009, entitled Home Infusion Therapy: Differences Between Medicare and Private Insurers Coverage, testimony before the Senate Finance Committee in September 2009 acknowledged the current gap in coverage and potential benefits of home infusion therapy to the Medicare program and beneficiaries. At this time, we cannot predict whether legislation will be passed or whether CMS will include a demonstration project in a future work plan.

Enrollment and Accreditation of Durable Medical Equipment Suppliers; Surety Bond Requirements. While we support the elimination of fraudulent suppliers and are working with CMS to support these initiatives, some of the CMS initiatives and developments with respect to the enrollment and accreditation of providers could impact our operations in the future. For example, all durable medical equipment providers who bill the Medicare program for DMEPOS services and products are required by MIPPA to be accredited. Although we and all of our branches currently are accredited, if we or any of our branches lose accreditation, or if any of our new branches are unable to become accredited, that could have a material adverse effect on our results of operations, cash flow and capital resources.

CMS also requires that all durable medical equipment providers who bill the Medicare program maintain a surety bond of $50,000 per NPI number which Medicare has approved for billing privileges. We obtained the required surety bonds for all of our applicable locations before the October 2009 deadline and received confirmation from the National Supplier Clearinghouse (NSC) that the NSC has recorded the bonds properly in its records. In addition, the NSC prescribes an elevated bond amount of $50,000 per occurrence of an adverse legal action within the 10 years preceding enrollment, reenrollment or revalidation. The rule is designed to ensure that Medicare can recover any erroneous payment amounts or civil money penalties up to $50,000 that result from fraudulent or abusive supplier billing practices.

In October 2008, CMS announced enhancements to its program integrity initiatives designed to identify and prevent waste, fraud and abuse. The initiatives include: (i) conducting more stringent reviews of DMEPOS suppliers applications, including background checks of new DMEPOS suppliers principals and owners to ensure they have not been suspended by Medicare; (ii) making unannounced site visits to suppliers and home health agencies to ensure they are active, legitimate businesses; (iii) implementing extensive pre- and post-payment claims review; (iv) verifying the relationship between physicians who order a large volume of DMEPOS equipment and the beneficiaries for whom they ordered these services; and (v) identifying and visiting beneficiaries to ensure appropriate receipt of Medicare-reimbursable items and services. We work cooperatively with CMS and its contractors in response to these initiatives but cannot predict whether CMS various program integrity efforts will or will not negatively impact our operations.

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In August 2010, CMS released a final rule imposing more stringent standards for DMEPOS suppliers, which introduced several new enrollment standards and expanded some existing standards and participation requirements, all of which DMEPOS suppliers must meet to establish and maintain billing privileges in the Medicare program. These standards became effective on September 27, 2010.

Following the implementation of a 3-year demonstration program using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare fee-for-service program, the Tax Relief and Health Care Act of 2006 required HHS to establish the RAC initiative as a permanent, nationwide program by January 1, 2010. CMS selected the four RAC contractors for the permanent RAC program and the permanent RAC program is currently underway. Prior to initiating any audits, RACs are required to obtain CMS pre-approval of the issue that will be subject to audit, and then post the approved audit issue on their websites. All RACs have now posted CMS-approved audit issues on their websites. The currently posted approved audit issues include those which apply to durable medical equipment (DME) suppliers. States have also implemented similar state Medicaid audit programs, often know as Medicaid Integrity Contractors (MICs). The Reform Package expands the RAC program to include Medicare Parts C and D in the program. In addition, the Reform Package requires states to establish contracts with RACs to identify underpayments and overpayments and to recoup overpayments made for services provided under State Medicaid programs. In addition, in March of 2010, President Obama issued a presidential memorandum announcing a government-wide program expanding the use payment recapture audits in order to reclaim improper payments. We cannot at this time quantify any negative impact that the expansion of the RAC program or other similar programs may have on us.

Also in October 2008, CMS announced the establishment of new Zone Program Integrity Contractors (ZPICs), who are responsible for ensuring the integrity of all Medicare-related claims. The ZPICs assumed the responsibilities previously held by Medicare s Program Safeguard Contractors (PSCs). Industry-wide, ZPIC audit activity increased in the second half of 2010 and is expected to continue to increase for the foreseeable future. The industry trade association is advocating for more contractor transparency and consistency surrounding all government audit activity directed toward the DMEPOS industry.

Other Issues

Medical Necessity & Other Documentation Requirements. In order to ensure that Medicare beneficiaries only receive medically necessary and appropriate items and services, the Medicare program has adopted a number of documentation requirements. For example, the DMEMAC Supplier Manuals provide that clinical information from the patient s medical record is required to justify the initial and ongoing medical necessity for the provision of DME. Some DMEMACs, CMS staff and government subcontractors have recently taken the position, among other things, that the patient s medical record refers not to documentation maintained by the DME supplier but instead to documentation maintained by the patient s physician, healthcare facility or other clinician, and that clinical information created by the DME supplier s personnel and confirmed by the patient s physician is not sufficient to establish medical necessity. It may be difficult, and sometimes impossible, for us to obtain documentation from other healthcare providers. Moreover, auditors interpretation of these policies is inconsistent and subject to individual interpretation. This is then translated to individual supplier significant error rates and aggregated into a DMEPOS industry error rate. High error rates lead to further audit activity and regulatory burdens. If these or other burdensome positions are generally adopted by auditors, DMEMACs, other contractors or CMS in administering the Medicare program, we would have the right to challenge these positions as being contrary to law. If these interpretations of the documentation requirements are ultimately upheld, however, it could result in our making significant refunds and other payments to Medicare and our future revenues from Medicare may be reduced. We cannot currently predict the adverse impact, if any, these interpretations of the Medicare documentation requirements might have on our operations, cash flow and capital resources, but such impact could be material.

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Inherent Reasonableness. The Balanced Budget Act of 1997 granted authority to HHS to increase or reduce Medicare Part B reimbursement for home medical equipment, including oxygen, by up to 15% each year under an inherent reasonableness authority. Pursuant to that authority, CMS published a final rule that established a process by which such adjustments may be made. The rule applies to all Medicare Part B services except those paid under a physician fee schedule, a prospective payment system, or a competitive bidding program. Neither HHS nor CMS has issued any subsequent communication or information for several years and therefore, we cannot predict whether or when HHS would exercise its authority in this area or predict any negative impact of any such change.

The impact of changes in Medicare reimbursement that have been enacted to date are reflected in our results of operations for the applicable periods through December 31, 2010. We cannot estimate the combined possible impact of all legislative, regulatory and contemplated reimbursement changes that could have a material adverse effect on our results of operations, cash flow, and capital resources. Moreover, our estimates of the impact of certain of these changes appearing in this Government Regulation section are based on a number of assumptions and are subject to uncertainties and there can be no assurance that the actual impact was not or will not be different from our estimates.

Medicaid Reimbursement. State Medicaid programs implement reimbursement policies for the items and services we provide that may or may not be similar to those of the Medicare program. Budget pressures on these state programs often result in pricing and coverage changes that may have a detrimental impact on our operations and/or financial performance. States sometimes have interposed intermediaries to administer their Medicaid programs, or have adopted alternative pricing methodologies for certain drugs, biologicals, and home medical equipment under their Medicaid programs that reduce the level of reimbursement received by us without a corresponding offset or increase to compensate for the service costs incurred. For example, Medi-Cal adopted a regulation that limits the amounts a provider can bill for certain durable medical equipment and medical supplies. In March 2009, the California Association of Medical Product Suppliers (CAMPS) initiated a lawsuit to invalidate this regulation as having been adopted in violation of California s Administrative Procedure Act. On August 3, 2009, the court entered a decision denying CAMPS petition. CAMPS has appealed the court s decision. If the regulation is ultimately upheld, it would most likely result in our making refunds and other payments to Medi-Cal, and our future revenues from Medi-Cal may be reduced. Historically, when such regulatory or administrative burdens have been imposed, or such alternative pricing methodologies were adopted, we have sometimes elected to stop accepting new Medicaid patient referrals for the affected drugs, biologicals, and home medical equipment. We are currently evaluating the possibility of stopping or reducing our Medicaid business in a number of states with reimbursement or administrative policies that make it difficult for us to safely care for patients or conduct operations profitably. Moreover, the Reform Package increases Medicaid enrollment over a number of years and imposes additional requirements on states which, combined with the current economic environment and state deficits, could further strain state budgets and therefore result in additional policy changes or rate reductions. We cannot currently predict the adverse impact, if any, that any such change to or reduction in our Medicaid business might have on our operations, cash flow and capital resources, but such impact could be material. In addition, we cannot predict whether other states will consider similar or other reimbursement reductions, whether healthcare reform provisions pertaining to Medicaid will ultimately be passed into law or whether any such changes would have a material adverse effect on our results of operations, cash flow and capital resources.

HIPAA. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is comprised of a number of components pertaining to the privacy and security of certain protected health information (PHI), as well as the standard formatting of certain electronic health transactions. Many states have similar, but not identical, restrictions. Existing and any new laws or regulations have a significant effect on the manner in which we handle healthcare related data and communicate with payors. Among other provisions, the HITECH Act of the American Recovery and Reinvestment Act of 2009 (ARRA) includes additional requirements related to the privacy and security of PHI, clarifies and increases penalties of HIPAA and provides State Attorneys General with HIPAA enforcement authority. We have adopted a number of policies and procedures to conform to HIPAA requirements, as modified by the HITECH Act of ARRA, throughout our operations and educated our workforce about HIPAA provisions. We face potential administrative, civil and criminal sanctions if we do not comply with the existing or new laws and regulations. Imposition of these sanctions could have a material adverse effect on our operations.

Enforcement of Healthcare Fraud and Abuse Laws. In recent years, the federal government has made a policy decision to significantly increase the financial resources allocated to enforcing the healthcare fraud and abuse laws. Moreover, Congress adopted a number of additional provisions in the Reform Package that are designed to reduce

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healthcare fraud and abuse. In addition, private insurers and various state enforcement agencies have increased their level of scrutiny of healthcare claims in an effort to identify and prosecute fraudulent and abusive practices in the healthcare area. From time to time, we may be the subject of investigations or a party to additional litigation which alleges violations of law. If any of those matters were successfully asserted against us, there could be a material adverse effect on our business, financial position, results of operations or prospects.

Anti-Kickback Statutes. As a provider of services under the Medicare and Medicaid programs, we must comply with a provision of the federal Social Security Act, commonly known as the federal anti-kickback statute. The federal anti-kickback statute prohibits the offer or receipt of any bribe, kickback or rebate in return for the referral or arranging for the referral of patients, products or services covered by federal healthcare programs. Federal healthcare programs have been defined to include plans and programs that provide health benefits funded by the United States Government, including Medicare, Medicaid and TRICARE (formerly known as the Civilian Health and Medical Program of the Uniformed Services or CHAMPUS), among others. Some courts and the OIG interpret the statute to cover any arrangement where even one purpose of the remuneration is to influence referrals. Violations of the federal anti-kickback statute may result in civil and criminal penalties and exclusion from participation in federal healthcare programs.

Due to the breadth of the federal anti-kickback statute s broad prohibition, there are a few statutory exceptions that protect various common business transactions and arrangements from prosecution. In addition, the OIG has published safe harbor regulations that outline other arrangements that also are deemed protected from prosecution under the federal anti-kickback statute, provided all applicable criteria are met. The failure of an activity to meet all of the applicable safe harbor criteria does not necessarily mean that the particular arrangement violates the federal anti-kickback law, but these arrangements will be subject to greater scrutiny by enforcement agencies.

Some states have enacted statutes and regulations similar to the federal anti-kickback statute, but which apply not only to the federal healthcare programs, but also to any payor source of the patient. These state laws may contain exceptions and safe harbors that are different from those of the federal law and that may vary from state to state. A number of states in which we operate have laws that prohibit fee-splitting arrangements between healthcare providers, if such arrangements are designed to induce or encourage the referral of patients to a particular provider. Additionally, several states have passed laws further regulating interactions between healthcare providers and physician referral sources. In late 2009, the state of New York enacted a requirement for certain healthcare providers to file a formal annual statement in which they attest that they have adopted a formal corporate compliance program which meets the state s specific requirements; we comply with that annual requirement. Possible sanctions for violations of these restrictions include exclusion from state-funded healthcare programs, loss of licensure, and civil and criminal penalties. Such statutes vary from state to state, are often vague and often have been subject to only limited court or regulatory agency interpretation.

Marketing Laws. Because of our drug compounding and oxygen services, we may be subject to new and increasingly common state laws and regulations regarding our marketing activities and the nature of our interactions with physicians and other healthcare entity customers. These laws may require us to comply with certain codes of conduct, limit or report certain marketing expenses, disclose certain physician and customer arrangements, and ensure the appropriate licensure of certain sales personnel. There have also been similar federal legislative and regulatory initiatives. Violations of these laws and regulations, to the extent applicable, could subject us to civil and criminal fines and penalties, as well as possible exclusion from participation in federal healthcare programs, such as Medicare and Medicaid. From time to time, we may be the subject of investigations or audits or be a party to litigation which alleges violations of these laws. If any of those matters were successfully asserted against us, there could be a material adverse effect on our business, financial position, results of operations or prospects.

Physician Self-Referral. Certain provisions of the Omnibus Budget Reconciliation Act of 1993 (the Stark Law) prohibit healthcare providers such as us, subject to certain exceptions, from submitting claims to the Medicare and Medicaid programs for designated health services if we have a financial relationship with the physician making the referral for such services or with a member of such physician s immediate family. The term designated health services includes several services commonly performed or supplied by us, including durable medical equipment and home health services. In addition, financial relationship is broadly defined to include any ownership or investment interest or compensation arrangement pursuant to which a physician receives remuneration from the provider at issue. The Stark Law prohibition applies regardless of the reasons for the financial relationship and the referral; and therefore, unlike the federal anti-kickback statute, an intent to violate the law is not required. Like the

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federal anti-kickback statute, the Stark Law contains a number of statutory and regulatory exceptions intended to protect certain types of transactions and business arrangements from penalty.

