APRIA HEALTHCARE GROUP INC
Form 10-K
March 30, 2012
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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**
DECEMBER 31, 2011 FOR THE FISCAL YEAR ENDED DECEMBER 31, 2011

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 x No ¨

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 ¨ No x

(Note: As a voluntary filer not subject to the filing requirements of Section 13 or 15(d) of the Exchange Act, the registrant has filed all reports pursuant to Section 13 or 15(d) of the Exchange Act during the preceding 12 months as if the registrant were subject to such filing requirements.)

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§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 (Do not check if a smaller reporting company)	Smaller reporting company ¨

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

The aggregate market value of voting common stock held by non affiliates of the registrant as of June 30, 2011, the last business day of the registrant s most recently completed second fiscal quarter was zero.

As of March 26, 2012, 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. Examples of such factors include the following:

- 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 Healthcare 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 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 medical equipment, home infusion therapy, including transparental nutrition services, and enteral nutrition services to over two million patients annually in all 50 states through approximately 540 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 physicians, discharge planners, hospitals and third-party payors. For the years ended December 31, 2011 and 2010 our net revenues were $2.30 billion and $2.08 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 four core service lines: home respiratory therapy, home medical equipment, home infusion therapy, including transparental nutrition services, and enteral nutrition services. 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.

On March 4, 2011, we completed the asset acquisition of Praxair, Inc. s (NYSE: PX) and Praxair Healthcare Services, Inc. s (collectively, Praxair) United States homecare business.

Home Respiratory Therapy and Home Medical Equipment ($1,176.6 million and $1,083.2 million, or 51.1% and 52.1%, of our net revenues for the years ended December 31, 2011 and 2010, respectively)

Home Respiratory Therapy

We are the largest provider of home respiratory therapies in the United States to the managed care market serving approximately 1.6 million patients annually through our nationwide distribution platform that includes approximately 440 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.);

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

congestive heart failure; and

lung cancer.

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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 policies and pricing guidelines. As an example, Medicare oxygen accounted for less than 9% of our total net revenues for each of the years ended December 31, 2011 and 2010.

We employ a nationwide clinical staff of more than 900 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. This branch-based model allows our 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.

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 ($1,124.8 million and $997.5 million, or 48.9% and 47.9%, of our net revenues for the years ended December 31, 2011 and 2010, respectively)

We are the leading provider of home infusion therapy services in the United States serving approximately 150,000 patients annually through 75 infusion pharmacy locations nationwide. We provide patients with intravenous and injectable medications and clinical services at home or in one of our 71 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 costs significantly less than the cost to provide that service in a hospital setting.

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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 also provide transparental nutrition (TPN) services for patients and TPN is provided to patients whose gastrointestinal system is unable to absorb nutrients.

We believe we are also a leading provider of enteral nutrition services 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 TPN and enteral nutrition service. Some patient s care moves between TPN and enteral. 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 Developments

Realignment of Management. On March 14, 2012, we announced the realignment of management responsibilities for our operating segments. In connection with these changes, Daniel E. Greenleaf was promoted to Chief Executive Officer of Coram, Inc., the principal operating subsidiary of our Home Infusion Therapy Segment. In connection with this appointment, Mr. Greenleaf no longer serves as the Chief Operating Officer of our Home Respiratory/Home Medical Equipment Segment.

In addition, Daniel J. Starck was named Chief Executive Officer of Apria Healthcare, Inc., the principal operating subsidiary for our Home Respiratory Therapy/Home Medical Equipment Segment. Mr. Starck joins Apria from CorVel Corporation, where he served as Chief Executive Officer since 2007. Norman C. Payson, M.D. will continue to serve as our Executive Chairman and Chief Executive Officer of the parent company, overseeing both operating segments.

On July 11, 2011, we announced the realignment of management responsibility for certain functions, including those related to revenue management and information technology. In connection with these changes, James G. Gallas, who served as our Executive Vice President and Chief Administrative Officer, ceased to oversee revenue management, information technology and certain related functions. Management of those functions was assumed by other members of our senior management team, and Mr. Gallas assumed a special projects role during a transitional period, which concluded on January 20, 2012 in accordance with the terms of his Amended and Restated Executive Severance Agreement dated as of March 10, 2009.

Industry Overview

The home healthcare market, which is estimated to have generated revenues of approximately $66 billion in the United States in 2011, comprises a broad range of products and services including respiratory therapy, 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 5.0% from 2011 through 2016 according to October 2011 IBISWorld Industry Report, despite slowing growth in the Medicare sector due to various cost control programs. Our industry is highly-fragmented and no player in the industry accounts for more than 3.0% of industry revenue.

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 majority of our patients will represent a higher percentage of the overall population. According to a 2010 U.S. Census Bureau projection, the U.S. population aged 65 and over is expected to grow substantially from 13% of the population in 2010 to 19% of the population by 2030. An

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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. Between 2010 and 2020, the nation s healthcare spending is projected to increase to $4.6 trillion, growing at an average annual rate of 5.8%, 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.

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 September 2011 national telephone survey conducted by Harris Interactive found that over 79% of the respondents believe that the Federal government should strengthen access to home medical equipment and services. A similar 2007 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 and new home therapies in the development pipeline and new indications for existing therapies. 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 14,300 employees and a national distribution footprint of approximately 540 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 and nutrition therapies and sleep apnea treatments, 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 customers as our industry continues to grow. Our national presence and scale enables us to frequently obtain preferred provider status from 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, in some instances, 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 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.

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We contract with a substantial majority of the national managed care organizations including Aetna Health Management, Anthem, Humana Health Plans, Kaiser Foundation Health Plan and United HealthCare Services, as well as a large number of regional and local payors. All of our contracted managed care organizations combined service over 210 million people.

Our acquisition of Coram, Inc. 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% of our net revenues for each of the years ended December 31, 2011 and 2010, with no single payor contract accounting for more than 8% of net revenues during the same periods.

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 540 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.

Patients who rely on CPAP and bi-level devices periodically require replacement accessories to ensure that they remain compliant with therapy prescribed by their physician. These accessories include masks, tubing and supplies. Now in operation for over seven 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 $168.0 million and $142.0 million and represented 49% and 47% of our total CPAP/bi-level net revenues for the years ended December 31, 2011 and 2010, 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 have with them.

Experienced Management Team

We have a strong and experienced senior management team with over 190 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.

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 the home infusion therapy segment and expanded our platform for further cross-selling opportunities. Our acquisition of Praxair s homecare business in the United States in March 2011 expanded our geographic footprint and market share in several key markets in the southeastern, south central and western areas of the country. Since January 1, 2010, we have expanded our home respiratory therapy and home medical equipment sales force by 40%, of which 9% relates to the acquisition of Praxair assets. This expansion 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. On an ongoing basis, we continually evaluate the size of our sales force.

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 enables us to sign preferred provider agreements and participating Health Maintenance Organization (HMO) agreements with managed care organizations. Managed care represented approximately 70% of our total net revenues for the year ended December 31, 2011.

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Leverage our national distribution infrastructure. With approximately 540 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 CPAP/ bi-level supply replenishment program, enteral nutrition and 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, prosthetics, orthotics and supplies (DMEPOS), effective October 1, 2009, per 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 20 years of continuous accreditation by The Joint Commission longer than any other homecare provider.

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 four core service lines: home respiratory therapy, home medical equipment, home infusion therapy, including transparental nutrition services, and enteral nutrition services. 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 segment, expressed as percentages of total net revenues:

	Year Ended December 31, 2011	Year Ended December 31, 2010	Year Ended December 31, 2009
Home respiratory therapy	44%	45%	48%
Home medical equipment	7	7	8
Total home respiratory and home medical equipment segment	51	52	56
Home infusion therapy segment	49	48	44
Total net revenues	100%	100%	100%

Organization and Operations

Organization. Our approximately 540 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

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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. Our enterprise-wide corporate compliance program applies to all operating divisions and is grounded in existing laws, rules and regulations and guidelines for healthcare organizations issued by the Office of Inspector General (OIG). 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.

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. We outsource our internal audit function to a Big Four accounting firm.

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 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, 2011, 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. During 2011, certain payor-related functions were and a limited number of administrative functions continue to be, administered by Intelenet Global Services Private Limited (Intelenet). We have policies and procedures in place to manage the claims submission process, including patient qualification and insurance 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, Offshoring and Onshoring 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.*

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

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 96% of our home respiratory and home medical equipment claims and approximately 78% 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 continue to be administered by Intelenet, while others have been incorporated into our existing customer care centers. We have established policies and procedures for Intelenet to perform effectively on our behalf. See *Risk Factors Risks Relating to Our Business 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,* *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:

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 cost savings through careful risk assessment, management, and appropriate utilization management techniques.

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.

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.

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.

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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.

Apria Great Escapes® Travel Program. Our more than 540 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.

Sales

As of December 31, 2011, we employed approximately 1,300 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 market. The ultimate decision makers for healthcare services vary greatly, from closed model managed care organizations to 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, 2011. Among our more significant managed care customers are Aetna Health Management, Anthem, Humana Health Plans, Kaiser Foundation Health Plans 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 individual hospitals and hospital systems, physicians and physician groups, home health agencies, health maintenance organizations, managed services intermediaries and pharmacy benefit managers (PBMs), 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

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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 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 Perot Systems Corporation (now Dell Services), to perform select services.

Intelenet Agreement

In May 2009, we entered into the Master Service Agreement (Intelenet Agreement) with Intelenet, an Indian company formerly affiliated with the Sponsor, regarding the outsourcing of certain functions relating to billing, collections and other administrative and clerical services. In July, 2011, an affiliate of the Sponsor, along with other shareholders of Intelenet, sold Intelenet to Serco Group PLC, an international services company. During the year ended December 31, 2011, we paid approximately $22.5 million to Intelenet. We continue to rely on Intelenet to perform certain administrative functions, but other administrative functions included in the original Intelenet Agreement are now incorporated into our internal Company-run customer care centers and branch operations staffed with our personnel.

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 $243.0 million to Dell Services over the ten-year term of the Perot Agreement. During the year ended December 31, 2011, we paid approximately $26.4 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, our policies, procedures and programs subject to these laws. We also maintain various educational and internal 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 or of organizations we acquire. 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, among other factors, 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*.

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Medicare and Medicaid Revenues. In the years ended December 31, 2011 and 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, 2011. The majority of our 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 7% of total net revenues for the year ended December 31, 2011.

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); the Deficit Reduction Act of 2005 (DRA); MIPPA, which became law in 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 are significant to us and continue to have an impact on our operations today.

Budget Control Act of 2011. On August 2, 2011, the Budget Control Act of 2011 was signed into law. The Budget Control Act of 2011 authorized increases in the United State s debt limit of at least $2.1 trillion, established caps on funding appropriations estimated to reduce federal spending by $917 billion over the next ten years, and created the Joint Select Committee on Deficit Reduction (Joint Committee), a bipartisan committee consisting of twelve Members of Congress instructed to develop legislation to reduce the federal deficit by at least another $1.5 trillion over the ten-year period of fiscal years 2012 2021. The Joint Committee was not limited in what it could propose to reduce the federal deficit. If the proposal had been issued by November 23, 2011, it would have been subject to special, expedited procedures in Congress. Because Congress and the President failed to enact legislation reducing the deficit by at least $1.2 trillion over the ten-year period of fiscal years 2012 2021 by the January 15, 2012 deadline, automatic spending reductions in fiscal years 2013 2021 through sequestration, the required cancellation of budgetary resources, have been triggered. Under sequestration, certain federal programs are protected, including Medicaid. However, payments to Medicare providers and suppliers would be reduced by an amount not to exceed 2% beginning in 2013. Such a reduction would be applicable to both competitively bid and non-competitively bid markets and products. On November 29, 2011, a bill titled To Amend to Exempt the Medicare Program from Fallback Sequestration Under the Budget Control Act of 2011 (H.R. 3519) was introduced in the House of Representatives. The bill would exempt payments to Medicare providers and suppliers from the automatic spending reductions beginning in 2013. The bill is currently pending in the House Committee on the Budget. At this time, we cannot predict whether Congress will pass this bill or other legislation averting or limiting the automatic spending reductions in fiscal years 2013 2021 or, if Congress does pass such legislation, whether the President will sign the legislation into law. Any reduction in provider and supplier reimbursement rates under federal healthcare programs could have a material adverse effect on our financial condition and results of operations.

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. 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. 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 November 2010, CMS published a final rule containing several provisions related to the competitive bidding program. The rule included a 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 formal definition of mail order and non-mail order items and a provision for suppliers to provide a minimum level of product choices to patients who require diabetic testing strips (The 50 Percent Rule), to which interested bidders must certify. The Round 2 markets are now final.

Under MIPPA, the initial CBAs and product categories subject to rebidding in the Round 1 Rebid are very similar to those of Round 1. However, MIPPA excludes Negative Pressure Wound Therapy Pumps and Related Supplies and

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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.

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. As a result of that reconsideration, CMS awarded us an additional contract. The rates took effect on January 1, 2011 for the Round 1 Rebid markets. CMS reports that the average price reduction for all products in all Round 1 Rebid CBAs was 32%. Based on 2008 data 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 accounted for, the estimated annual total net revenues associated with items subject to competitive bidding in the Round 1 Rebid is approximately 1.0% of our annual total net revenues. Approximately $22 million of our net revenues for the fiscal year ended December 31, 2011 was generated by the products and CBAs included in the Round 1 Rebid.

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 and Reform Package implementation schedule, we will experience a reduction in reimbursement, as will most if not all other DMEPOS suppliers in the impacted areas. In addition, there is an increasing risk that the competitive bidding prices will become a benchmark for reimbursement from other payors, as evidenced by the Administration s fiscal budget proposal which would cap state Medicaid reimbursement levels at competitive bid rates using an as-yet-undetermined methodology. Neither MIPPA nor the Reform Package prevents 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. In August 2011, CMS announced the product categories that will be included in Round 2. Round 2 will include the majority of the same product categories, but CMS will expand the program by (i) combining standard power wheelchairs and manual wheelchairs into a single new product category, (ii) including Negative Pressure Wound Therapy as a category in all markets and (iii) expanding the Support Surfaces (Group 2 mattresses and overlays) category across all Round 2 markets. Assuming few changes to the Round 2 bidding rules and the markets currently being implemented and/or planned by CMS, we estimate that approximately $141 million of our net revenues for the fiscal year ending December 31, 2011 would be subject to competitive bidding.

In November 2011, CMS announced the bidding timeline for Round 2. Bidder registration subsequently began in early December 2011. The bid submission process began on January 30 and will end on March 30, 2012, at which time CMS will begin the bid evaluation process. CMS expects to announce Single Payment Amounts (SPAs) and begin the contracting process in the fall of 2012. CMS anticipates making announcements about the contract suppliers in the spring of 2013. The new Round 2 rates and guidelines are currently scheduled to take effect in July of 2013. We cannot estimate the impact of potential Round 2 rate reductions on our revenues until more specific information is published by CMS and its contractors, but it could be material.