In order to qualify an arrangement under a Stark Law exception, compliance with all of the exception s requirements is necessary. Violations of the Stark Law may result in loss of Medicare and Medicaid reimbursement, civil penalties and exclusion from participation in the Medicare and Medicaid programs.

In addition, a number of the states in which we operate have similar prohibitions against physician self-referrals, which may not necessarily be limited to Medicare or Medicaid services and may not include the same statutory and regulatory exceptions found in the Stark Law.

False Claims. The federal False Claims Acts impose civil and criminal liability on individuals or entities that submit false or fraudulent claims for payment to the government. Violations of the federal civil False Claims Act may result in treble damages, civil monetary penalties and exclusion from the Medicare, Medicaid and other federally funded healthcare programs. If certain criteria are satisfied, the federal civil False Claims Act allows a private individual to bring a qui tam suit on behalf of the government and, if the case is successful, to share in any recovery. Federal False Claims Act suits brought directly by the government or private individuals against healthcare providers, like us, are increasingly common and are expected to continue to increase.

The federal government has used the federal False Claims Act to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs. The government and a number of courts also have taken the position that claims presented in violation of certain other statutes, including the federal anti-kickback statute or the Stark Law, can be considered a violation of the federal False Claims Act, based on the theory that a provider impliedly certifies compliance with all applicable laws, regulations and other rules when submitting claims for reimbursement.

On May 20, 2009, President Obama signed into law the Fraud Enforcement and Recovery Act of 2009 (FERA). Among other things, FERA modifies the federal False Claims Act by expanding liability to contractors and subcontractors who do not directly present claims to the federal government. FERA also expanded the False Claims Act liability for what is referred to as a reverse false claim by explicitly making it unlawful to knowingly conceal or knowingly and improperly avoid or decrease an obligation owed to the federal government.

A number of states have enacted false claims acts that are similar to the federal False Claims Act. Even more states are expected to do so in the future because Section 6031 of the DRA amended the federal law to encourage these types of changes in law at the state level. In addition, there is a corresponding increase in state-initiated false claims enforcement efforts.

Other Fraud and Abuse Laws. HIPAA created, in part, two new federal crimes: Healthcare Fraud and False Statements Relating to Healthcare Matters. The Healthcare Fraud statute prohibits executing a knowing and willful scheme or artifice to defraud any healthcare benefit program. A violation of this statute is a felony and may result in fines and/or imprisonment. The False Statements statute prohibits knowingly and willfully falsifying, concealing or covering up a material fact by any trick, scheme or device or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. A violation of this statute is a felony and may result in fines and/or imprisonment.

The increased public focus on waste, fraud and abuse and their related cost to society will likely result in additional Congressional hearings, CMS regulatory changes or new laws. The Reform Package also provides for new regulatory authority, additional fines and penalties. At this time, we cannot predict whether these or other reforms will ultimately become law, or the impact of such reforms on our business operations and financial performance.

Certification of Compliance Agreement. Pursuant to the merger agreement to acquire Coram, we assumed Coram s obligations. On August 22, 2007, Coram entered into a three-year Compliance Agreement with the OIG which obligated Coram to maintain a compliance program to monitor and ensure compliance with federal healthcare program requirements and submit timely reports to the government regarding the same. Violation of the terms of the Compliance Agreement could have resulted in the imposition of penalties and sanctions, including disqualification from Medicare and other reimbursement programs. After submitting our final report to the OIG (as required under the Compliance Agreement), the OIG issued a closure letter to us dated September 21, 2010 that stated that the

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Compliance Agreement has concluded to the satisfaction of the OIG. The Company and its Coram division will continue to implement an enterprise-wide corporate compliance program which is grounded in existing laws, rules and regulations and guidelines for healthcare organizations issued by the OIG.

Facility and Clinician Licensure. Various federal and state authorities and clinical practice boards regulate the licensure of our facilities and clinical specialists working for us, either directly as employees or on a per diem or contractual basis. Regulations and requirements vary from state to state, and in some states, we are required to make filings in connection with transactions that may be defined as a change of control. Moreover, several states are currently contemplating the establishment or expansion of facility licensure related to the home healthcare industry. We are committed to complying with all applicable licensing requirements and maintain centralized functions to manage over 4,500 facility licenses and/or permits that are required to operate our business.

Healthcare Reform Legislation. Economic, political and regulatory influences are causing fundamental changes in the healthcare industry in the United States. Various healthcare reform proposals are formulated and proposed by the legislative and administrative branches of the federal government on a regular basis. In addition, some of the states in which we operate periodically consider various healthcare reform proposals. Even with the passage of the Reform Package, we anticipate that federal and state governments will continue to review and assess alternative healthcare delivery systems and payment methodologies and public debate of these issues will continue in the future. The 2010 mid-term election changed the composition of the Congress and may affect the priorities related to healthcare. Congress is likely to debate the potential to repeal or amend the Reform Package altogether. A number of other parties, including some State governments, have begun to challenge the Reform Package, and we cannot predict the outcome of such challenges. Changes in the law or new interpretations of existing laws can have a substantial effect on permissible activities, the relative costs associated with doing business in the healthcare industry and the amount of reimbursement by governmental and other third-party payors. In the coming years, the government is expected to promulgate the implementing rules and regulations of the Reform Package, including additional requirements related to our business. Until those rules are more clearly understood, and due to uncertainties regarding the ultimate features of additional reform initiatives and their enactment and implementation, we cannot predict which, if any, of such reform proposals will be adopted, or when they may be adopted, or that any such reforms will not have a material adverse effect on our results of operations, cash flow, capital resources and liquidity.

Employees

As of December 31, 2010, we had approximately 12,300 employees, of which 10,900 were full-time and 1,400 were part-time and per diem. As of December 31, 2010, none of our employees were represented by a labor union or other labor organization.

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ITEM 1A. RISK FACTORS

We operate in a rapidly changing environment that involves a number of risks. The following discussion highlights some of these risks and others are discussed elsewhere in this report. These and other risks could materially and adversely affect our business, financial condition, prospects, operating results or cash flows. The following risk factors are not an exhaustive list of the risks associated with our business. New factors may emerge or changes to these risks could occur that could materially affect our business.

Risks Relating to Our Business

Continued Reductions in Medicare and Medicaid Reimbursement Rates Could Have a Material Adverse Effect on Our Business Results of Operations and Financial Condition.

There are ongoing legislative and regulatory efforts to reduce or otherwise adversely affect Medicare reimbursement rates for products and services we provide. For example, the regulations implementing the mandates under the MMA, the DRA and MIPPA reduced the reimbursement for a number of products and services we provide and established a competitive bidding program for certain durable medical equipment under Medicare Part B. The Medicare DMEPOS competitive bidding program is intended to further reduce reimbursement for certain products and to decrease the number of companies permitted to serve Medicare beneficiaries. In July 2008, MIPPA was passed and included a delay to the competitive bidding program. In order to ensure that the delay would achieve the same level of savings projected for the DMEPOS competitive bidding program, Congress adopted a nationwide average payment reduction of 9.5% in the DMEPOS fee schedule for those product categories included in Round 1, effective January 1, 2009.

In 2009, CMS released an interim final rule implementing certain MIPPA provisions requiring CMS to conduct the Round 1 Rebid and mandated certain changes for both the Round 1 Rebid and subsequent rounds of the program. Approximately $21 million of our net revenues for the fiscal year ended December 31, 2009 was generated by the products and CBAs included in the Round 1 Rebid. Although we may experience increases in volume as a result of our competitive bidding contracts, we estimate that the initial results of the Round 1 Rebid would reduce our net revenues in the fiscal year ending December 31, 2011 by approximately $8 million, assuming the current contracts and no changes in volume. Assuming that Round 2 would include the same product categories, bidding rules and markets currently being proposed by CMS, we estimate that approximately $109 million of our net revenues for the fiscal year ending December 31, 2011 would be subject to competitive bidding. Although the bidding process for Round 2 is currently scheduled to commence in 2011, the effective date of new Round 2 rates and guidelines would take effect in January 2013 at the earliest. Therefore, we cannot estimate the impact of potential Round 2 rate reductions on our business until more specific information is published by CMS and its contractors. The Reform Package also made changes to the competitive bidding program and gave the Secretary of Health and Human Services the authority to apply competitive bid pricing to non-bid areas after a rulemaking process, but this could take effect by 2016. At this time, we cannot quantify what negative impact, if any, the revised program will have upon our revenue or operations when the program is reinitiated, but such impact could be material.

Further, the DRA resulted in reduced reimbursement rates for certain durable medical equipment, including the home oxygen equipment and services we provide, a reduced period for rental revenue, and potential increased costs to us associated with replacement of certain patient-owned equipment. There have been various administrative and legislative proposals to further reduce the maximum capped rental period for oxygen equipment below the 36-month level mandated by the DRA to 13 and 18 months, respectively, and/or to reduce the monthly payment rates for oxygen equipment.

There are also ongoing state and federal legislative and regulatory efforts to reduce or otherwise adversely affect Medicaid reimbursement rates for products and services we provide. For a number of years, some states have adopted alternative pricing methodologies for certain drugs, biologicals and home medical equipment reimbursed under the Medicaid program. In a number of states, the changes reduced the level of reimbursement we received for these items without a corresponding offset or increase to compensate for the service costs we incurred. For example, California s Medicaid program (Medi-Cal) adopted a regulation that limits the amounts a provider can bill for certain durable medical equipment and medical supplies. In March 2009, CAMPS initiated a lawsuit to invalidate this regulation as having been adopted in violation of California s Administrative Procedure Act. On August 3,

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2009, the court entered a decision denying CAMPS petition. CAMPS has appealed the court s decision. If the regulation is ultimately upheld, it could result in our making refunds and other payments to Medi-Cal and our future revenues from Medi-Cal may be reduced. In addition to this Medi-Cal regulation, we currently are examining other similar Medicaid program rules to confirm whether we have complied with the particular states Medicaid reimbursement methodologies. The review could result in our making refunds and other payments to these state Medicaid programs and our future revenues may be reduced. Historically, when we have learned that states have adopted such alternative reimbursement methodologies, we have sometimes elected to stop accepting new Medicaid patient referrals for the affected drugs, biologicals and home medical equipment. We are currently evaluating the possibility of stopping or reducing our Medicaid business in a number of states with reimbursement policies that make it difficult for us to conduct operations profitably. Moreover, the Reform Package increases Medicaid enrollment over a number of years and imposes additional requirements on states, which could further strain state budgets and therefore result in additional policy changes or rate reductions. In addition, changes to the federal regulations pertaining to prescription drug pricing may also impact the Medicaid reimbursement available to us. We cannot currently predict the adverse impact, if any, that any such changes to or reduction in our Medicaid business might have on our operations, cash flow and capital resources, but such impact could be material. In addition, we cannot predict whether other states will consider similar or other reimbursement reductions or whether any such changes could have a material adverse effect on our results of operations, cash flow and capital resources.

We cannot estimate the ultimate impact of all legislated and contemplated Medicare and Medicaid reimbursement changes or provide assurance to investors that additional reimbursement reductions will not be made or will not have a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

For further information, see *Business Government Regulation*.

The Comprehensive Healthcare Reform Law and Other Federal and State Legislative Efforts Could Have a Material Adverse Effect on Our Business, Results of Operations and Financial Condition.

Federal and State legislative and regulatory activities may materially affect reimbursement policies and rates for other items and services we provide and may otherwise affect our business results of operations and financial condition. For example, in March 2010, Congress enacted the Reform Package which includes comprehensive healthcare reform. Among many other provisions, the Reform Package expands the Medicaid program, mandates extensive insurance market reforms, creates new health insurance access points (e.g., insurance exchanges), provides certain insurance subsidies (e.g., premiums and cost sharing), imposes individual and employer health insurance requirements and makes a number of changes to the Code.

There are various provisions in the Reform Package that impact our business. For example, the Reform Package requires certain pharmaceutical and medical device manufacturers to pay an excise tax to the government, which may, in turn, increase our costs for these products. The Reform Package also provides for cuts in some Medicare payments made to certain providers and substantial cuts to Medicare Advantage plans, through which we contract to provide services to Medicare beneficiaries. Also included in the Reform Package are (i) an expansion of the Recovery Audit Contractor Program, (ii) certain fraud and abuse prevention measures and (iii) expanded regulatory authority concerning the types of conduct that can result in additional fines and penalties for those healthcare providers who do not comply with applicable laws and regulations. Furthermore, the Reform Package grants the Secretary of Health and Human Services authority to set a date by which certain providers and suppliers will be required to establish a compliance program.

The Reform Package makes a number of changes to how certain of the Company s products will be reimbursed by Medicare. As discussed above, the Reform Package also makes changes to the Medicare durable medical equipment CPI adjustment for 2011 and each subsequent year based upon the CPI-U reduced by a new multi-factor productivity adjustment which may result in negative updates. The law also includes changes to the Medicare DMEPOS competitive bidding program.

In an effort to further strengthen the integrity of the Medicare program, the Reform Package includes additional requirements concerning physician enrollment and certain mandatory face-to-face patient/physician visits in conjunction with the ordering of durable medical equipment. These provisions will be the subject of rulemaking and are a high priority for the American Association for Homecare and other industry representative organizations. We

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expect the Administration to continue to enhance its oversight efforts and the Company strives to incorporate any necessary changes into its overall policies, procedures, corporate compliance and internal audit programs on a regular basis.

The effective dates of the various provisions within the Reform Package are staggered over the next several years, with some changes occurring immediately. Much of the interpretation of what the Reform Package requires will be subject to administrative rulemaking, the development of agency guidance and court interpretations. We cannot currently predict the full impact of the Reform Package on our operations, cash flow and capital resources, but such impact could be material. In addition, other legislative and regulatory changes could have a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

We Believe That Continued Pressure to Reduce Healthcare Costs Could Have a Material Adverse Effect on Us.