The Reform Package also gives the Secretary of Health and Human Services additional authority to apply competitive bid pricing to non-bid areas via a rulemaking process and that could occur by 2016. In addition, efforts to repeal the competitive bidding program altogether or mandate significant program changes continue. In March 2011, the Fairness in Medicare Bidding Act of 2011 (FIMBA) was introduced into the U.S. House of Representatives and referred to the House Subcommittee on Health. FIMBA would repeal the program without specifying a reduction in the industry s current reimbursement levels. Other efforts are underway by independent economists who seek to alter certain critical aspects of the program. Specifically, those efforts are designed to change the way in which CMS conducts the auction process itself, establishes the single payment rates, determines supplier capacity needed and related aspects which, if adopted by CMS in their entirety or in part, would change how Round 2 would be administered. We cannot predict whether these or other efforts to repeal or amend the program will be successful, or their potential impact on us.

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, the bidding rules are complex and it is possible for bidders to be disqualified for technical reasons other than pricing. 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

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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 for the contract term of program, unless we elect to continue to service existing patients under the grandfathering provision of the program s final rule for certain products or we acquire a winning supplier. Also, CMS takes the position that it has the authority to determine if an acquired supplier is still needed to serve the CBA, and there is no guarantee that agency staff will approve such an acquisition or do so in a timely manner. Because of our combination of both managed care and 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 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 was +1.1%, the multi-factor productivity adjustment was -1.2%, so the net result was a 0.1% decrease in DMEPOS fee schedule payments in 2011 for items and services not included in an area subject to competitive bidding. The CPI-U for 2012 is +3.6%, but the multi-factor productivity adjustment remains -1.2%, so the net result is a 2.4% increase in DMEPOS fee schedule payments in 2012 for items and services not included in an area subject to competitive bidding.

Capped Rentals, Oxygen Equipment and CPAP Patient Compliance. 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. DRA regulations published in November 2008 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.

With respect to oxygen equipment, Medicare reimbursement for oxygen equipment is limited to a maximum of 36 months, after which time the equipment continues to be owned by the home oxygen provider for as long as the patient s medical need exists and the provider continues to be responsible for his/her care. Limited reimbursement is available to providers from months 37 through 60, depending on the oxygen modality and patient s needs. For example, the DRA also 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. CMS does 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 did not establish any reimbursement rates for non-routine services patients may require after the 36-month rental period. In fact, implementing regulations impose 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. The existing implementing regulations to the DRA and MIPPA provisions 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. After the five year useful life is reached, the patient may request replacement equipment and, if he/she can be requalified for the Medicare benefit, a new maximum 36-month rental period would begin. The supplier may not arbitrarily issue new equipment.

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

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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, 2011, 2012 or 2013 budget proposals nor the Reform Package included a reduction in the oxygen rental period. However, President Obama s most recent budget proposal would further reduce the amount state Medicaid programs pay for oxygen therapy and other durable medical equipment services and products by mandating that state Medicaid rates be no higher than Medicare rates, including those impacted by the Medicare DMEPOS competitive bidding program. It is premature to know whether this or 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 DME MACs issued coverage determinations for positive airway pressure (PAP) devices, including CPAP and bi-level devices. Among other changes, the Medicare DME MAC 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 four (4) hours per night on 70% of nights during a consecutive 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. We adjusted our operational model, patient care and payment policies to comply with these Medicare requirements. These requirements 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 and Medicare Advantage payors are now implementing the same or similar rules as those adopted by Medicare. Despite our intensive efforts to educate patients about the importance of complying with their physician-prescribed therapy, some of our patients do not meet the threshold for compliance. We continue to educate patients and referral sources concerning the importance of compliance with the patient s prescribed therapy and the government s need for documentation pertaining to initial and ongoing medical necessity. However, these and similar LCDs and trends are likely to continue to significantly impact the PAP industry.

Reimbursement for Inhalation and Infusion Therapy Drugs. As a result of the MMA, Medicare Part B reimbursement for most drugs, including inhalation drugs, is based upon the manufacturer-reported average sales price (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 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. At this time, however, we cannot predict whether the Medicare

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reimbursement methodology for these drugs will change, as these drugs/therapies could be included in future phases of the DMEPOS competitive bidding program.

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. In December 2007, the President signed into law the Medicare, 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 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, the Center for Medicare and Medicaid Innovation (CMMI) 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, 111th and 112th Congresses to consolidate home infusion therapy coverage under Part B. The currently proposed 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 s or the CMMI s work plan or future legislation. In addition to a June 2010 report issued by the Government Accountability Office (GAO), 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 and/or the CMMI 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 National Provider Identifier (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, more recently, for acquired companies. 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

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cooperatively with CMS and its contractors in response to these initiatives but cannot predict whether CMS s various program integrity efforts will or will not negatively impact our operations.

In February 2011, CMS released a final rule implementing certain provisions of the Reform Package intended to prevent fraud, waste and abuse. This final rule includes new requirements regarding enrollment screening, enrollment application fees, payment suspension, temporary moratoria on enrollment and supplier termination. Significantly, as part of the final rule, CMS classified providers and suppliers as limited, moderate and high risk according to their risk of fraud, waste and abuse. Currently enrolled DMEPOS suppliers are classified in the moderate risk category while newly enrolled DMEPOS suppliers are classified in the high risk category. As such, DMEPOS suppliers will be under greater scrutiny relative to many other healthcare providers and suppliers. In October 2011, Senators Orrin Hatch and Charles Grassley sent a letter to U.S. Secretary of Health and Human Services Kathleen Sebelius, asking for an explanation as to why CMS had yet to impose temporary moratoria on the enrollment of new providers and suppliers where there is a high risk for fraud. Among the requests made in this letter was a request for facts in connection with CMS s decision not to impose a moratorium on DMEPOS suppliers in South Florida. Additionally, CMS recently announced plans to implement a provider and supplier enrollment screening system in January 2012 that would automate its pre-enrollment risk assessment and screening processes. We work cooperatively with CMS and its contractors in response to these initiatives to prevent fraud, waste and abuse but cannot predict whether CMS s various program integrity efforts will negatively impact our operations.

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 in September 2010.

Following the implementation of a three-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 it is currently underway. Prior to initiating any audits, RACs are required to obtain CMS s 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 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. Absent an exception, states were required to implement their RAC programs by January 1, 2012. In addition, in March of 2010, President Obama issued a presidential memorandum announcing a government-wide program expanding the use of 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 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 significantly throughout 2010 and accelerated in 2011; it is expected to continue to increase for the foreseeable future as additional ZPICs become operational across the country. The industry trade associations are advocating for more standardized audit procedures, 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 DME MAC 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 DME MACs, CMS staff and government subcontractors have 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 interpretations of these policies are inconsistent and subject to individual interpretation. This is then translated to individual supplier significant error rates and aggregated into a DMEPOS industry error rate, which is significantly higher than other Medicare

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provider/supplier types. High error rates lead to further audit activity and regulatory burdens. In fact, DME MACs have continued to conduct extensive pre-payment reviews across the DME industry and have determined a wide range of error rates. For example, error rates for CPAP claims have ranged from 50% to 80%. DME MACs have repeatedly cited medical necessity documentation insufficiencies as the primary reason for claim denials. If these or other burdensome positions are generally adopted by auditors, DME MACs, 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 significantly reduced. We have adjusted certain operational policies to address the current expectations of Medicare and its contractors. We cannot predict the adverse impact, if any, these interpretations of the Medicare documentation requirements or our revised policies might have on our operations, cash flow and capital resources, but such impact could be material.

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, 2011. 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. However, given the recent significant increases in industry audit volume and the increasing regulatory burdens associated with responding to those audits, it is likely that the negative pressures from legislative and regulatory changes will continue and accelerate.