As a result of continuing reductions in payor reimbursement, we, like many other healthcare companies, are making substantial efforts to reduce our costs in providing healthcare services and products. Certain managed care organizations and larger insurers also regularly attempt to seek reductions in the prices at which we provide services to them and their patients, or propose onerous payment rules and other administrative burdens. We have a large number of contractual arrangements with managed care organizations and other parties, which represented approximately 70% and 72% of our total net revenues for the year ended December 31, 2010 and 2009, respectively, and we expect that we will continue to enter into more of these contractual arrangements. Also, the Reform Package significantly reduces the government s payment rates to Medicare Advantage plans. Other provisions impose minimum medical-loss ratios, state and federal premium review procedures and benefit requirements on insurers. These public policy changes have unpredictable effects on the insurance industry on which we rely. There can be no assurance that we will retain or obtain Medicare Advantage or other such managed care contracts or that such plans will not attempt to further reduce the rates they pay to providers. In addition, if we are unable to successfully reduce our costs, we may be unable to continue to provide services directly to patients of certain payors or through these contractual arrangements. This would have a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

The segment of the healthcare market in which we operate is highly competitive. In each of our service lines, there are a number of national providers and numerous regional and local providers. Other types of healthcare providers, including industrial gas manufacturers, individual hospitals and hospital systems, home health agencies and health maintenance organizations, have entered and may continue to enter the market to compete with our various service lines. With access to significantly greater financial and market resources than what is available to us, some of these competitors may be better positioned to compete in the market. This may increase pricing pressure and limit our ability to maintain or increase our market share and may have a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

Non-Compliance With Laws and Regulations Applicable to Our Business and Future Changes in or Interpretations of Those Laws and Regulations Could Have a Material Adverse Effect on Us.

We are subject to many stringent and frequently changing laws and regulations, and interpretations thereof, at both the federal and state levels, requiring compliance with burdensome and complex billing and payment, substantiation and record-keeping requirements. We implement policies and procedures designed to meet the various documentation requirements of government payors as they have been interpreted and applied. Examples of such documentation requirements are contained in the DMEMAC Supplier Manuals which provide that clinical information from the patient s medical record is required to justify the medical necessity for the provision of DME. Some DMEMACs and other government auditors have recently taken the position, among other things, that the patient s medical record refers not to documentation maintained by the DME supplier but instead to documentation maintained by the patient s physician, healthcare facility, or other clinician, and that clinical information created by the DME supplier s personnel and confirmed by the patient s physician is not sufficient to establish medical necessity. It may be difficult, and sometimes impossible, for us to obtain such documentation from other healthcare providers. Also, auditors interpretation of these policies is inconsistent and subject to individual interpretations leading to high supplier and industry error rates. If these or other challenging positions continue to be adopted by auditors, DMEMACs, other contractors or CMS in administering the Medicare program, we have the right to contest these positions as being contrary to law. If these interpretations of the documentation requirements are ultimately upheld, however, it could result in our making significant refunds and other payments to Medicare

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and our future revenues from Medicare would likely be substantially reduced. We cannot currently predict the adverse impact, if any, that these new, more onerous interpretations of the Medicare documentation requirements might have on our relationships with referral sources, operations, cash flow and capital resources, but such impact could be material.

The federal False Claims Act imposes civil and criminal liability on individuals or entities that submit false or fraudulent claims for payment to the government. The federal government and a number of courts also have taken the position that claims presented in violation of certain other statutes, including the federal anti-kickback statute or the Omnibus Budget Reconciliation Act of 1993 (the Stark Law), can be considered a violation of the federal False Claims Act. Violations of the federal civil False Claims Act may result in treble damages, civil monetary penalties and exclusion from the Medicare, Medicaid and other federally funded healthcare programs. If certain criteria are satisfied, the federal civil False Claims Act allows a private individual to bring a qui tam suit on behalf of the government and, if the case is successful, to share in any recovery. Federal False Claims Act suits brought directly by the government or private individuals against healthcare providers, like us, are increasingly common and are expected to continue to increase.

The Reform Package also includes certain fraud and abuse prevention measures and expands regulatory authorities concerning the types of conduct that can result in additional fines and penalties for those healthcare providers who do not comply with applicable laws and regulations.

Financial relationships between us and physicians and other referral sources are also subject to strict limitations under laws such as the Stark Law and anti-kickback laws. In addition, strict licensure, accreditation, safety and marketing requirements apply to the provision of services, pharmaceuticals and medical equipment.

Violations of these laws and regulations could subject us to civil and criminal enforcement actions; licensure revocation, suspension or non-renewal; severe fines; facility shutdowns; repayment of amounts received from third party payors and possible exclusion from participation in federal healthcare programs such as Medicare and Medicaid. We cannot assure you that we are in compliance with all applicable existing laws and regulations or that we will be able to comply with any new laws or regulations that may be enacted in the future. In addition, from time to time, we may be the subject of investigations or audits or be a party to qui tam or other False Claims Act litigation which alleges violations of law. If any of those matters were successfully asserted against us, there could be a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources, liquidity or prospects.

Changes in public policy, healthcare law, new interpretations of existing laws, or changes in payment methodology may have a significant effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

Expanded Government Auditing and Oversight of Medicare Suppliers and More Stringent Interpretations by Those Auditors of Regulations and Rules Concerning Billing for Our Services and Products Could Have a Material Adverse Effect on Us.

Current law, including the recent Reform Package and an executive order signed by the President, provides for a significant expansion of the government s auditing and oversight of suppliers who care for patients covered by various government healthcare programs. Examples of this expansion include audit programs being implemented by the DME MAC contractors, the Zone Program Integrity Contractors (ZPICs), the Recovery Audit Contractors (RACs) and the Comprehensive Error Rate Testing contractors (CERTs) operating under the direction of CMS**.** We work cooperatively with these auditors and have long maintained a process for centrally tracking and managing our responses to their audit requests. However, unlike other government programs that are subject to a formal rulemaking process, there are only limited publicly-available guidelines and methodologies for determining errors or for providing clear and timely communications to DMEPOS suppliers in connection with these new types of audits. As a result, there is significant lack of clarity regarding the authority of the auditors, their expectations for document production requested during audits and the methodology for determining errors and calculating error rates.

We have recently been subject to audits conducted under these new programs. Some of these audits have preliminarily ascribed error rates to our audited locations that are significantly higher than we, and others in the industry, have experienced in the past. In some cases, these high error rates appear to be based on the auditors incomplete or erroneous review of our submitted documentation or unclear scoring methodologies used by the

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auditors. In other instances, high error rates have resulted from the auditors use of more stringent interpretations of the types of medical necessity documentation required for CMS to pay for the services we provide. We are appealing the results of these recent audits, but cannot predict the outcome of such appeals.

As a result, we have been informed by these auditors that other healthcare providers and all suppliers of certain DMEPOS product categories are expected to experience increased scrutiny from these new audit programs. When a government auditor ascribes a high error rate to one or more of our locations, it generally results in protracted pre-payment claims review, payment delays, refunds and other payments to the government and/or our need to request more documentation from referral sources than has historically been required. Our error rate, aggregated with other DMEPOS suppliers in the industry, is then reported to Medicare contractors and Congress. The DMEPOS industry error rate in 2009 was 51.9% and, according to industry sources, may be over 70% in 2010. We cannot currently predict the adverse impact, if any, that these new audits, methodologies and interpretations might have on our operations, cash flow and capital resources, but such adverse impact could be material.

See *Risks Relating to Our Business Non-Compliance with Laws and Regulations Applicable to Our Business and Future Changes in or Interpretations of These Laws and Regulations Could Have a Material Adverse Effect on Us* for additional information.

Our Business and Financial Performance May Be Adversely Affected By Our Inability to Effectively Execute and Implement Cost Savings Initiatives.

We launched a substantial multi-year cost reduction plan in late 2007 across a number of identified initiatives presently targeting estimated pre-tax savings of approximately $168 million on an annualized basis, of which we have realized approximately $153 million through December 31, 2010. The programs related to the remaining targeted annual savings of approximately $15 million include certain customer service and billing center centralization, purchasing cost reduction initiatives, outsourcing certain functions of our information technology department, a branch optimization program, outsourced equipment pickups and exchanges and document imaging. Projected costs and savings associated with these initiatives are subject to a variety of risks, including:

- the contemplated costs to effect these initiatives may exceed estimates;
- the initiatives we are contemplating may require consultation with various customers, employees, labor representatives or regulators, and such consultations may influence the timing, costs and extent of expected savings;
- the loss of skilled employees in connection with the initiatives; and
- the projected savings contemplated under these programs may fall short of targets.

While we have begun and expect to continue to implement these cost savings initiatives, there can be no assurance that we will be able to do so successfully or that we will realize the projected benefits of these and other restructuring and cost savings initiatives. If we are unable to realize these anticipated cost savings initiatives, our business may be adversely affected. Moreover, our continued implementation of cost savings initiatives may have a material adverse effect on our business, results of operations and financial condition, including but not limited to the loss of revenue, increases in accounts receivable and reserves and/or write-offs of accounts receivable. Also, in response to changing business conditions, we may discontinue or significantly adjust our cost savings initiatives which would affect our ability to achieve future cost savings.

Our Failure to Successfully Design, Modify and Implement Computer and Other Process Changes to Maximize Productivity and Ensure Compliance Could Ultimately Have a Significant Negative Impact on Our Results of Operations and Financial Condition.

We have identified a number of areas throughout our operations where we intend to modify the current processes or systems in order to attain a higher level of productivity or ensure compliance. The ultimate cost savings expected from the successful design and implementation of such initiatives will be necessary to help offset the impact of Medicare and Medicaid reimbursement reductions and continued downward pressure on pricing. Additionally, Medicare and Medicaid often change their documentation requirements. The DMEPOS competitive bidding program, once fully implemented, will also impose new reporting requirements on contracted providers. From time to time, our outsourcing contractor for certain information systems functions, Perot Systems Corporation, makes operational, leadership or other changes that could impact our plans and cost-savings goals. Our failure to

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successfully design and implement system or process modifications could have a significant impact on our operations and financial condition. Further, the implementation of these system or process changes could have a disruptive effect on related transaction processing and operations.

Our Failure to Maintain Controls and Processes Over Billing and Collections or to Execute the Outsourcing Effectively, the Deterioration of the Financial Condition of Our Payors or Disputes With Third Parties Could Have a Significant Negative Impact on Our Results of Operations and Financial Condition.

The collection of accounts receivable is one of our most significant challenges and requires constant focus and involvement by management and ongoing enhancements to information systems and billing center operating procedures. For example, we have experienced an increase in accounts receivable attributable, among other things, to transitioning of some of our billing and collection functions to our outsourcing contractor and to changes in payment practices by some of our payors and their intermediaries. Despite an adjustment to our outsourcing initiative in this area, there can be no assurance that we will be able to return to our historic levels or maintain our current levels of collectibility and days sales outstanding in future periods. Further, some of our payors and/or patients may experience financial difficulties, or may otherwise not pay accounts receivable when due, resulting in increased write-offs. If we are unable to properly bill and collect our accounts receivable, our results will be adversely affected. In addition, from time to time we are involved in disputes with various parties, including our payors and their intermediaries regarding their performance of various contractual or regulatory obligations. These disputes sometimes lead to legal and other proceedings and cause us to incur costs or experience delays in collections, increases in our accounts receivable or loss of revenue. In addition, in the event such disputes are not resolved in our favor or cause us to terminate our relationships such parties, there may be an adverse impact on our results of operations or financial condition.

Our Outsourcing, Offshoring and Onshoring Activities Subject Us to Risks That Could Have a Significant Negative Impact on Our Results of Operations and Financial Condition.

We have pursued an outsourcing strategy with respect to certain business functions. We have outsourced certain billing, collections and other administrative and clerical services to Intelenet and certain information systems functions to Perot Systems Corporation. There is intense competition around the world for skilled business process and technical professionals and we expect that competition to increase, which could result in our outsourcing strategy not having the favorable economic impact currently projected. Operations in other parts of the world involve certain regional geopolitical risks that are different than operating in the United States, including the possibility of civil unrest, terrorism and substantial regulation by the individual governments. In addition, federal and state regulators have expressed concerns regarding the impact of offshoring on American business in general, including, for example, job loss, security and privacy concerns. These factors may cause disruptions in our business processes which could have a material adverse impact on our operations. We also may experience negative reactions from federal and state regulators, payors, patients and referral sources as a result of the actual or perceived concerns caused by the outsourcing of portions of our business operations, including increases in accounts receivable or reserves, write-offs of accounts receivable and/or loss of revenues. In addition, in 2010 we determined to return certain of the outsourced functions to our personnel in the United States. This transition may result in various one-time costs and temporary operational inefficiencies. There are no assurances that we will be successful in the transitioning of these functions back to the United States. Among other things, risks associated with the transition process may result in our inability to bill for our services, cause increases in our accounts receivable, impact our ability to collect current or future accounts receivables or cause us to increase accounts receivable reserves, all of which may have an adverse impact on our results of operations or financial condition.

Our Failure to Maintain Required Licenses Could Impact Our Operations.

We are required to maintain a significant number of state and/or federal licenses for our operations and facilities. Certain employees primarily those with clinical expertise in pharmacy, nursing, respiratory therapy and nutrition are required to maintain licenses in the states in which they practice. We manage the facility licensing function centrally. In addition, individual clinical employees are responsible for obtaining, maintaining and renewing their professional licenses and we also have processes in place designed to notify branch or pharmacy managers of renewal dates for the clinical employees under their supervision. State and federal licensing requirements are complex and often open to subjective interpretation by various regulatory agencies. In addition, from time to time, we may become subject to new or different licensing requirements due to legislative or regulatory

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requirements developments or changes in our business, and such developments may cause us to make further changes in our business, the results of which may be material. Although we believe we have appropriate systems in place to monitor licensure, violations of licensing requirements may occur and our failure to acquire or maintain appropriate licensure for our operations, facilities and clinicians could result in interruptions in our operations, refunds to state and/or federal payors, sanctions or fines, which could have an adverse material impact on our business, financial condition, results of operation, cash flow, capital resources and liquidity.

Our Failure to Maintain Accreditation Could Impact Our Operations.