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 and extended payment practices 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. In August 2009, the trial court entered a decision denying CAMPS petition. CAMPS appealed the court s decision but on September 16, 2011, the Court of Appeal upheld the trial court s decision. CAMPS did not file a further appeal and the validity of the regulation was accordingly upheld. As a result, we expect to make refunds to Medi-Cal, and our future revenues from Medi-Cal may be reduced. We periodically evaluate 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. The President s most recent budget proposal, would limit the amount state Medicaid programs pay for DMEPOS to be no higher than Medicare payment levels, including those impacted by Medicare competitive bidding. 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 states will consider similar or other reimbursement reductions, whether or how healthcare reform provisions pertaining to Medicaid will ultimately be implemented 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

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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 we have educated our workforce about these requirements. With such a large workforce that relies on mobile technology for operations, we cannot, however, guarantee that we will not have a HIPAA privacy or data security concern in the future. We face potential administrative, civil and possible criminal sanctions if we do not comply with the existing or new laws and regulations dealing with the privacy and security of PHI. Imposition of any such 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 and accelerate 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 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.

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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 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 and/or new laws. The Reform Package also provides for new regulatory authority, additional fines and penalties. More recently, additional legislation has been proposed in the U.S. Senate which would further expand the government s oversight of the healthcare industry via new regulatory authority. In addition, a Senate bill released in June 2011 (S. 1251) would require pre-payment review of all claims for durable medical equipment that are at high risk for fraud and abuse. 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.

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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. 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 Congress and affected certain priorities related to healthcare. Congress is debating the potential to repeal or amend the Reform Package altogether. A number of other parties, including some State governments, are challenging 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. Also, the government has begun to promulgate the implementing rules and regulations of the Reform Package, including additional requirements related to our business and that of our customers. Until those rules are more clearly understood, and due to uncertainties regarding the ultimate features of additional reform initiatives and their enactment and implementation over the next few years, 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, 2011, we had approximately 14,300 employees, of which 12,900 were full-time and 1,400 were part-time and per diem. As of December 31, 2011, 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 and Medicaid reimbursement rates for products and services we provide. For example, the regulations implementing the mandates under the MMA, the DRA, MIPPA and the Reform Package reduced the reimbursement for a number of products and services we provide and established or expanded 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. In November 2010, CMS published a final rule containing several provisions related to the competitive bidding program. Approximately $22 million of our net revenues for the fiscal year ended December 31, 2010 was generated by the products and CBAs included in the Round 1 Rebid. Although we have experienced increases in volume in certain markets as a result of our competitive bidding contracts, we estimate that the initial results of the Round 1 Rebid reduced our net revenues in the fiscal year ending December 31, 2011 by approximately $8 million, assuming the current contracts and no changes in volume. In August 2011, CMS announced that Round 2 would include the majority of the same product categories, but also include (i) a new product category including standard power wheelchairs and manual wheelchairs, (ii) Negative Pressure Wound Therapy, (iii) Support Surfaces (Group 2 mattresses and overlays) in all Round 2 markets and (iv) a national mail order competition for diabetic supplies. Assuming the bidding rules for Round 2 are similar to the Round 1 Rebid, we estimate that approximately $141 million of our net revenues for the fiscal year ending December 31, 2011 would be subject to Round 2 competitive bidding. The bidding process for Round 2 commenced in late 2011 with bidder registration and the new Round 2 rates and guidelines are currently scheduled to take effect in July of 2013. We cannot estimate the impact of potential Round 2 rate reductions or our ability to win competitively bid contracts on our business until more specific information is published by CMS and its contractors and results of the Round 2 bidding process are announced. However, we will likely experience significant pricing reductions on any bids we win and loss of revenue for bids we did not win. 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 would likely 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, 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. In August 2009, the trial court entered a decision denying CAMPS petition. CAMPS appealed the court s decision but on September 16, 2011, the Court of Appeal upheld the trial court s decision. CAMPS did not file a further appeal and the validity of the regulation was accordingly upheld. As a result, we expect to make refunds to Medi-Cal

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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. We periodically evaluate 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. The President s most recent budget proposal would limit the amount state Medicaid programs pay for DMEPOS services and products to be no higher than Medicare s rates, including those impacted by the competitive bidding program. 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. However, given the recent significant increases in industry audit volume, auditors interpretation and enforcement of documentation requirements and the increasing regulatory burdens associated with responding to those audits, it is likely that the negative pressures from legislative and regulatory changes will continue and accelerate.

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 our products will be reimbursed by Medicare. As discussed above, the Reform Package made 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 have been and will continue to be the subject of rulemaking and are a high priority for the American Association for Homecare and other industry representative organizations. We expect the Administration to continue to enhance its oversight efforts and we strive 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 several years. 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

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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.

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 of uninsured persons remains high.

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. Many managed care organizations and insurers also regularly attempt to seek reductions in the prices at which we provide services to them and their patients. Some managed care organizations and insurers also propose to limit coverage for our products and services and implement onerous payment rules, policies, administrative burdens, audits and other requirements that adversely impact our reimbursement and increase our costs of providing services and products. In addition to this increasing pressure to reduce costs, the use by managed care payors of benefit managers and other intermediaries is also increasing and may adversely impact us, including for example by imposing of burdensome reimbursement policies we must comply with and adverse changes in our participation status with managed care organizations and insurers. We have a large number of contractual arrangements with managed care organizations and other parties, which represented approximately 70% of our total net revenues for each of the years ended December 31, 2011 and 2010, and we expect that we will continue to enter into more of these contractual arrangements. Many of these contracts allow, usually after due notice, for payors to alter their payment policies (or newly enforced policies that were previously enacted). We could be materially adversely affected by adverse payment policy practices. 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 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. Examples of such documentation requirements are contained in the DME MAC 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 DME MACs 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 interpretations of these policies are inconsistent and subject to individual interpretations leading to high supplier and industry error rates. In fact, DME MACs have continued to conduct significant pre-payment reviews across the DME industry and have determined a wide range of error rates. For example, error rates for CPAP claims have ranged from 50% to 80%. DME MACs have repeatedly cited medical necessity documentation insufficiencies as the primary reason for claim denials. In addition, certain states have established unique documentation requirements concerning direct patient care activities provided by DME suppliers staff. In the absence of such documentation, the state may request a refund or impose sanctions such as fines. If these or other challenging positions continue to be adopted by auditors, DME MACs, states, CMS or its contractors in administering the Medicare program, we have the right to contest these positions as being contrary to law. Such appeal processes may be protracted and costly, even when the initial determinations are overturned. If these interpretations of the documentation requirements are ultimately upheld, it could result in our making significant refunds and other payments to Medicare and/or Medicaid and our future revenues from Medicare and/or Medicaid would likely be reduced. We cannot

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currently predict the adverse impact, if any, that these new, more onerous interpretations of the Medicare and/or Medicaid documentation requirements, or revised internal operational policies to address them, 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. The federal government also announced that it will apply real-time monitoring technologies to the Medicare claim management process, similar to technologies used in other industries. Although we cannot quantify at this time what, if any, impact such processes might have on our relationships with referral sources, operations, cash flow and capital resources, such impact could be material.

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 material effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

Expanded Government Auditing and Oversight of Medicare and Medicaid 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 MACs, 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.

Along with other healthcare providers and suppliers, we have recently been subject to a significant increase in the number of audits conducted under these new programs. Many of these audits have 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, our inability to retrieve physician or hospital documentation from their records, the auditors enforcement of requirements for documentation for patients begun on service during a time period when lesser levels of documentation were accepted practice, or unclear scoring methodologies used by the auditors, among other factors. 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 have appealed the results of certain of these audits and made changes to our operating policies and procedures,

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but cannot predict the ultimate impact that the government s expanded and more stringent auditing, or our policies, may have on our business, financial conditions or results of operations.