Accreditation is required by most of our managed care payors and became a mandatory requirement for all Medicare DMEPOS providers effective October 1, 2009. In June 2010, we completed a nationwide independent triennial accreditation renewal process conducted by The Joint Commission, and the Commission renewed our accreditation for another three years. The Joint Commission accreditation encompasses our full complement of services including home health, home medical equipment, clinical respiratory, ambulatory infusion services, pharmacy dispensing, and clinical consultant pharmacist services. We have more than 19 years of continuous accreditation by The Joint Commission longer than any other homecare provider. If we or any of our branches lose accreditation, or if any of our new branches are unable to become accredited, our failure to maintain accreditation or become accredited could have a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

Political and Economic Conditions and the Recent Financial Turmoil in the United States and Global Capital and Credit Markets As Well As Significant Global or Regional Developments Such As Economic and Political Events, International Conflicts, Natural Disasters That are Out of Our Control and the Ongoing Number of the Uninsured Could Adversely Affect Our Revenue and Results of Operations and Overall Financial Growth and Could Have a Material Adverse Effect on Us.

Our business can be affected by a number of factors that are beyond our control such as general geopolitical, economic and business conditions, conditions in the financial services markets, and general political and economic developments. For example, federal deficit spending levels, the costs of military and security activities, government expenditures to support or bail out financial institutions or the U.S. credit markets in light of historical significant declines and volatility in the financial markets, or prolonged relief efforts in response to a natural disaster could increase pressure to reduce government expenditures for other purposes, including government-funded programs such as Medicare and Medicaid. The mid-term elections in 2010 changed the composition of Congress; reductions in reimbursement from Medicare and Medicaid programs could result if there is a significant change in government spending priorities as a result. Any such reimbursement reductions could have a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

Turmoil in the financial markets, including in the capital and credit markets, the ongoing economic slowdown and the uncertainty over its breadth, depth and duration may continue to put pressure on the global economy and could have a negative effect on our business. Further, historical worldwide financial and credit turmoil has reduced the availability of liquidity and credit to fund the continuation and expansion of business operations worldwide. The shortage of liquidity and credit combined with substantial losses in worldwide equity markets could extend the economic recession in the United States or worldwide. As widely reported, financial markets in the United States, Europe and Asia have experienced extreme disruption, including, among other things, extreme volatility in security prices, severely diminished liquidity and credit availability, rating downgrades of certain investments and declining valuations of others. Governments have taken unprecedented actions intended to address extreme market conditions that include severely restricted credit and declines in real estate values. There can be no assurance that the deterioration in financial markets will not impair our ability to obtain financing in the future, including, but not limited to, our ability to draw on funds under our ABL Facility and our ability to incur additional indebtedness. If conditions in the global economy, U.S. economy or other key vertical or geographic markets remain uncertain or weaken further, we could experience material adverse impacts on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

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Our Strategic Growth Plan, Which Involves the Acquisition of Other Companies, May Not Succeed.

Our strategic growth plan involves, in part, the acquisition of other companies such as our 2007 acquisition of Coram and our planned acquisition of the assets of Praxair Healthcare Services home healthcare services division in the United States. Such growth involves a number of risks, including:

- difficulties related to combining previously separate businesses into a single unit, including product and service offerings, distribution and operational capabilities and business cultures;
- availability of financing to the extent needed to fund acquisitions;
- customer loss and other general business disruption;
- managing the integration process while completing other independent acquisitions or dispositions;
- diversion of management s attention from day-to-day operations;
- assumption of liabilities of an acquired business, including unforeseen or contingent liabilities or liabilities in excess of the amounts estimated;
- failure to realize anticipated benefits and synergies, such as cost savings and revenue enhancements;
- potentially substantial costs and expenses associated with acquisitions and dispositions;
- failure to retain and motivate key employees;
- coordinating research and development activities to enhance the introduction of new products and services; and
- difficulties in applying our internal control over financial reporting and disclosure controls and procedures to an acquired business.

Also, the number of the uninsured in the United States has had an impact on certain healthcare services and products that may be more discretionary in nature. This has resulted in a slowing down of certain growth rates due to the patients more limited ability to pay the associated out-of-pocket fees. This could continue as the number uninsured remains high.

We May Not Be Able to Realize Anticipated Cost Savings, Revenue Enhancements or Synergies From the Transactions or From Our Acquisitions.

We may not be able to realize the potential cost savings, synergies and revenue enhancements that we anticipate from the Transactions or from our acquisitions, either in the amount or within the time frame that we expect, and the costs of achieving these benefits may be higher than, and the timing may differ from, what we expect. Our ability to realize anticipated cost savings, synergies and revenue enhancements may be affected by a number of factors, including, but not limited to, the following:

the use of more cash or other financial resources on integration and implementation activities than we expect;

increases in other expenses unrelated to the Transactions or our acquisitions, which may offset the cost savings and other synergies from those transactions;

our ability to eliminate effectively duplicative back office overhead and overlapping and redundant selling, general and administrative functions; and

our ability to avoid labor disruptions in connection with any integration, particularly in connection with any headcount reduction.

In addition, estimated cost savings are only estimates and may not actually be achieved in the timeframe anticipated or at all. If we fail to realize anticipated cost savings, synergies or revenue enhancements, our financial results will be adversely affected, and we may not generate the cash flow from operations that we anticipated, or that is sufficient to repay our indebtedness.

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There is an Inherent Risk of Liability in the Provision of Healthcare Services; Damage to Our Reputation or Our Failure to Adequately Insure Against Losses Could Have a Material Adverse Effect on Our Operations, Financial Condition or Prospects.

There is an inherent risk of liability in the provision of healthcare services and many of our patients are gravely ill. As participants in the healthcare industry, we expect to periodically be subject to lawsuits, some of which may involve large claims and significant costs to defend. In that case, the coverage limits under our insurance programs may not be adequate to protect us. We also cannot be assured that we will be able to maintain this insurance on acceptable terms in the future. A successful claim in excess of our coverage could have a material adverse effect upon our business, financial condition, results of operations, cash flow, capital resources and liquidity. Even where our insurance is adequate to cover claims against us, damage to our reputation in the event of a judgment against us could have an adverse effect on our business, financial condition, results of operations, cash flow, capital resources, liquidity or prospects.

We Experience Competition From Numerous Other Home Respiratory/Home Medical Equipment and Home Infusion Therapy Service Providers, and This Competition Could Adversely Affect Our Revenues and Our Business.

The home respiratory/home medical equipment and home infusion therapy markets are highly competitive and include a large number of providers, some of which are national providers, but most of which are either regional or local providers, including hospital systems, physician specialists and sleep labs. We believe that the primary competitive factors are quality considerations such as responsiveness, the technical ability of the professional staff and the ability to provide comprehensive services. These markets are very fragmented. Some of our competitors may now or in the future have greater financial or marketing resources than we do. In addition, in certain markets, competitors may have more effective sales and marketing activities. Our largest national home respiratory/home medical equipment provider competitors are American HomePatient, Inc., Lincare Holdings, Inc. and Rotech Healthcare Inc. Our largest competitors in the home infusion therapy service market are Walgreens/OptionCare and Accredo/Critical Care Systems. The rest of the market in the United States consists of several medium-size competitors, as well as numerous small (under $3.5 million in revenues) local operations. There are relatively few barriers to entry in local home healthcare markets. We cannot assure you that the competitive nature of the homecare environment will not adversely affect our revenues and our business.

Our Business Operations are Labor Intensive. Difficulty Hiring Enough Additional Management and Other Employees, Increasing Costs of Compensation or Employee Benefits, and the Potential Impact of Unionization and Organizing Activities Could Have an Adverse Effect on Our Costs and Results of Operations.

The success of our business depends upon our ability to attract and retain highly motivated, well-qualified management and other employees. One of our largest costs is in the payment of salaries and benefits to our approximately 12,300 employees. We face significant competition in the recruitment of qualified employees, which has caused increased salary and wage rates among certain employee groups. If we are unable to recruit or retain a sufficient number of qualified employees, or if the costs of compensation or employee benefits increase substantially, our ability to deliver services effectively could suffer and our profitability would likely be adversely affected. The Reform Package may materially increase our cost of providing health benefits to our employees and their dependents. In addition, union organizing activities have occurred in the past and may occur in the future, and the adverse impact of unionization and organizing activities on our costs and operating results could be substantial.

We are Highly Dependent Upon Senior Management; Our Failure to Attract and Retain Key Members of Senior Management Could Have a Material Adverse Effect on Us.

We are highly dependent on the performance and continued efforts of our senior management team. Our future success is dependent on our ability to continue to attract and retain qualified executive officers and senior management. Any inability to manage our operations effectively could have a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

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Our Reliance on Relatively Few Suppliers for the Majority of Our Patient Service Equipment, Pharmaceuticals and Supplies and New Excise Taxes Which Are To Be Imposed on Certain Manufacturers of Such Items Could Adversely Affect Our Ability to Operate.

We currently rely on a relatively small number of suppliers to provide us with the majority of our patient service equipment, pharmaceuticals and supplies. Significant price increases, or disruptions in the ability to obtain such equipment, pharmaceuticals and supplies from existing suppliers, may force us to use alternative suppliers. Additionally, the Reform Package calls for significant new excise taxes to be imposed on manufacturers of certain medical equipment and pharmaceuticals taxes which they could attempt to pass on to customers such as us. Such manufacturers may be forced to make other changes to their products or manufacturing processes that are unacceptable to us, resulting in our desire to change suppliers. Any change in suppliers we use could cause delays in the delivery of such products and possible losses in revenue, which could adversely affect our results of operations. In addition, alternative suppliers may not be available, or may not provide their products and services at similar or favorable prices. If we cannot obtain the patient service equipment, pharmaceuticals and supplies we currently use, or alternatives at similar or favorable prices, our ability to provide such products may be severely impacted, which could have an adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

Our Failure to Establish and Maintain Relationships With Hospital and Physician Referral Sources May Cause Our Revenue to Decline.

Our success is significantly dependent on referrals from hospital and physician sources. If we are unable to successfully establish new referral sources and maintain strong relationships with our current referral sources, or if efforts to increase the skill level and effectiveness of our sales force fail, our revenues may decline.

Changes in Medical Equipment Technology and Development of New Treatments May Cause Our Current Equipment or Services to Become Obsolete.

We evaluate changes in home medical equipment technology and treatments on an ongoing basis for purposes of determining the feasibility of replacing or supplementing items currently included in the patient service equipment inventory and services that we offer our customers. The selection of medical equipment and services we offer is formulated on the basis of a variety of factors, including overall quality, functional reliability, availability of supply, payor reimbursement policies, product features, labor costs associated with the technology, acquisition, repair and ownership costs and overall patient and referral source demand, as well as patient therapeutic and lifestyle benefits. Manufacturers continue to invest in research and development to introduce new products to the marketplace. It is possible that major changes in available technology, payor benefit or coverage policies related to those changes, or the preferences of patients and referral sources may cause our current product offerings to become less competitive or obsolete, and it will be necessary for us to adapt to those changes. Unanticipated changes could cause us to incur increased capital expenditures and accelerated equipment write-offs, and could force us to alter our sales, operations and marketing strategies.

Our Operations Involve the Transport of Compressed and Liquid Oxygen, Which Carries an Inherent Risk of Rupture or Other Accidents With the Potential to Cause Substantial Loss.

Our operations are subject to the many hazards inherent in the transportation of medical gas products and compressed and liquid oxygen, including ruptures, leaks and fires. These risks could result in substantial losses due to personal injury or loss of life, severe damage to and destruction of property and equipment and pollution or other environmental damage and may result in curtailment or suspension of our related operations. If a significant accident or event occurs, it could adversely affect our business, financial position and results of operations.

Our Medical Gas Facilities and Operations are Subject to Extensive Regulation by Federal and State Authorities and There Can Be No Assurance That Our Medical Gas Facilities Will Achieve and Maintain Compliance With Such Regulations.

We have a number of medical gas facilities in several states subject to federal and state regulatory requirements. Our medical gas facilities and operations are subject to extensive regulation by the Food and Drug Administration (FDA) and other federal and state authorities. The FDA regulates medical gases, including medical oxygen, pursuant to its authority under the federal Food, Drug and Cosmetic Act (FFDCA). Among other requirements, the FDA s

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current Good Manufacturing Practice (cGMP) regulations impose certain quality control, documentation and recordkeeping requirements on the receipt, processing and distribution of medical gas. Further, in each state in which we do business, our medical gas facilities are subject to regulation under state health and safety laws, which vary from state to state. The FDA and state authorities conduct periodic, unannounced inspections at medical gas facilities to assess compliance with the cGMP and other regulations, and we expend significant time, money and resources in an effort to achieve substantial compliance with the cGMP regulations and other federal and state law requirements at each of our medical gas facilities. We also comply with the FDA s requirement for medical gas providers to register their sites with the agency. There can be no assurance, however, that these efforts will be successful and that our medical gas facilities will achieve and maintain compliance with federal and state law regulations. Our failure to achieve and maintain regulatory compliance at our medical gas facilities could result in enforcement action, including warning letters, fines, product recalls or seizures, temporary or permanent injunctions, or suspensions in operations at one or more locations, and civil or criminal penalties which would materially harm our business, financial condition, results of operations, cash flow, capital resources and liquidity.

We Have in the Past Identified a Material Weakness in Our Internal Controls Over Financial Reporting as it Relates to the Calculation of Accounts Receivable Reserves. If We Do Not Maintain Effective Internal Controls Over Financial Reporting, We Could Fail to Accurately Report Our Financial Results.

We have in the past identified a material weakness in our internal control over financial reporting. In light of this material weakness in internal control over financial reporting, we also concluded that our disclosure controls and procedures were not effective as of certain dates in 2007 and 2008.

A material weakness is defined by the standards issued by the Public Company Accounting Oversight Board as a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected. We did not effectively design and perform control activities to prevent or detect material misstatements that might exist in our reserve for uncollectible accounts receivable. Specifically, we did not perform an analysis with a sufficient level of detail to support management s estimate of the reserve for uncollectible accounts receivable.

During 2008, we implemented a remediation program designed to address such material weakness. In the fourth quarter of 2008, we concluded that our remediation program was operating effectively and as of December 31, 2008, management concluded that the material weakness was remediated and did not exist as of that date. If our remediation efforts are insufficient to address the material weakness, or if additional material weaknesses in our internal controls are discovered in the future, they may adversely affect our ability to record, process, summarize and report financial information timely and accurately and, as a result, our financial statements may contain material misstatements or omissions.

We have completed a number of acquisitions in the past several years, and may continue to pursue growth through strategic acquisitions. Among the risks associated with acquisitions are the risks of control deficiencies that result from the integration of the acquired business.

It is possible that control deficiencies could be identified by our management or by our independent auditing firm in the future or may occur without being identified. Such a failure could result in regulatory scrutiny, cause investors to lose confidence in our reported financial condition, lead to a default under our indebtedness and otherwise materially adversely affect our business and financial condition.

Affiliates of the Sponsor Own Substantially All of the Equity Interests in Us and May Have Conflicts of Interest With Us or the Holders of the Notes in the Future.

Investment funds affiliated with the Sponsor collectively own a substantial majority of our capital stock, and the Sponsor designees hold a majority of the seats on our board of directors. As a result, affiliates of the Sponsor have control over our decisions to enter into any corporate transaction and have the ability to prevent any transaction that requires the approval of stockholders regardless of whether holders of our Notes believe that any such transactions are in their own best interests. For example, affiliates of the Sponsor could collectively cause us to make acquisitions that increase the amount of our indebtedness or to sell assets, or could cause us to issue additional capital stock or declare dividends. So long as investment funds affiliated with the Sponsor continue to indirectly own a significant amount of the outstanding shares of our common stock, affiliates of the Sponsor will continue to

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be able to strongly influence or effectively control our decisions. The indenture governing the Notes and the credit agreement governing our ABL Facility permit us to pay advisory and other fees, dividends and make other restricted payments to the Sponsor under certain circumstances and the Sponsor or its affiliates may have an interest in our doing so. In addition, the Sponsor has no obligation to provide us with any additional debt or equity financing.

Additionally, the Sponsor is in the business of making investments in companies and may from time to time acquire and hold interests in businesses that compete directly or indirectly with us or that supply us with goods and services. For example, the Sponsor controls Intelenet, an Indian company with which we contracted in 2009 to assist us with the outsourcing of certain revenue management functions. The Sponsor may also pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us. The holders of the Notes should consider that the interests of the Sponsor and other members of the Investor Group may differ from their interests in material respects.

Proposed Federal Legislation, If Passed, Would Encourage Greater Unionization and Could Materially Impact Our Labor Costs and Customer Service Provided to Patients.

The Employee Free Choice Act, which was introduced in both the 110th and 111th Congresses would change existing laws concerning union representation. It is expected that similar legislation will be introduced into the 112th Congress. Previous versions of the Employee Free Choice Act would have, in certain circumstances, eliminated the secret ballot voting process, shortened the time window in which a contract negotiation between an employee and a labor union must take place and mandated arbitration of contract terms if a negotiated contract is not met within certain timeframes. While the ultimate outcome of this legislation is still unclear, any increased union representation within the homecare industry or mandatory arbitration of contract terms would potentially increase labor and other operating expenses. Additional unionization could also negatively impact our ability to provide high quality service to patients in the event of a strike or other work stoppage.

Our Ability to Retain Certain Hospital-Based Referral Revenue is Contingent on the Quality of Our Referral Process and Patient Service.

For over a decade, we implemented a contractual business model with a number of hospitals which facilitates continuity of care and quality for patients who are being discharged from those hospitals to the homecare setting. We discontinued most of these arrangements in 2009. In these cases, we continue to work closely with the hospitals to accept discharges for their patients who require our services. However, the dissolution of a contractual relationship may result in the decision by hospitals to refer patients to our competitors in lieu of or in addition to us. We are not able to predict whether the discontinuance of any additional hospital arrangements will have a material impact on our overall operational and financial results.

Our Payor Contracts are Subject to Renegotiation or Termination Which Could Result in a Decrease in Our Revenue and Profits.

From time to time, our payor contracts are amended, renegotiated or terminated altogether. Sometimes in the renegotiation process, certain lines of business may not be renewed or a payor may enlarge its provider network or otherwise adversely change the way it conducts its business with us. In other cases, a payor may reduce its provider network in exchange for lower payment rates. Our revenue from a payor may also be adversely affected if the payor alters its administrative procedures for payments and audits, changes its order of preference among the providers to which it refers business or imposes a third party administrator, network manager or other intermediary. Any significant reduction in our actual or projected revenues as a result of these or other factors could lead to an impairment of the value of our goodwill and intangible assets which would result in a decrease in these assets on our balance sheet. We cannot assure you that we will not have such an impairment charge or that our payor contracts will not be terminated or altered in ways that are unfavorable to us as a result of renegotiation or such administrative changes.

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Risks Relating to Our Indebtedness

Our Substantial Indebtedness Could Adversely Affect Our Financial Condition and Prevent Us From Fulfilling Our Obligations Under our Indebtedness.

We have a substantial amount of debt, which requires significant interest and principal payments. As of December 31, 2010, we had approximately $1,019.4 million of total debt outstanding. Subject to the limits contained in the credit agreement governing our ABL Facility, the indenture governing the Notes and our other debt instruments, we may be able to incur substantial additional debt from time to time to finance working capital, capital expenditures, investments or acquisitions, or for other purposes. If we do so, the risks related to our high level of debt could intensify. Specifically, our high level of debt could have important consequences, including the following:

- making it more difficult for us to satisfy our obligations with respect to our debt;
- limiting our ability to obtain additional financing to fund future working capital, capital expenditures, acquisitions or other general corporate requirements;
- requiring a substantial portion of our cash flows to be dedicated to debt service payments instead of other purposes, thereby reducing the amount of cash flows available for working capital, capital expenditures, acquisitions and other general corporate purposes;
- increasing our vulnerability to general adverse economic and industry conditions;
- exposing us to the risk of increased interest rates as certain of our borrowings may be at variable rates of interest;
- limiting our flexibility in planning for and reacting to changes in the industry in which we compete;
- placing us at a disadvantage compared to other, less leveraged competitors; and
- increasing our cost of borrowing.

Our Variable Rate Indebtedness Subjects Us to Interest Rate Risk, Which Could Cause Our Indebtedness Service Obligations to Increase Significantly.

Borrowings under our ABL Facility are at variable rates of interest and expose us to interest rate risk. If interest rates increase, our debt service obligations on the variable rate indebtedness would increase even though the amount borrowed remained the same, and our net income and cash flows, including cash available for servicing our indebtedness, would correspondingly decrease.

We May Be Unable to Service Our Indebtedness.

The Indenture Governing the Notes and the Credit Agreement Governing Our ABL Facility Impose Significant Operating and Financial Restrictions on Our Company and Our Subsidiaries, Which May Prevent Us From Capitalizing on Business Opportunities.

The indenture governing the Notes and the credit agreement governing our ABL Facility impose significant operating and financial restrictions on us. These restrictions limit our ability, among other things, to:

incur additional indebtedness or enter into sale and leaseback obligations;

pay certain dividends or make certain distributions on our capital stock or repurchase or redeem our capital stock;

make certain capital expenditures;

make certain loans, investments or other restricted payments;

place restrictions on the ability of our subsidiaries to pay dividends or make other payments to us;

engage in transactions with stockholders or affiliates;

sell certain assets or engage in mergers, acquisitions and other business combinations;

amend or otherwise alter the terms of our indebtedness;

alter the business that we conduct;

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guarantee indebtedness or incur other contingent obligations; and

create liens.

Our ABL Facility also includes financial covenants. Our ability to comply with these covenants is dependent on our future performance, which will be subject to many factors, some of which are beyond our control.

As a result of these covenants and restrictions, we are limited as to how we conduct our business and we may be unable to raise additional debt or equity financing to compete effectively or to take advantage of new business opportunities. The terms of any future indebtedness we may incur could include more restrictive covenants. We cannot assure you that we will be able to maintain compliance with these covenants in the future and, if we fail to do so, that we will be able to obtain waivers from the lenders and/or amend the covenants.

Our failure to comply with the restrictive covenants described above as well as other terms of our existing indebtedness and/or the terms of any future indebtedness from time to time could result in an event of default, which, if not cured or waived, could result in our being required to repay these borrowings before their due date. If we are forced to refinance these borrowings on less favorable terms, our results of operations and financial condition could be adversely affected.

Our Failure to Comply With the Agreements Relating to Our Outstanding Indebtedness, Including as a Result of Events Beyond Our Control, Could Result in an Event of Default That Could Materially and Adversely Affect Our Results of Operations and Our Financial Condition.

If there were an event of default under any of the agreements relating to our outstanding indebtedness, the holders of the defaulted debt could cause all amounts outstanding with respect to that debt to be due and payable immediately. We cannot assure you that our assets or cash flow would be sufficient to fully repay borrowings under our outstanding debt instruments if accelerated upon an event of default. Further, if we are unable to repay, refinance or restructure our indebtedness under our secured debt, the holders of such debt could proceed against the collateral securing that indebtedness. In addition, any event of default or declaration of acceleration under one debt instrument could also result in an event of default under one or more of our other debt instruments.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

We lease our headquarters, located in Lake Forest, California, which consists of approximately 100,000 square feet of office space. The lease expires in 2012.

We have approximately 500 locations that serve patients in all 50 states, including branches, billing centers, pharmacies, warehouse and storage facilities. The regional facilities usually house a branch and various regional support functions such as repair, billing and distribution. The regional facilities are typically located in light industrial areas and generally range from 16,000 to 133,000 square feet. The typical branch facility, other than those that share a building with a region, is a combination warehouse and office and can range from 650 to 50,000 square feet. We lease substantially all of our facilities with lease terms of ten years or less.

ITEM 3. LEGAL PROCEEDINGS

We are engaged in the defense of certain claims and lawsuits arising out of the ordinary course and conduct of its business, the outcomes of which are not determinable at this time. Insurance policies covering such potential losses, where such coverage is cost effective, are maintained. In the opinion of management, any liability that might be incurred upon the resolution of these claims and lawsuits will not, in the aggregate, have a material adverse effect on our financial condition or results of operations, cash flows and liquidity.

ITEM 4. [Removed and Reserved]

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PART II

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

We are a wholly-owned subsidiary of Sky Acquisition LLC, which in turn is wholly owned through intermediate holding companies by the Investor Group. Accordingly, presently there is no public trading market for our common stock.

ITEM 6. SELECTED FINANCIAL DATA

The selected financial data set forth below should be read in conjunction with the Consolidated Financial Statements and related notes thereto and *Management s Discussion and Analysis of Financial Condition and Results of Operations* included in this Annual Report. We derived the selected financial data for the years ended December 31, 2010 and December 31, 2009, and the periods October 29, 2008 to December 31, 2008 and January 1, 2008 to October 28, 2008 and as of December 31, 2010 and 2009 from our Consolidated Financial Statements and notes thereto appearing in this Annual Report. The selected financial data for the years ended December 31, 2007 and December 31, 2006, and as of 2008, 2007 and 2006 are derived from our consolidated financial statements, which are not included herein.

(in thousands)	2010 (Successor)	2009(1) (Successor)	Period October 29, 2008 to December 31, 2008(2) (Successor)	Period January 1, 2008 to October 28, 2008(2) (Predecessor)	2007(3) (Predecessor)	2006(4) (Predecessor)
Statements of Operations Data:						
Net revenues	$ 2,080,718	$ 2,094,561	$ 356,665	$ 1,773,289	$ 1,631,801	$ 1,516,691
Net (loss) income	(17,432)	(3,820)	(1,894)	56,453	86,039	74,263
Balance Sheet Data (As of December 31):						
Total assets	$ 2,201,137	$ 2,309,047	$ 2,210,813		$ 1,597,802	$ 1,154,636
Long-term obligations, including current maturities	1,019,421	1,021,146	1,022,233		687,283	487,145
Stockholders equity	665,312	678,731	672,820		512,025	399,693

(1) Net revenues for 2009 reflect $108.7 million in Medicare reimbursement reductions related to Medicare reimbursement reductions for oxygen, respiratory drugs, enteral and home medical equipment.

(2) We were acquired by Sky Acquisition LLC, a company controlled by private investment funds affiliated with the Sponsor, on October 28, 2008. This acquisition affects the comparability of our 2008 financial statements to prior periods. See Note 2 The Merger, contained in the Notes to the Consolidated Financial Statements for a detailed discussion of this acquisition. Net revenues for the periods October 29, 2008 to December 31, 2008 and January 1, 2008 to October 28, 2008 were reduced by $4.1 million and $18.6 million, respectively, in Medicare reimbursement reductions on respiratory medications and related to reductions in equipment rental periods.

(3) We acquired Coram on December 3, 2007 for an aggregate cash payment of approximately $350 million. This acquisition affects the comparability of 2007 financial information to prior fiscal years. The results of operations and financial condition of Coram have been included in our consolidated financial statements since the acquisition date. Net revenues for 2007 were reduced by $7.3 million in Medicare reimbursement reductions related to reductions in equipment rental periods.

(4) Net revenues for 2006 reflect $15.0 million in incremental Medicare reimbursement reductions for respiratory drugs, oxygen and oxygen equipment.

We did not pay any cash dividends on our common stock during any of the periods set forth in the table above.

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

This Management s Discussion and Analysis of Financial Condition and Results of Operations is intended to assist in understanding and assessing the trends and significant changes in our results of operations and financial condition. Historical results may not be indicative of future performance. Our forward-looking statements reflect our current views about future events, are based on assumptions and are subject to known and unknown risks and uncertainties such as the current global economic uncertainty, including the tightening of the credit markets and the recent significant declines and volatility in our global financial markets, that could cause actual results to differ materially from those contemplated by these statements. Factors that may cause differences between actual results and those contemplated by forward-looking statements include, but are not limited to, those discussed in the Risk Factors and Forward-Looking Statements sections of this annual report on Form 10-K. This Management s Discussion and Analysis of Financial Condition and Results of Operations should be read in conjunction with our consolidated financial statements and the related notes and other information included in this annual report on Form 10-K. References in this report to the Company, we, us and our refer to Apria Healthcare Group Inc. and its subsidiaries, unless otherwise noted or the context requires otherwise.