We have been informed by these auditors that other healthcare providers and all suppliers of certain DMEPOS product categories are expected to experience further increased scrutiny from these 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. It may also result in additional audit activity in other locations of ours in that state or DME MAC jurisdiction. Our error rate, aggregated with other DMEPOS suppliers in the industry, is then reported to Medicare contractors and Congress. According to the CERT contractors utilizing the more stringent interpretations of the medical necessity documentation requirements, the DMEPOS industry error rate in 2009 was 51.9% and was over 70% in 2010. Further, DME MACs have continued to conduct extensive pre-payment reviews across the DME industry and, for example, have found that error rates for CPAP claims have ranged from 50% to 80%. 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 realizing approximately $179 million in annualized pre-tax savings through December 31, 2011. Because of the ongoing reimbursement pressures on our industry, we plan to implement additional changes in our operating model to further reduce our costs. Projected cost savings associated with our future 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 expect to continue to implement and develop cost savings initiatives, there can be no assurance that we will be able to do so successfully or that we will realize all of the projected benefits. If we are unable to realize the anticipated cost savings from our initiatives, our business may be adversely affected. Moreover, our 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 off of accounts receivable. Also, in response to changing business conditions from time to time we may discontinue or significantly adjust our cost savings initiatives which could 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 standards and rules for health care transactions, code sets and unique identifiers also continue to evolve, such as ICD 10 and HIPAA 5010. Moreover, government programs and/or commercial payors may have difficulties administering new standards and rules for health care transactions and this may adversely affect timelines of payment or payment error rates. The DMEPOS competitive bidding program also imposes new reporting requirements on

contracted providers. From time to time, our outsourced contractor for certain information systems functions, Perot Systems Corporation (now Dell Services), makes operational, leadership or other changes that could impact our plans and cost-savings goals. Our failure to successfully design and implement system or process modifications could have a significant impact on our operations and financial condition. The implementation of many of the new standards and rules will require us to make substantial investments. Further, the implementation of these system or process changes could have a disruptive effect on related transaction processing and operations.

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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 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 and the return of many of those functions to our personnel in the United States, there can be no assurance that we will be able to return to our historic levels or maintain our current levels of collectability 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.

Beginning in 2009, we outsourced certain billing, collections and other administrative and clerical services to Intelenet and certain information systems functions to Perot Systems Corporation (now Dell Services), both of which perform many of these services outside of the United States. 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. During 2010, we experienced 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 related to certain billing, collections and other administrative and clerical services and we experienced increases in accounts receivable, reserves, write-offs of accounts receivable and loss of revenues. Accordingly, we determined to return certain of these outsourced functions to our personnel in the United States. This transition has resulted in various one-time costs and operational inefficiencies. For example, despite a training program for new personnel, there will likely be a further delay before our new work force will handle these functions as efficiently as they were handled before the outsourcing. There are no assurances that we will be successful in effectively completing the transition of these functions back to our personnel in the United States. In addition, we are outsourcing our collection of past due receivables from patients to a newly selected collection agency which may or may not improve collections. Among other things, risks associated with the onshoring transition process and our new patient pay collections outsourcing may result in our inability to bill for our services, cause further increases in our accounts receivable, impact our ability to collect current or future accounts receivables or cause us to further 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. Accurate licensure is also a critical threshold issue for the Medicare competitive bidding program. From time to time, we may also become subject to new or different licensing requirements due to legislative or regulatory 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 or the inability to serve Medicare beneficiaries in competitive bidding markets which could have an adverse material impact on our business, financial condition, results of operation, cash flow, capital resources and liquidity.

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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. More recently, The Joint Commission extended that accreditation to the former Praxair Healthcare Services locations we acquired in March 2011. 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 20 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.

The Budget Control Act of 2011 authorized increases in the United State s debt limit of at least $2.1 trillion, established caps on funding appropriations estimated to reduce federal spending by $917 billion over the next ten years, and created the Joint Committee, a bipartisan committee consisting of twelve Members of Congress instructed to develop legislation to reduce the federal deficit by at least another $1.5 trillion over the ten-year period of fiscal years 2012 2021. The Joint Committee was not limited in what it could propose to reduce the federal deficit. If the proposal had been issued by November 23, 2011, it would have been subject to special, expedited procedures in Congress. Because Congress and the President failed to enact legislation reducing the deficit by at least $1.2 trillion over the ten-year period of fiscal years 2012 2021 by the January 15, 2012 deadline, automatic spending reductions in fiscal years 2013 2021 through sequestration, the required cancellation of budgetary resources, have been triggered. Under sequestration, certain federal programs are protected, including Medicaid. However, payments to Medicare providers and suppliers would be reduced by an amount not to exceed 2%, beginning in 2013. On November 29, 2011, a bill titled To Amend to Exempt the Medicare Program from Fallback Sequestration Under the Budget Control Act of 2011 (H.R. 3519) was introduced in the House of Representatives. The bill would exempt payments to Medicare providers and suppliers from the automatic spending reductions beginning in 2013. The bill is currently pending in the House Committee on the Budget. At this time, we cannot predict whether Congress will pass this bill or other legislation averting or limiting the automatic spending reductions in fiscal years 2013 2021 or, if Congress does pass such legislation, whether the President will sign the legislation into law. Any reduction in provider and supplier reimbursement rates under federal healthcare programs could have a material adverse effect on our financial condition and results of operations.

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

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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.

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 March 2011 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 patient transitions, 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;
- difficulties in applying our internal control over financial reporting and disclosure controls and procedures to an acquired business;
- obtaining necessary regulatory licenses and payor-specific approvals, which may impact the timing of when we are able to bill and collect for services rendered;
- our ability to transition patients in a timely manner may impact our ability to collect amounts for services rendered;

- our estimates for revenue accruals during the integration of acquisitions may require adjustments in future periods as the transition of patient information is finalized; and

- delays in obtaining new government and commercial payor identification numbers for acquired branches, resulting in a slow down and /or loss of associated revenue.

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

We may not be able to realize the potential cost savings, synergies and revenue enhancements that we anticipate 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 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 Other 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 Home Care, Medco, Express Scripts and Bioscript. The rest of the homecare market in the United States consists of several medium-size competitors, as well as numerous small (under $3.5 million in annual revenues) local operations. There are relatively few barriers to entry in local home healthcare markets. Hospitals and health systems are routinely looking to provide coverage and better control of post acute health care services, including homecare services of the types we provide. These trends may continue as new payment models evolve, including bundled payment models, shared savings programs, value based purchasing and other payment systems. For example, the Reform Package introduced various new payment and delivery system models, including Accountable Care Organizations (ACOs). ACOs can share in savings, assuming certain quality metrics are met or exceeded. The shared savings feature in ACOs cause them to reduce the amount of services they refer to us. ACOs may be formed by a variety of providers and/or suppliers, including hospitals and health systems, as well as home respiratory, home medical equipment and home infusion therapy service providers. Although participation in an ACO is voluntary, participation by our competitors in an ACO in certain markets may force us to participate as well or face a loss of business from ACO participants who are unwilling to refer to non-ACO participants. Even when we do participate, we may lose business if we do not meet the quality metrics that ACOs must earn to share in any savings they achieve. Moreover, commensurate with the formation of an ACO physicians and/or hospitals may decide to provide home healthcare services through a new developed capacity owned and/or controlled by themselves. Similar programs may be adopted by other governmental, state and commercial payors, and we cannot predict the impact, if any, of such new models on our business. In addition, some managed care payors are developing their own pharmacy benefit managers (PBMs) or are expanding their contractual relationships with PBMs, and those PBMs then expand their scope of services into new areas such as specialty infusion and compete with us. We cannot assure you that these and other industry changes and 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 14,300 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.

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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. We have recently reorganized our operating and associated management structure as described under *Business Recent Developments*. We cannot predict what effect his will have on our ability to retain management.