Overview. We have three core service lines: home respiratory therapy, home medical equipment and home infusion therapy. In these core service lines, we offer a variety of patient care management programs, including clinical and administrative support services, products and supplies, most of which are prescribed by a physician as part of a care plan. We provide these services to patients through approximately 500 locations throughout the United States. We have two reportable operating segments:

- home respiratory therapy and home medical equipment; and
- home infusion therapy.

Strategy. Our strategy is to position ourselves in the marketplace as a high-quality provider of a broad range of healthcare services and patient care management programs to our customers. The specific elements of our strategy are to:

Grow profitable revenue and market share. We are focused on growing profitable revenues and increasing market share in our core home infusion therapy and home respiratory therapy service lines. We have undertaken a series of steps towards this end. Since our acquisition of Coram in December 2007, we have grown our revenue and patient census in this segment and expanded our platform for further cross-selling opportunities. Since January 1, 2007, we have expanded our home respiratory therapy and home medical equipment sales force by 51%. This focus has allowed us to more efficiently cover each market served by promoting our products and services to physicians, hospital discharge planners and managed care organizations.

Continue to participate in the managed care market. We participate in the managed care market as a long-term strategic customer group because we believe that our scale, expertise, nationwide presence and array of home healthcare products and services will enable us to sign preferred provider agreements with managed care organizations. Managed care represented approximately 70% of our total net revenues for the year ended December 31, 2010.

Leverage our national distribution infrastructure. With approximately 500 locations and a robust platform supporting shared national services, we believe that we can efficiently add products, services and patients to our systems to grow our revenues and leverage our cost structure. For example, we have successfully leveraged this distribution platform across a number of product and service offerings, including a continuous positive airway pressure (CPAP)/ bi-level supply replenishment program, enteral nutrition and negative pressure wound therapy (NPWT) services, and we are using our nursing capacity to provide infusion services through our growing network of ambulatory infusion suites. We seek to achieve margin improvements through operational initiatives focused on the continual reduction of costs and delivery of incremental efficiencies. At the same time, we believe that it is essential to consistently deliver superior customer service in order to increase referrals and retain existing patients. Performance improvement initiatives are underway in all aspects of our operations including customer service, patient satisfaction,

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logistics, supply chain, clinical services and billing/collections. We believe that by being responsive to the needs of our patients and payors we can provide ourselves with opportunities to take market share from our competitors.

Continue to lead the industry in accreditation. The Medicare Improvement for Patients Act of 2008 (MIPPA) made accreditation mandatory for Medicare providers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), effective October 1, 2009, per Centers for Medicare and Medicaid Services (CMS) regulation. We were the first durable medical equipment provider to seek and obtain voluntary accreditation from The Joint Commission. In June 2010, we completed a nationwide independent triennial accreditation renewal process conducted by The Joint Commission and, the Commission renewed our accreditation for another three years. The Joint Commission accreditation encompasses our full complement of services including home health, home medical equipment, clinical respiratory, ambulatory infusion services, pharmacy dispensing, and clinical consultant pharmacist services. We have more than 19 years of continuous accreditation by The Joint Commission longer than any other homecare provider.

Execute our strategic initiatives to drive profitability. For the past several years, we have successfully engaged in a range of cost savings initiatives to ease pressure on our revenue that has been and continues to be caused by Medicare and Medicaid reimbursement changes. These initiatives are designed to improve customer service, delivery and vehicle routing services, streamline the billing and payment process, effectively manage purchasing costs and improve the overall experience of the patients we serve. We launched a substantial multi-year cost reduction plan in late 2007. To date, we have made significant progress across a number of the identified initiatives targeting expected annual savings of approximately $168 million, of which we realized approximately $153 million through December 31, 2010.

Recent Events.

Acquisition of Praxair U.S. Home Healthcare Business. On February 2, 2011, we, along with Praxair, Inc. and Praxair Healthcare Services, Inc. (collectively, Praxair), jointly announced that our wholly owned subsidiary, Apria Healthcare, Inc. (AHI) and Praxair have entered into a definitive asset purchase agreement whereby AHI will acquire the assets of Praxair s home healthcare services division in the United States. The transaction is expected to close during the first quarter of 2011. Assuming a March 31, 2011 closing date, this business is expected to contribute approximately $85 to $95 million to our revenue in 2011. This estimate and the acquired business s contribution in future periods will be subject to decreases as a result of the impact of Medicare competitive bidding and other factors.

Critical Accounting Policies. We consider the accounting policies that govern revenue recognition and the determination of the net realizable value of accounts receivable to be the most critical in relation to our consolidated financial statements. These policies require the most complex and subjective judgments of management. Additionally, the accounting policies related to goodwill, long-lived assets, share-based compensation and income taxes require significant judgment.

Revenue and Accounts Receivable. Revenues are recognized under fee for service/product arrangements for equipment we rent to patients, sales of equipment, supplies, pharmaceuticals and other items we sell to patients and under capitation arrangements with third party payors for services and equipment we provide to the patients of these payors. Revenue generated from equipment that we rent to patients is recognized over the rental period, typically one month, and commences on delivery of the equipment to the patients. Revenue related to sales of equipment, supplies and pharmaceuticals is recognized on the date of delivery to the patients. Revenues derived from capitation arrangements were approximately 8% of total net revenues for each of the years ended December 31, 2010, and December 31, 2009 and the periods October 29, 2008 to December 31, 2008 and January 1, 2008 to October 28, 2008. Capitation revenue is earned as a result of entering into a contract with a third party to provide its members certain services without regard to the actual services provided, therefore revenue is recognized in the period that the beneficiaries are entitled to health care services. All revenues are recorded at amounts estimated to be received under reimbursement arrangements with third-party payors, including private insurers, prepaid health plans, Medicare and Medicaid.

In our business, there are multiple services and products delivered to patients. These arrangements involve equipment that is rented and related supplies that may be sold that cannot be returned. In arrangements with multiple deliverables, revenue is recognized when each deliverable is provided to the patient. For example, revenues from equipment rental supplies sales are recognized upon confirmation of delivery of the products, as the supplies sold

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are considered a separate unit of accounting.

Included in accounts receivable are earned but unbilled receivables of $55.2 million and $44.6 million at December 31, 2010 and 2009, respectively. Delays ranging from a day up to several weeks between the date of service and billing can occur due to delays in obtaining certain required payor-specific documentation from internal and external sources. Earned but unbilled receivables are aged from date of service and are considered in the analysis of historical performance and collectibility.

Due to the nature of the industry and the reimbursement environment in which we operate, certain estimates are required to record total net revenues and accounts receivable at their net realizable values. Inherent in these estimates is the risk that they will have to be revised or updated as additional information becomes available. Specifically, the complexity of many third-party billing arrangements and the uncertainty of reimbursement amounts for certain services from certain payors may result in adjustments to amounts originally recorded. Such adjustments are typically identified and recorded at the point of cash application, claim denial or account review.

Management performs periodic analyses to evaluate accounts receivable balances to ensure that recorded amounts reflect estimated net realizable value. Specifically, management considers historical realization data, accounts receivable aging trends, other operating trends, the extent of contracted business and business combinations. Also considered are relevant business conditions such as governmental and managed care payor claims processing procedures and system changes. Additionally, focused reviews of certain large and/or problematic payors are performed. Due to continuing changes in the healthcare industry and third-party reimbursement, it is possible that management s estimates could change in the near term, which could have an impact on operations and cash flows.

Accounts receivable are reduced by an allowance for doubtful accounts which provides for those accounts from which payment is not expected to be received, although services were provided and revenue was earned. Upon determination that an account is uncollectible, it is written-off and charged to the allowance.

Goodwill and Long-Lived Assets. Goodwill is recorded as the difference, if any, between the aggregate consideration paid for an acquisition and the fair value of the net tangible and intangible assets acquired. The amounts and useful lives assigned to intangible assets acquired, other than goodwill, impact the amount and timing of future amortization.

Goodwill and indefinite-lived intangible assets are not amortized but instead tested at least annually for impairment or more frequently when events or changes in circumstances indicate that the assets might be impaired. Goodwill is tested for impairment by comparing the carrying value to the fair value of the reporting unit to which the goodwill is assigned. A two-step test is used to identify the potential impairment and to measure the amount of impairment, if any. The first step is to compare the fair value of the reporting unit with its carrying amount, including goodwill. If the fair value of the reporting unit exceeds its carrying amount, goodwill is considered not impaired; otherwise, goodwill is impaired and the loss is measured by performing step two. Under step two, the impairment loss is measured by comparing the implied fair value of the reporting unit with the carrying amount of goodwill. Management has determined that our two operating segments, home respiratory therapy/home medical equipment and home infusion therapy, are reporting units. The Company performs the annual test for impairment as of the first day of its fourth quarter and determines fair value based on a combination of the income approach and the market approach. The income approach is based on discounted cash flows. The market approach uses a selection of comparable companies in determining value. This determination of fair value is affected by assumptions regarding a number of highly complex and subjective variables. Changes in these assumptions can materially affect the estimate of fair value. Goodwill and indefinite-lived intangible assets were tested for impairment on October 1, 2010 and resulted in the fair value of each substantially exceeding its carrying value; therefore, we were not at risk of failing step one based upon our current assumptions. If an asset had been deemed impaired, an impairment loss would have been recognized to the extent the carrying value of the asset exceeded its estimated fair market value.

Long-lived assets, including property and equipment and purchased intangible assets, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset or asset group may not be recoverable. Significant judgment is required in determining whether a potential indicator of impairment of long-lived assets exists and in estimating future cash flows for any necessary impairment tests.

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Recoverability of assets to be held and used is measured by the comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such an asset is considered to be impaired, the impairment to be recognized is measured as the amount by which the carrying amount of the asset exceeds the fair value of the asset. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell. As of December 31, 2010 and 2009, there was no impairment.

Purchased intangible assets consist primarily of trade names, patient backlog, capitated relationships and payor relationships resulting from the Merger. Purchased intangible assets that have definite lives are amortized over the estimated useful lives of the related assets, generally ranging from one to twenty years.

Share-Based Compensation. We measure and recognize compensation expense for all share-based payment awards made to employees and non-employee directors based on estimated fair values on the date of grant. The value of the portion of the award that is ultimately expected to vest is recognized as expense over the requisite service period in our consolidated financial statements. Forfeitures are estimated at the time of grant and revised, if necessary, in subsequent periods if actual forfeitures differ from those estimates. We recognize share-based compensation expense on a straight-line basis over the requisite service period. Prior to the Merger, we estimated fair value of our share-based payment awards using the Black-Scholes valuation model. Subsequent to the Merger, the estimate of fair value of share-based awards on the date of grant is determined through the allocation of all outstanding securities to a business enterprise valuation. The enterprise valuation is based upon a combination of the income approach and the market approach. The income approach is based on discounted cash flows. The market approach uses a selection of comparable companies in determining value. This determination of fair value is affected by assumptions regarding a number of highly complex and subjective variables. Changes in the subjective assumptions can materially affect the estimate of their fair value.

Income Taxes. Deferred income tax assets and liabilities are computed for differences between the carrying amounts of assets and liabilities for financial statement and tax purposes. Deferred income tax assets are required to be reduced by a valuation allowance when it is determined that it is more likely than not that all or a portion of a deferred tax asset will not be realized.

In determining the necessity and amount of a valuation allowance, all available information (both positive and negative) is considered and analysis is performed to determine the appropriate weight that should be afforded to available objective and subjective evidence. Cumulative losses in recent years are considered significant negative evidence which could result in the accrual of a valuation allowance against deferred tax assets.

We have not sustained a cumulative book loss over the three-year period ended December 31, 2010. In evaluating our cumulative book income or loss, we considered the impact of certain non-recurring historical items which are not indicative of our ability to generate future income.

Based on all available evidence, we concluded that a valuation allowance against deferred tax assets will not be required at December 31, 2010. We will continue to assess the need for a valuation allowance as additional positive and negative evidence becomes available.

For state tax purposes, we accrued a valuation allowance of $4.0 million at December 31, 2010 for certain state tax net operating loss carryover amounts which are not expected to be realized in certain tax jurisdictions.

Our provision for income taxes is based on expected income, statutory tax rates and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining the provision for income taxes. We are routinely under audit by federal, state or local authorities regarding the timing and amount of deductions, allocation of income among various tax jurisdictions and compliance with federal, state and local tax laws. Tax assessments related to these audits may not arise until several years after tax returns have been filed. Although predicting the outcome of such tax assessments involves uncertainty, we believe that the recorded tax liabilities appropriately reflect our potential obligations.

Recent Accounting Pronouncements. In October 2009, the FASB issued ASU 2009-13, *Multiple-Deliverable Revenue Arrangements* which amends ASC Topic 605, *Revenue Recognition* (ASU 2009-13) Under this standard, management is no longer required to obtain vendor-specific objective evidence or third party evidence of fair value for each deliverable in an arrangement with multiple elements, and where evidence is not available we may now estimate the proportion of the selling price attributable to each deliverable. ASU 2009-13 will be effective prospectively for revenue arrangements entered into or materially modified in the fiscal years beginning on or after June 15, 2010. The Company is currently evaluating the impact of ASU 2009-13 on its financial position, results of operations, cash flows and disclosures.

In January 2010, the FASB issued ASU 2010-6, *Improving Disclosures About Fair Value Measurements* (ASU 2010-6) which requires reporting entities to make new disclosures about recurring or nonrecurring fair-value measurements including significant transfers into and out of Level 1 and Level 2 fair-value measurements and information on purchases, sales, issuances, and

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settlements on a gross basis in the reconciliation of Level 3 fair- value measurements. ASU 2010-6 is effective for annual reporting periods beginning after December 15, 2009, except for Level 3 reconciliation disclosures which are effective for annual periods beginning after December 15, 2010. The adoption of ASU 2010-6 did not have a material impact on our consolidated financial statements.