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. Many pharmaceuticals we procure have supply limitations and are subject to supply disruptions. Our inability to procure certain pharmaceuticals including maintaining and renewing certain agreements and access arrangements could have a materially adverse effect on our results of operations. We often use pharmaceuticals and other suppliers selectively for quality and cost reasons. If we select against a certain pharmaceutical manufacturer or supplier we may still be dependent on them for some products. However we face a risk that they would terminate or raise prices where we are dependent on them. 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. Additionally, corrective action plans, fines or other sanctions may be levied by government regulators who oversee transportation of hazardous

materials such as compressed or liquid oxygen.

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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 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 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 maintain compliance with federal and state law regulations. Our failure to 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.

If We Do Not Maintain Effective Internal Controls Over Financial Reporting, We Could Fail to Accurately Report Our Financial Results.

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.

If 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. 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 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.

We May Be Required to Take Significant Write Downs in Connection with Impairment of our Goodwill, Intangible or Other Long-lived Assets.

Goodwill, intangible and other long-lived assets comprise a significant portion of our total assets. Intangible assets include trade names, capitated relationships, payor relationships, leasehold interest, customer lists and accreditations with commissions. An impairment review of goodwill and indefinite-lived intangible assets is conducted at least once a year in connection with the annual audit and if events or changes in circumstances indicate that their carrying value may not be recoverable. Intangible assets with a finite life and other long-lived assets are tested for recoverability whenever changes in circumstances indicate that their carrying value may not be fully recoverable.

In connection with the annual impairment test for fiscal 2011, we recorded the following non-cash impairment charges of $657.9 million, of which $654.3 million relates to our home respiratory therapy/home medical equipment reporting unit:

(i) Goodwill impairment of $509.9 million;

(ii) Trade name impairment of $60.0 ($56.4 million of which relates to the home respiratory therapy/home medical equipment reporting unit and $3.6 million of which relates to the home infusion therapy reporting unit);

(iii) Capitated relationships intangible asset impairment of $30.4 million;

(iv) Patient service equipment impairment of $45.5 million; and

(v) Property, equipment and improvements impairment of $12.1 million.

Depending on the future business performance of our reporting units and other events, we may be required to recognize increased levels of future intangible amortization, or incur further charges to recognize the impairment of our assets. Such charges may be significant.

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

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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 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, until recently affiliates of the Sponsor controlled Intelenet, an Indian company with which we contracted in 2009 to assist us with the outsourcing of certain revenue management functions. In July 2011, an affiliate of the Sponsor, along with other shareholders of Intelenet, sold Intelenet to Serco Group PLC, an international services company. The affiliate of the Sponsor may receive additional payments based on Intelenet s performance through 2013. 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.

It is Becoming more Difficult to Retain Certain Hospital-Based Referral Revenue.

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 attempt to continue working 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. In addition, some hospitals are expanding the scope and geographic coverage of their existing home infusion and durable medical equipment businesses, or establishing new such affiliates, with the result that they refer their discharged patients to these affiliated home healthcare businesses and reduce their referrals to other providers like us. We are not able to predict whether the discontinuance of any additional hospital arrangements or the increasing competition from hospitals 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 (sometimes by unilateral action by payors regarding payment policy), 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 reduction in our projected home respiratory therapy/home medical equipment reporting unit revenues as a result of these or other factors could lead to a further impairment of the value of our intangible assets which would result in a further decrease in these assets on our balance sheet. We cannot assure you that we will not have another such 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. Payors may decide to refer business to their owned provider subsidiaries such as for specialty pharmaceuticals and/or their owned pharmacy benefit managers. Some payors have developed or acquired an ownership interest in our competitors or administrative intermediaries. These activities could materially reduce our revenue from these payors.

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, 2011, we had approximately $1,028.0 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;

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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;

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

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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 2022.

We have approximately 540 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 our 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. MINE SAFETY DISCLOSURES

Not applicable.

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PART II

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

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, 2011, 2010 and 2009, and as of December 31, 2011 and 2010 from our Consolidated Financial Statements and notes thereto appearing in this Annual Report. The selected financial data for the periods October 29, 2008 to December 31, 2008, January 1, 2008 to October 28, 2008 and the year ended December 31, 2007, and as of December 31, 2009, 2008 and 2007 are derived from our consolidated financial statements, which are not included herein.

(in thousands)	2011(1) (Successor)	2010 (Successor)	2009(2) (Successor)	Period October 29, 2008 to December 31, 2008(3) (Successor)	Period January 1, 2008 to October 28, 2008(3) (Predecessor)	2007(4) (Predecessor)
Statements of Operations Data:						
Net revenues	$ 2,301,379	$ 2,080,718	$ 2,094,561	$ 356,665	$ 1,773,289	$ 1,631,801
Net (loss) income	(747,324)	(17,432)	(3,820)	(1,894)	56,453	86,039
Balance Sheet Data (As of December 31):						
Total assets	$ 1,500,028	$ 2,190,540	$ 2,309,047	$ 2,210,813		$ 1,597,802
Long-term obligations, including current maturities	1,028,056	1,019,421	1,021,146	1,022,233		687,283
Stockholders (deficit) equity	(79,600)	665,312	678,731	672,820		512,025

(1) Net loss for 2011 includes the non-cash impairment charges listed below based on the results of our 2011 annual impairment testing, the tax impact associated with the impairment charges and charges related to deferred tax valuation allowances. Except as noted, all of the impairment charges relate to the home respiratory therapy/home medical equipment reporting unit.

(i) Goodwill impairment of $509.9 million;

(ii) Trade name impairment of $60.0 million ($56.4 million of which relates to the home respiratory therapy/home medical equipment reporting unit and $3.6 million of which relates to the home infusion therapy reporting unit);

(iii) Capitated relationships intangible asset impairment of $30.4 million;

(iv) Patient service equipment impairment of $45.5 million;

(v) Property, equipment and improvements impairment of $12.1 million;

(vi) Tax benefit relating to the goodwill, intangible and long-lived assets impairment of $166.9 million; and

(vii) Valuation allowance against our net deferred tax assets of $220.5 million.

All of these items resulted in a $711.5 million increase in our net loss in fiscal 2011.

(2) 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.

(3) 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.

(4) We acquired Coram on December 3, 2007 for an aggregate cash payment of approximately $350 million. 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.

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 four core service lines: home respiratory therapy, home medical equipment, home infusion therapy, including transparental nutrition services and enteral nutrition services. 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 540 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 the home infusion therapy segment and expanded our platform for further cross-selling opportunities. Our acquisition of Praxair s homecare business in the United States in March 2011 expanded our geographic footprint and market share in several key markets in the southeastern, south central and western areas of the country. Since January 1, 2010, we have expanded our home respiratory therapy and home medical equipment sales force by 40%, of which 9% relates to the acquisition of Praxair assets. This expansion 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. On an ongoing basis, we continually evaluate the size of our sales force.

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 enables us to sign preferred provider agreements and participating Health Maintenance Organization (HMO) agreements with managed care organizations. Managed care represented approximately 70% of our total net revenues for the year ended December 31, 2011.

Leverage our national distribution infrastructure. With approximately 540 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.

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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 20 years of continuous accreditation by The Joint Commission longer than any other homecare provider.

We review our business on an ongoing basis in the light of current and anticipated market conditions and other factors and, from time to time, may undertake restructuring efforts and/or engage in dispositions of our existing assets or businesses in order to optimize our overall business, performance or competitive position. From time to time, we may also engage in acquisitions of new assets and/or businesses, some of which may be significant. In addition, significant dispositions or restructuring transactions could result in material reductions of our assets, revenues or profitability or otherwise have a material adverse effect on our results of operations, cash flow and capital resources. To the extent any such decisions are made, we would likely incur costs, expenses, impairment and/or restructuring charges associated with such transactions, which could be material.