Government Regulation

We are subject to extensive government regulation, including numerous laws directed at regulating reimbursement of our products and services under various government programs and preventing fraud and abuse. We maintain certain safeguards intended to reduce the likelihood that we will engage in conduct or enter into arrangements in violation of these restrictions. Corporate contract services and legal department personnel review and approve written contracts subject to these laws. We also maintain various educational and audit programs designed to keep our managers updated and informed regarding developments on these topics and to reinforce to employees our policy of strict compliance in this area. Federal and state laws require that we obtain facility and other regulatory licenses and that we enroll as a supplier with federal and state health programs. Under various federal and state laws, we are required to make filings or submit notices in connection with transactions that might be defined as a change of control of the Company. We are aware of these requirements and routinely make such filings with, and seek such approvals from, the applicable regulatory agencies. Notwithstanding these measures, due to changes in and new interpretations of such laws and regulations, and changes in our business, violations of these laws and regulations may still occur, which could subject us to civil and criminal enforcement actions; licensure revocation, suspension or non-renewal; severe fines and penalties; the repayment of amounts previously paid to us and even the termination of our ability to provide services, including those provided under certain government programs such as Medicare and Medicaid. See *Risk Factors Risks Relating to Our Business Continued Reductions in Medicare and Medicaid Reimbursement Rates and the Comprehensive Healthcare Reform Package Could Have a Material Adverse Effect on Our Results of Operations and Financial Condition* and *Risk Factors Risk Factors Risks Relating to Our Business Our Failure To Maintain Required Licenses Could Impact Our Operations*.

For additional information about government regulation of our business and industry, see *Business Government Regulation*.

Key Factors and Trends Expected to Impact our Business in 2011

Although other factors and trends will likely impact us, including some we do not foresee at this time, we believe our performance in 2011 will be affected by the following key factors and trends:

Changes in outsourcing strategy. As a part of our ongoing review of our outsourcing strategy, we have determined to return certain of the outsourced functions to our personnel in the United States. Consequently, we expect that in future periods we will experience increased administrative costs because we will no longer have the full benefit of the favorable offshore labor rates.

Increasing Costs. We expect our selling, distribution and administrative costs to increase in 2011 as a result of the full year impact of additional sales personnel added for a portion of 2010.

Medicare Competitive Bidding. We expect an unfavorable impact related to the implementation of Medicare Competitive Bidding starting in January 2011.

Collectability of accounts receivable. The collection of accounts receivable is expected to remain one of our most significant challenges. We expect that our provision for doubtful accounts in 2011 as a percentage of net revenue will be at a rate comparable to that which we experienced in 2010.

Results of Operations

Year Ended December 31, 2010 Results Compared to the Year Ended December 31, 2009 Results

***Net Revenues*.** Net revenues in the year ended December 31, 2010 were $2.08 billion compared to $2.09 billion in the year ended December 31, 2009. Revenue for the year ended December 31, 2010 decreased primarily due to the non-renewal or termination of, or changes to, certain payor contracts, partially offset by an increase in home infusion therapy revenue. We expect to continue to strategically evaluate our payor

contracts. In addition, revenue in the year ended December 31, 2009 was positively impacted by the recognition of monthly rental revenue previously deferred for services that were initiated prior to certain 2009 Medicare reimbursement reductions.

We expect to continue to face pricing pressures from Medicare and Medicaid as well as from our managed care customers as these payers seek to lower costs by obtaining more favorable pricing from providers such as us. In addition to the pricing reductions, such changes could cause us to provide reduced levels of certain products and services in the future, resulting in a corresponding reduction in revenue. See *Business Government Regulation*.

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Gross Profit. Gross profit margin is defined as total net revenues less total costs of total net revenues divided by total net revenues. The gross profit margin for the year ended December 31, 2010 was 59.9%, compared to 58.6% for the year ended December 31, 2009. Included in cost of revenue for the year ended December 31, 2009 was intangible asset amortization related to our patient backlog intangible asset of $44.0 million, which was fully amortized during the year ended December 31, 2009 and did not recur in 2010, and the favorable impact of certain cost of goods sold adjustments. Excluding the impact of intangible asset amortization of $44.0 million and the favorable impact of certain cost of goods sold adjustments of $6.3 million, the overall gross profit margin percentage for the year ended December 31, 2009 would have been 60.4%. The decline in gross profit margin percentage is primarily due to an increase in the revenue of the home infusion therapy segment as a percent of total net revenue. Our home infusion therapy segment has a lower gross profit margin as a percentage of net revenues than the home respiratory therapy and home medical equipment segment. This decline in the gross profit margin percentage was partially offset by favorable pricing on the purchase of products and the termination of certain low margin or unprofitable payor contracts.

Provision for Doubtful Accounts. The provision for doubtful accounts is based on management s estimate of the net realizable value of accounts receivable. Accounts receivable estimated to be uncollectible are provided for by computing a required reserve using estimated future cash receipts based on historical cash receipts collections as a percentage of revenue. In addition, management adjusts for changes in billing practices, cash collection protocols or practices, or changes in general economic conditions, contractual issues with specific payors, new markets or products. The provision for doubtful accounts, expressed as a percentage of total net revenues, was 3.4% and 2.8% in the years ended December 31, 2010 and December 31, 2009, respectively. The increase in the provision for doubtful accounts in 2010 is the result of unfavorable collections experience occurring in the year ended December 31, 2010 primarily due to the outsourcing of our billing and collection process and the impact of a major payor using an intermediary. In August 2010, based upon a review of key outsourcing initiatives, we determined that certain outsourced billing and collections functions should instead be performed by us and we are currently transitioning such functions back to us.

Selling, Distribution and Administrative Expenses. Selling, distribution and administrative expenses are comprised of expenses incurred in direct support of operations and those associated with administrative functions. Expenses incurred by the operating locations include salaries and other expenses in the following functional areas: selling, distribution, clinical services, warehousing and repair. Many of these operating costs are directly variable with revenue growth patterns. Some are also very sensitive to market-driven price fluctuations such as facility lease and fuel costs. The administrative expenses include overhead costs incurred by the operating locations and regional and corporate support functions. These expenses are generally less sensitive to fluctuations in revenue growth than operating costs.

Selling, distribution and administrative expenses were $1,067.0 million, or 51.3%, of total net revenues for the year ended December 31, 2010 compared to $1,050.1 million, or 50.1%, of total net revenues for the year ended December 31, 2009.

Selling, distribution and administrative expenses increased by $16.9 million for the year ended December 31, 2010 compared to the year ended December 31, 2009. The increase was comprised of a $39.8 million increase in other operating expenses partially offset by a decrease in labor and other related expenses of $22.9 million.

The decrease in labor and other related expenses of $22.9 million was due to reduced salaries and termination benefits as a result of headcount reductions due primarily to the outsourcing of certain functions relating to documentation, billing, collections and information technology, and lower management incentive compensation program expense as a result of not meeting the targets in 2010. These decreases were partially offset by an increase in labor expenses due to increases in our home respiratory therapy and home medical equipment sales force. We expect 2011 labor expenses to increase as a result of the onshoring of our billing and collections functions.

The increases in other operating expenses of $39.8 million were primarily due to an increase in professional fees and expenses related to the outsourcing of certain functions relating to documentation, billing, collections and information technology, and an increase in travel and marketing expense related to sales force expansion and operations training, an increase in depreciation related to information technology assets, professional fees related to 2010 corporate initiative projects, and an increase in our sponsor management fee. The increase in other operating expenses was partially offset by a decrease in expense associated with other corporate initiative projects that occurred in 2009 that did not recur in 2010.

Amortization of Intangible Assets. Amortization of intangible assets was 4.8 million and $3.7 million in the years ended December 31, 2010 and December 31, 2009, respectively. The amortization expense primarily results from the revaluation of intangible assets as a result of the Merger, including the finalization of the intangible asset valuation in 2009.

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expenses was partially offset by a decrease in expense associated with other corporate initiative projects that occurred in 2009 that did not recur in 2010.

Amortization of Intangible Assets. Amortization of intangible assets was 4.8 million and $3.7 million in the years ended December 31, 2010 and December 31, 2009, respectively. The amortization expense primarily results from the revaluation of intangible assets as a result of the Merger, including the finalization of the intangible asset valuation in 2009.

Interest Expense. Interest expense increased $1.6 million, or 1.3%, to $130.8 million in the year ended December 31, 2010 from $129.2 million in the year ended December 31, 2009. This increase is primarily due to higher amortization of deferred debt costs related to the issuance in 2009 of, and a registered exchange offer in 2010 with respect to, $700.0 million of our 11.25% Senior Secured Notes due 2014 (Series A-1) (the Series A-1 Notes) and $317.5 million of our 12.375% Senior Secured Notes due 2014 (Series A-2) (the Series A-2 Notes).

Interest Income and Other. Interest income and other decreased to $0.9 million for the year ended December 31, 2010 from $1.6 million in the year ended December 31, 2009.

Income Tax Benefit. Our effective tax rate for the year ended December 31, 2010 was 31.2% compared with 68.8% for the year ended December 31, 2009. Our income tax benefit decreased $0.5 million to $(7.9) million in the year ended December 31, 2010 from $(8.4) million in the year ended December 31, 2009 due to the following changes:

(in thousands)	Year Ended December 31, 2010	Year Ended December 31, 2009	Change
Income tax expense at statutory rate	$ (8,870)	$ (4,290)	$ (4,580)
Non-deductible expenses	712	778	(66)
State taxes, net of federal benefit and state loss carryforwards	(7)	3,342	(3,349)
Share-based compensation	1,437	2,679	(1,242)
Change in valuation allowance	(396)	(4,646)	4,250
Change in liability for unrecognized tax benefits	495	(5,660)	6,155
Other	(1,283)	(641)	(642)
	$ (7,912)	$ (8,438)	$ 526

Segment Net Revenues and EBIT

The following table sets forth a summary of results of operations by segment:

(in thousands)	Year Ended December 31, 2010	Percentage of Net Revenues	Year Ended December 31, 2009	Percentage of Net Revenues
Net revenues:				
Home respiratory therapy and home medical equipment	$ 1,083,207	52.1%	$ 1,169,609	55.8%
Home infusion therapy	997,511	47.9	924,952	44.2
Total net revenues	$ 2,080,718	100.0%	$ 2,094,561	100.0%

(in thousands)	Year Ended December 31, 2010				
	Home Respiratory Therapy	Percentage of Segment Net Revenues	Home Infusion Therapy	Percentage of Segment Net Revenues	Total

	and Home Medical Equipment				
EBIT	$ (9,866)	(0.9)%	$ 114,358	11.5%	$ 104,492

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	Year Ended December 31, 2009				
(in thousands)	Home Respiratory Therapy and Home Medical Equipment	Percentage of Segment Net Revenues	Home Infusion Therapy	Percentage of Segment Net Revenues	Total
EBIT	$ 50,167	4.3%	$ 65,667	7.1%	$ 115,834

We allocate certain expenses that are not directly attributable to a product line based upon segment headcount.

See reconciliation of EBIT included at the end of this section.

Home Respiratory Therapy and Home Medical Equipment Segment. For the home respiratory therapy and home medical equipment segment total net revenues decreased $86.4 million, or 7.4%, to $1,083.2 million in the year ended December 31, 2010 from $1,169.6 million in the year ended December 31, 2009. Revenues for the home respiratory therapy and home medical equipment segment decreased to 52.1% of total revenue in the year ended December 31, 2010 from 55.8% in the year ended December 31, 2009.

Home respiratory therapy revenues are derived primarily from the provision of oxygen systems, obstructive sleep apnea equipment, home ventilators, nebulizers, respiratory medications and related services. Revenues from the home respiratory therapy service line decreased by 7.8% in the year ended December 31, 2010 compared to the year ended December 31, 2009. The decrease in revenue resulted primarily from decreases in oxygen, sleep apnea and other respiratory revenue, primarily due to the termination of, or changes to, certain payor contracts, as well as the impact of revenue recognized in the three months ended March 31, 2009 that was previously deferred for services performed prior to certain Medicare reimbursement reductions.

Home medical equipment revenues are derived from the rental and sale of equipment to assist patients with ambulation, safety and general care in and around the home. Home medical equipment revenues decreased by 4.5% in the year ended December 31, 2010 compared to the year ended December 31, 2009. The decrease was primarily due to the termination of, or changes to, certain payor contracts.

EBIT for the home respiratory therapy and home medical equipment segment in the year ended December 31, 2010 was a negative $9.9 million compared to a positive $50.2 million in the year ended December 31, 2009. The negative EBIT was 0.9% of segment net revenues in the year ended December 31, 2010 compared to positive 4.3% of segment net revenues in the year ended December 31, 2009. EBIT for the year ended December 31, 2009 included $36.0 million of amortization expense related to our patient backlog intangible asset which was fully amortized during the year ended December 31, 2009. Adjusting for the impact of this $36.0 million of amortization in the year ended December 31, 2009, EBIT would have been $86.2 million or 7.4% of segment net revenue. The decrease in the EBIT as a percentage of segment net revenues from 7.4% for the year ended December 31, 2009 to a negative 0.9% in the year ended December 31, 2010 is primarily due to increases in the provision for doubtful accounts primarily due to the outsourcing of our billing and collections process and in the sales, distribution and administrative costs as a percentage of net revenues in the year ended December 31, 2010 compared to the year ended December 31, 2009.

Home Infusion Therapy Segment. For the home infusion therapy segment, total net revenues increased $72.5 million, or 7.8% to $997.5 million for the year ended December 31, 2010 from $925.0 million in the year ended December 31, 2009. Revenues for the home infusion therapy segment increased to 47.9% of total revenue in the year ended December 31, 2010 from 44.2% in the year ended December 31, 2009.

The home infusion therapy segment involves the administration of drugs or nutrients directly into the body intravenously through a needle or catheter. Infusion therapy services also include administering enteral nutrients directly into the gastrointestinal tract through a feeding tube. The growth in home infusion therapy revenue resulted primarily from an increase in the overall volume of specialty drugs, core drugs, and enteral nutrients. These increases were partially offset by a decrease in revenue due to the termination of certain payor contracts.

EBIT for the home infusion therapy segment in the year ended December 31, 2010 was $114.4 million compared to $65.7 million in the year ended December 31, 2009. EBIT was 11.5% of segment net revenues in the year ended December 31, 2010 compared to 7.1% of segment net revenues in the year ended December 31, 2009. EBIT for the year ended December 31, 2009 included $8.0 million of amortization expense related to our patient backlog

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intangible asset which was fully amortized during the year ended December 31, 2009. Adjusting for the impact of this $8.0 million of amortization in the year ended December 31, 2009, EBIT would have been $73.7 million of 8.0% of segment net revenues. The increase in EBIT as a percentage of net segment revenues from 8.0% for the year ended December 31, 2009 to 11.5% for the year ended December 31, 2010 was primarily due to improvements in the gross profit margin, and decreases in sales, distribution and administrative costs and the provision for doubtful accounts as a percentage of segment net revenues in the year ended December 31, 2010 compared to the year ended December 31, 2009.

Year Ended December 31, 2009 Results Compared to the Period October 29, 2008 to December 31, 2008 Results

The following table compares year ended December 31, 2009 results with the period October 29, 2008 to December 31, 2008.

(in thousands)	Year Ended December 31, 2009	Percentage of Net Revenues	Period October 29, 2008 to December 31, 2008	Percentage of Net Revenues
Net revenues:				
Fee for service arrangements	$ 1,930,464	92.2%	$ 328,005	92.0%
Capitation	164,097	7.8	28,660	8.0
TOTAL NET REVENUES	2,094,561	100.0	356,665	100.0
Costs and expenses:				
Cost of net revenues:				
Product and supply costs	638,452	30.5	105,120	29.5
Patient service equipment depreciation	101,681	4.9	17,539	4.9
Amortization of intangible assets	44,000	2.1		
Home respiratory therapy services	34,700	1.7	6,270	1.8
Nursing services	36,345	1.7	6,276	1.8
Other	12,281	0.6	2,555	0.7
TOTAL COST OF NET REVENUES	867,459	41.4	137,760	38.6
Provision for doubtful accounts	57,919	2.8	14,329	4.0
Selling, distribution and administrative	1,050,134	50.1	179,362	50.3
Amortization of intangible assets	3,716	0.2	1,008	0.3
TOTAL COSTS AND EXPENSES	1,979,228	94.5	332,459	93.2
OPERATING INCOME	115,333	5.5	24,206	6.8
Interest expense	129,200	6.2	26,167	7.3
Interest income and other	(1,609)	(0.1)	(726)	(0.2)
LOSS BEFORE TAXES	(12,258)	(0.6)	(1,235)	(0.3)
Income tax (benefit) expense	(8,438)	(0.4)	659	0.2
NET LOSS	$ (3,820)	(0.2)%	$ (1,894)	(0.5)%

***Net Revenues*.** Net revenues in the year ended December 31, 2009 were $2,094.6 million compared to $356.7 million in the period October 29, 2008 to December 31, 2008. Revenue for the year ended December 31, 2009 increased due to more operating days in the year ended December 31, 2009 compared to the period October 29, 2008 to December 31, 2008. In the year ended December 31, 2009 revenue was impacted by Medicare reimbursement reductions of $108.7 million that did not occur in the period October 29, 2008 to December 31, 2008. The Medicare reimbursement reductions primarily related to:

respiratory drug reimbursement reductions effective April 1, 2008;

changing the maximum rental period of oxygen equipment from an unlimited rental period to 36 months (regulation effective date of January 2006); and

MIPPA legislation authorized an average of 9.5% payment reduction in the DMEPOS fee schedule effective January 2009.

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We expect to continue to face pricing pressures from Medicare and Medicaid as well as from our managed care customers as these payers seek to lower costs by obtaining more favorable pricing from providers such as us. In addition to the pricing reductions, such changes could cause us to provide reduced levels of certain products and services in the future, resulting in a corresponding reduction in revenue. See *Business Government Regulation.*

Gross Profit. Gross profit margin is defined as total net revenues less total costs of total net revenues divided by total net revenues. The gross profit margin for the year ended December 31, 2009 was 58.6%, compared to 61.4% in the period October 29, 2008 to December 31, 2008. Included in cost of revenue for the year ended December 31, 2009 is $44.0 million of amortization related to our patient backlog intangible asset which was provisional in the period October 29, 2008 to December 31, 2008. In addition, this decrease in gross profit margin was primarily due to the negative impact of the Medicare reimbursement reductions. Excluding the intangible asset amortization and the impact of Medicare reimbursement reductions, the overall gross profit margin percentage for the year ended December 31, 2009 would have been 62.4%, compared to 61.4% in the period October 29, 2008 to December 31, 2008. This improvement in the gross profit margin was due to a shift in product mix to a higher volume of products with lower costs as a percentage of revenue in our home respiratory therapy service line and our ability to obtain favorable pricing on the purchase of products and supplies in our all three of our service lines. These improvements in the gross profit margin were partially offset by a decrease in the gross profit margin in our home infusion therapy service line as a result of a shift in product mix to more specialty drugs, which have a higher product cost as a percentage of revenue.

Provision for Doubtful Accounts. The provision for doubtful accounts is based on management s estimate of the net realizable value of accounts receivable after considering actual write-offs of specific receivables. Accounts receivable estimated to be uncollectible are provided for by computing a required reserve using estimated future cash receipts based on historical cash receipts collections as a percentage of revenue. In addition, management may adjust for changes in billing practices, cash collection protocols or practices, or changes in general economic conditions, contractual issues with specific payors, new markets or products. The provision for doubtful accounts, expressed as a percentage of total net revenues, was 2.8% and 4.0% in the year ended December 31, 2009 and the period October 29, 2008 to December 31, 2008, respectively. The decrease in the provision for doubtful accounts in 2009 is primarily the result of favorable collections experience occurring in the year ended December 31, 2009 as a percentage compared to the period October 29, 2008 to December 31, 2008.

Selling, Distribution and Administrative Expenses. Selling, distribution and administrative expenses are comprised of expenses incurred in direct support of operations and those associated with administrative functions. Expenses incurred by the operating locations include salaries and other expenses in the following functional areas: selling, distribution, clinical services, warehousing and repair. Many of these operating costs are directly variable with revenue growth patterns. Some are also very sensitive to market-driven price fluctuations such as facility lease and fuel costs. The administrative expenses include overhead costs incurred by the operating locations and regional and corporate support functions. These expenses are generally less sensitive to fluctuations in revenue growth than operating costs.

Selling, distribution and administrative expenses, expressed as a percentage of total net revenues were 50.1% for the year ended December 31, 2009 compared to 50.3% for the period October 29, 2008 to December 31, 2008. Adjusted for Medicare reimbursement reductions of $108.7 million in the year ended December 31, 2009, the selling, distribution and administrative expense percentage for 2009 would have been 47.7% of revenue in the year ended December 31, 2009.

In the year ended December 31, 2009 and the period October 29, 2008 to December 31, 2008 labor and other related expenses as a percentage of total net revenues were 33.0% and 32.9%, respectively. For the year ended December 31, 2009 when adjusting for the impact of Medicare reimbursement reductions, labor and related costs were 31.4% of total revenue. The decrease in labor and other related expenses was primarily due to reduced salaries and wages as a result of headcount reductions in 2009 and lower outside labor. These decreases were partially offset by increases due to higher management incentive compensation program expense, as a result of meeting the targets in 2009 and not in 2008, and higher termination and retention expense due to the projects to outsource certain billing, collection and information technology functions.

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In the year ended December 31, 2009 and the period October 29, 2008 to December 31, 2008 other operating expenses as a percentage of total net revenues were 17.1% and 17.4%, respectively. For the year ended December 31, 2009 when adjusting for the impact of Medicare reimbursement reductions, other operating expenses were 16.3% of total revenue. The decreases in other operating expenses were primarily due to delivery costs, principally lower fuel prices and lower freight costs due to renegotiation of a contract with a vendor. These decreases were partially offset by expenses incurred in 2009 associated with our projects to outsource certain billing, collection and information technology functions that did not exist in 2008, professional fees incurred in connection with the sale of Series A-1 Notes and Series A-2 Notes and expenses associated with other corporate initiative projects in 2009.

Amortization of Intangible Assets. Amortization of intangible assets was 0.2% and 0.3% of total net revenues in the year ended December 31, 2009 and the period October 29, 2008 to December 31, 2008, respectively. The amortization expense primarily results from the revaluation of intangible assets as a result of the Merger, including the finalization of the intangible asset valuation in 2009.

Interest Expense. Interest expense as a percentage of total net revenues was 6.2% for the year ended December 31, 2009. Adjusted for the impact of Medicare reimbursement reductions interest expense was 5.9% of total net revenues in the year ended December 31, 2009. Interest expense for the period October 29, 2008 to December 31, 2008 was 7.3% of revenue. This decrease is primarily due to higher interest expense in the two month period due to higher borrowing on the ABL facility and higher deferred debt costs in 2008 related to the Predecessor Revolving Credit Facility and Senior Secured Bridge Credit Agreement.

Interest Income and Other. Interest income and other was 0.1% as a percentage of total net revenues for the year ended December 31, 2009 compared to 0.2% as a percentage of total net revenues for the period October 29, 2008 to December 31, 2008. This decrease is due to a decrease in interest rates earned on invested cash.

Income Tax Benefit. The income tax benefit as a percentage of total net revenues for the year ended December 31, 2009 was 0.4% compared to a tax expense as a percentage of total net revenues of 0.2% for the period October 29, 2008 to December 31, 2008. The effective tax rate was 68.8% at December 31, 2009 compared to 53.4% for the period October 29, 2008 to December 31, 2008. The income tax benefit in the year ended December 31, 2009 included (1) a reduction in our valuation allowances related to state net operating losses and other state deferred tax assets and (2) a decrease in our tax reserves due to settlements with state tax agencies and the expiration of statute of limitations.

Segment Net Revenues and EBIT

The following table sets forth a summary of results of operations by segment:

(in thousands)	Year Ended December 31, 2009	Percentage of Net Revenues	Period October 29, 2008 to December 31, 2008	Percentage of Net Revenues
Net revenues:				
Home respiratory therapy and home medical equipment	$ 1,169,609	55.8%	$ 209,567	58.8%
Home infusion therapy	924,952	44.2	147,098	41.2
Total net revenues	$ 2,094,561	100.0%	$ 356,665	100.0%

	Year Ended December 31, 2009				
(in thousands)	Home Respiratory Therapy and Home Medical Equipment	Percentage of Segment Net Revenues	Home Infusion Therapy	Percentage of Segment Net Revenues	Total
EBIT	$ 50,167	4.3%	$ 65,667	7.1%	$ 115,834

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	Period October 29, 2008 to December 31, 2008				
(in thousands)	Home Respiratory Therapy and Home Medical Equipment	Percentage of Segment Net Revenues	Home Infusion Therapy	Percentage of Segment Net Revenues	Total
EBIT	$ 26,255	12.5%	$ (1,740)	(1.2)%	$ 24,515

We allocate certain expenses that are not directly attributable to a product line based upon segment headcount.

See reconciliation of EBIT at the end of this section.

Home Respiratory Therapy and Home Medical Equipment Segment. Net revenues for the home respiratory therapy and home medical equipment segment in the year ended December 31, 2009 was $1,169.6 million compared to $209.6 million in the period October 29, 2008 to December 31, 2008. Revenues for the home respiratory therapy and home medical equipment segment decreased to 55.8% of total revenue in the year ended December 31, 2009 from 58.8% in the period October 29, 2008 to December 31, 2008.

Home respiratory therapy revenues are derived primarily from the provision of oxygen systems, home ventilators, obstructive sleep apnea equipment, nebulizers, respiratory medications and related services. Revenues from the respiratory therapy service line decreased to 48.4% of total revenue in the year ended December 31, 2009 compared to 51.5% in the period October 29, 2008 to December 31, 2008. The majority of Medicare reimbursement reductions discussed above impacted the home respiratory therapy services line. Such reductions were $104.0 million for the year ended December 31, 2009. Adjusted for the Medicare reimbursement reductions, respiratory therapy revenues for 2009 would have been 50.7%. Home respiratory therapy revenues as a percentage of total revenue decreased as a result of increased sales as a percentage of total revenue in our home infusion therapy service line.

Home medical equipment revenues are derived from the rental and sale of equipment to assist patients with ambulation, safety and general care in and around the home. Home medical equipment revenues were 7.5% of total revenue in the year ended December 31, 2009 compared to 7.3% of total revenue in the period October 29, 2008 to December 31, 2008. During the year ended December 31, 2009, $1.9 million of the Medicare reimbursement reductions impacted this service line. Excluding the impact of the Medicare reimbursement reductions, home medical equipment revenue would have been 7.2% of total revenues in the year ended December 31, 2009.

EBIT for the home respiratory therapy and home medical equipment segment in the year ended December 31, 2009 was $50.2 million compared to $26.3 million in the period October 29, 2008 to December 31, 2008. EBIT was 4.3% of segment net revenues in the year ended December 31, 2009 compared to 12.5% of segment net revenues in the period October 29, 2008 to December 31, 2008. This decrease in EBIT as a percentage of segment net revenues was primarily due to the negative impact of the Medicare reimbursement reductions. This decrease in the EBIT was partially offset by a shift in product mix to a higher volume of products with lower costs as a percentage of segment net revenues in our home respiratory therapy service line and our ability to obtain favorable pricing on the purchase of products and supplies.

Home Infusion Therapy Segment. Home infusion therapy involves the administration of drugs or nutrients directly into the body intravenously through a needle or catheter. Infusion therapy services also include administering enteral nutrients directly into the gastrointestinal tract through a feeding tube. Home infusion therapy revenues as a percentage of total revenue increased to 44.2% in the year ended December 31, 2009 compared to 41.2% in the period October 29, 2008 to December 31, 2008. The growth in revenue in the year ended December 31, 2009 resulted primarily from an increase in volume of specialty drugs (IVIG/Vivaglobin, Alpha 1, Factor, Remicade, Solaris and Tysabri), core drugs (TPN and Antibiotic) and enteral nutrients. The increase in these drugs was offset by a decrease in revenue due to the termination of a payor contract, and a decrease in volume of non-core revenue (Catheter Care, Chemotherapy, Hydration, and Other Therapies). As a result of increasing volume, specialty drug revenue also increased as a percentage of total home infusion therapy revenue. During the year ended December 31, 2009, Medicare reimbursement reductions impacted this service line by $2.8 million. Excluding the impact of Medica