Recent Developments

Realignment of Management. On March 14, 2012, we announced the realignment of management responsibilities for our operating segments. In connection with these changes, Daniel E. Greenleaf was promoted to Chief Executive Officer of Coram, Inc., the principal operating subsidiary of our Home Infusion Therapy Segment. In connection with this appointment, Mr. Greenleaf no longer serves as the Chief Operating Officer of our Home Respiratory/Home Medical Equipment Segment.

In addition, Daniel J. Starck was named Chief Executive Officer of Apria Healthcare, Inc., the principal operating subsidiary for our Home Respiratory Therapy/Home Medical Equipment Segment. Mr. Starck joins Apria from CorVel Corporation, where he served as Chief Executive Officer since 2007. Norman C. Payson, M.D. will continue to serve as our Executive Chairman and Chief Executive Officer of the parent company, overseeing both operating segments.

On July 11, 2011, we announced the realignment of management responsibility for certain functions, including those related to revenue management and information technology. In connection with these changes, James G. Gallas, who served as our Executive Vice President and Chief Administrative Officer, ceased to oversee revenue management, information technology and certain related functions. Management of those functions was assumed by other members of our senior management team, and Mr. Gallas assumed a special projects role during a transitional period, which concluded on January 20, 2012 in accordance with the terms of his Amended and Restated Executive Severance Agreement dated as of March 10, 2009.

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 7%, 8% and 8% of total net revenues for the years ended December 31, 2011, 2010 and 2009, respectively. 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 are considered a separate unit of accounting.

Included in accounts receivable are earned but unbilled receivables of $63.4 million and $55.2 million at December 31, 2011 and 2010, 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. Unbilled receivables can also be impacted by the transition of patients during the integration of acquisitions and overall revenue growth. Earned but unbilled receivables are aged from date of service and are considered in the analysis of historical performance and collectibility.

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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 and indefinite-lived intangible assets are not amortized but instead tested 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 amount of the reporting unit 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 s goodwill with the carrying amount of goodwill. We determined that our two operating segments are reporting units. As such, we have two reporting units: home respiratory therapy/home medical equipment and home infusion therapy. We perform the annual test for impairment as of the first day of our fourth quarter and determine fair value based on a combination of the income approach and the market approach. The income approach is based on discounted cash flows to determine fair value. The market approach uses a selection of comparable companies and transactions in determining fair 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 used in the impairment tests.

The annual indefinite-lived intangible assets impairment test in 2011 resulted in an impairment of the trade name in the home respiratory/home medical equipment reporting unit as the fair value of the trade name asset was less than the carrying amount of the trade name. The fair value of the home respiratory/home medical equipment trade name was determined using a relief from royalty method under the income approach, which uses projected revenue allocable to the trade name and an assumed royalty rate. This impairment resulted in a charge of $56.4 million to reduce the value of the trade name included in the home respiratory therapy/home medical equipment reporting unit due to the lowered expectations for this reporting unit. Any further reduction in our projected home respiratory therapy/home medical equipment reporting unit net revenues could lead to additional impairment of the value of the reporting unit s intangible assets. The 2011 annual impairment test related to indefinite-lived intangible assets in the home infusion therapy reporting unit, using the same method as described for the home respiratory/home medical equipment reporting unit, resulted in an impairment charge of $3.6 million as the fair value of the asset was less than the carrying amount related to the enteral business, which is part of the infusion therapy reporting unit.

Step one of the goodwill impairment test was completed for the home infusion therapy reporting unit and it was determined that there was no impairment of goodwill since the fair value of the reporting unit substantially exceeded the carrying amount.

Step one of the goodwill impairment test was completed for the home respiratory/home medical equipment reporting unit and it was determined that there was impairment of goodwill since the fair value of the reporting unit was less than the carrying amount. Accordingly, we first performed a test of our other identifiable assets for recoverability prior to performing a step two analysis. Recoverability of assets to be held and used is measured by the comparison of the carrying amount of an asset or asset group to future undiscounted net cash flows expected to be generated by the asset/asset group. 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. The results of this test indicated that there was impairment of our long lived assets. We determined the fair value of our capitated relationships intangible asset using the excess of earnings method under the income approach, which uses projected revenue and estimated earnings margins. The analysis resulted in an impairment of $30.4 million.

After determining the fair value of our intangible assets, we determined that the remaining excess of carrying amount over fair value of the assets of the reporting unit indicated that there was economic obsolescence related to our recorded tangible assets. The result of the economic obsolescence indicated an impairment of our patient service equipment and property, equipment and improvements of $45.5 million and $12.1 million, respectively.

We then proceeded to step two of the goodwill impairment test and determined that the implied fair value of the home respiratory therapy/home medical equipment reporting unit was less than the carrying amount of the reporting unit by $509.9 million and, therefore, recorded a goodwill impairment charge of $509.9 million. The circumstances leading to the impairment include a change in expectation related to increased costs of operating our intake, billing, and collections functions since those functions were offshored. We no longer expect that the offshored functions will be able to return to productivity and efficiency levels that were realized prior to the offshoring of those functions. A portion of the higher costs we expect to incur relate to the changing and increasing documentation requirements of our payors. In addition, we expect pricing pressures from payors in the near future to negatively impact our net revenues, gross margins and operating costs.

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The fair value measurements recorded as described above would be considered non-recurring Level 3 measurements under fair value hierarchy. This is due to the significant unobservable inputs that were utilized to measure fair value.

Additionally, we recorded a tax benefit relating the goodwill, intangible and long-lived assets impairment of $166.9 million offset by a tax expense arising from recording a valuation allowance against net deferred tax assets of $220.5 million.

Remaining intangible assets on our consolidated balance sheets 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.

Profit Interest Units. We measure and recognize compensation expense for all profit interest unit awards made to employees 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. Profit interest unit expense is recognized on a straight-line basis over the requisite service period. The estimate of fair value of profit interest unit 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. We provide for income taxes under the asset and liability method. Under this approach, deferred income taxes arise from temporary differences between the carrying amounts of assets and liabilities for tax and financial reporting 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 objective negative evidence which could result in the accrual of a valuation allowance against deferred tax assets.

For the three-year period ended December 31, 2011, we sustained a cumulative book loss, after adjusting for non-recurring items. Therefore, we determined that it is more likely than not that substantially all of our net deferred tax assets (excluding deferred tax liabilities with an indefinite life) will not be realized. Accordingly, we increased our valuation allowance by $220.5 million from $4.0 million at December 31, 2010 to $224.5 million at December 31, 2011.

Our valuation allowance will be maintained until sufficient positive evidence exists to support the reversal of all or a portion of our valuation allowance.

Our provision for income taxes is based on reported 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 June 2011, the Emerging Issues Task Force (EITF) issued EITF 09-H, *Health Care Entities: Presentation of the Provision for Bad Debts and Disclosures of Net Revenues and the Allowance for Doubtful Accounts* (EITF 09-H). EITF 09-H requires certain entities to present bad debt as an offset to revenue in the statement of operations. This issue will be effective for fiscal years beginning after December 15, 2011 and interim periods within those fiscal years. We are currently evaluating the impact of EITF 09-H on our financial position, results of operations, cash flows and disclosures.

In September 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2011-08, *Testing Goodwill for Impairment*, (ASU 2011-08), which amends the guidance in ASC 350-20, Intangibles Goodwill and Other Goodwill. Under ASU 2011-08, entities have the option of performing a qualitative assessment before calculating the fair value of the reporting unit when testing goodwill for impairment. If the fair value of the reporting unit is determined, based on qualitative factors, to be more likely than not less than the carrying amount of the reporting unit, then entities are required to perform the two-step goodwill impairment test. ASU 2011-08 will be effective for

fiscal years beginning December 1, 2012, with early adoption permitted. The adoption of ASU 2011-08 is not expected to have a material effect on our financial position, results of operations, cash flows and disclosures.

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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 2012

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

Changes in outsourcing strategy. As a part of our ongoing review of our outsourcing strategy, we determined in 2010 to return certain of the outsourced functions to our personnel and facilities in the United States. Consequently, we have experienced increased administrative costs because we no longer have the full benefit of the favorable offshore labor rates and we have increased our personnel related to these functions at higher than historical levels.

Increasing Audit Activity. We, along with others in the industry, have experienced a very significant increase in audits this year. We believe that such increased audit activity will continue to be the case for the foreseeable future. Such audits are designed to measure industry and provider claim error rates, primarily relating to medical necessity documentation in the treating physician s records for various DMEPOS items. Such audits are labor-intensive to respond to and are likely to result in refunds to the government. Additionally, commercial insurers have increased their post-payment audit volume in 2012 as well.

Results of Operations

Year Ended December 31, 2011 Results Compared to the Year Ended December 31, 2010 Results

***Net Revenues*.** Net revenues in the year ended December 31, 2011 were $2.30 billion compared to $2.08 billion in the year ended December 31, 2010. Revenue for the year ended December 31, 2011 increased primarily due to an increase in home infusion therapy segment revenue and the previously announced acquisition of Praxair assets. The revenue increase was partially offset by the non-renewal or termination of, or changes to, certain payor contracts, among other factors.

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, 2011 was 57.4%. Excluding the $45.5 million impairment charge identified in our fiscal 2011 impairment testing related to patient service equipment in our home respiratory therapy/home medical equipment reporting unit, the gross profit

margin for the year ended December 31, 2011 was 59.4%, compared to 59.9% for the year ended December 31, 2010. The decline in gross profit margin percentage is primarily due to a decrease in the home infusion therapy segment margin percentage due to an increase in specialty revenue as a percentage of infusion segment net revenue and an increase in the revenue of the home infusion segment as a percentage of total net revenue. Our specialty revenue has a lower gross profit margin as a percentage of net revenue than our other infusion therapy revenue. Our home infusion therapy

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segment has a lower gross profit margin as a percentage of net revenue than the home respiratory and home medical equipment segment.

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 3.0% and 3.4% in the years ended December 31, 2011 and December 31, 2010, respectively. The decrease in the provision for doubtful accounts in the year ended December 31, 2011 is the result of favorable collections experience occurring in the year ended December 31, 2011.

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 $1,225.4 million, or 53.2%, of total net revenues for the year ended December 31, 2011 compared to $1,067.0 million, or 51.3%, of total net revenues for the year ended December 31, 2010.

Selling, distribution and administrative expenses increased by $158.4 million for the year ended December 31, 2011 compared to the year ended December 31, 2010. The increase was comprised of an increase in labor costs of $125.4 million and a $33.0 million increase in other operating expenses.

The increase in labor costs of $125.4 million was primarily due to an increase in salaries and related benefits resulting from headcount increases associated with our decision to return certain outsourced functions relating to documentation, billing and collections back to Apria personnel, increases in headcount as a result of the acquisition of Praxair assets, growth in infusion headcount to support growth in our infusion revenue and growth in our respiratory therapy and home medical equipment sales force.

The increase in other operating expenses was $33.0 million, of which $17.5 million related to the acquisition of Praxair assets. Of the $17.5 million, $7.0 million of costs related primarily to the closing of certain Praxair facilities and professional fees associated with the acquisition. The remaining $15.5 million increase was primarily due to an increase in costs related to delivery as a result of the increase in revenue and higher fuel prices.

Amortization of Intangible Assets. Amortization of intangible assets was $4.5 million and $4.8 million in the years ended December 31, 2011 and December 31, 2010, respectively.

Non-Cash Impairment of Property, Equipment and Improvements Home Respiratory Therapy/Home Medical Equipment Reporting Unit. Impairment of property, equipment and improvements for the year ended December 31, 2011 was $12.1 million. The impairment charge relates to our home respiratory therapy/home medical equipment reporting unit. The decrease in the carrying value in the home respiratory therapy/home medical equipment reporting unit is primarily due to lowered estimates of future cash flows as a result of lowered expectations of future net revenues and increased estimates of future selling, general and administrative costs. The circumstances leading to the impairment include an expectation that increased costs related to operating our intake, billing and collections functions will continue at levels higher than originally anticipated and at levels higher than experienced prior to offshoring. A portion of these higher costs relates to the changing and increasing documentation requirements of our payors. In addition, we expect pricing pressures from our payors in the near future to negatively impact our net revenues, gross margins and operating costs as a percentage of net revenues.

Non-Cash Impairment of Goodwill and Intangible Assets. Impairment of goodwill and intangible assets for the year ended December 31, 2011 was $600.3 million. We recorded a $509.9 million goodwill impairment charge, a $60.0 million intangible asset impairment charge related to our trade name and a $30.4 million intangible asset impairment charge related to our capitated relationships. Of the $600.3 million of non-cash goodwill and intangible assets impairment charges, $596.7 million relates to our home respiratory therapy/home medical equipment reporting unit. The decrease in the carrying value in the home respiratory therapy/home medical equipment reporting unit is primarily due to lowered estimates of future cash flows as a result of lowered expectations of future net revenues and increased estimates of future selling, general and administrative costs. The circumstances leading to the impairment include an expectation that increased costs related to operating our intake, billing and collections functions will continue at levels higher than originally anticipated and at levels higher than experienced prior to offshoring. A portion of these higher costs relates to the changing and increasing documentation requirements of our payors. In addition, we

expect pricing pressures from our payors in the near future to negatively impact our net revenues gross margins and operating costs as a percentage of net revenues.

Interest Expense. Interest expense increased $1.7 million, or 1.3%, to $132.5 million in the year ended December 31, 2011 from $130.8 million in the year ended December 31, 2010. 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 $0.7 million for the year ended December 31, 2011 from $0.9 million in the year ended December 31, 2010.

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Income Tax Expense. Our effective tax rate for the year ended December 31, 2011 was (3.4)% compared with 31.2% for the year ended December 31, 2010. Our income tax expense increased $32.6 million to $24.7 million in the year ended December 31, 2011 from a $(7.9) million income tax benefit in the year ended December 31, 2010 due to the following changes:

(in thousands)	Year Ended December 31, 2011	Year Ended December 31, 2010	Change
Income tax expense at statutory rate	$ (252,924)	$ (8,870)	$ (244,054)
Non-deductible goodwill impairment	78,589		78,589
Non-deductible expenses	816	712	104
State taxes, net of federal benefit and state loss carryforwards	(19,096)	(7)	(19,089)
Share-based compensation	1,053	1,437	(384)
Change in federal and state valuation allowance	220,534	(396)	220,930
Change in liability for unrecognized tax benefits	(4,348)	495	(4,843)
Other	60	(1,283)	1,343
	$ 24,684	$ (7,912)	$ 32,596

Our tax expense for 2011 was higher than the statutory rate by $78.6 million as a result of the non-deductible portion of our goodwill impairment charge.

Our state tax benefit, before considering the change in valuation allowance, increased $19.1 million to $19.1 million in the year ended December 31, 2011 from $0 in the year ended December 31, 2010 primarily due to the increase in the book loss sustained in the year ended December 31, 2011 compared to the year ended December 31, 2010.

We increased our valuation allowance by $220.5 million from $4.0 million at December 31, 2010 to $224.5 million at December 31, 2011 because we determined that, based on all available evidence, it is more likely than not that substantially all of our net deferred tax assets will not be realized in the near future. Our valuation allowance will be maintained until sufficient positive evidence exists to support the reversal of all or a portion of our valuation allowance.

Our liability for unrecognized tax benefits decreased $4.4 million for the year ended December 31, 2011, primarily due to tax law changes and the expiration of statutes of limitations for assessment.

Segment Net Revenues and EBIT

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

	Net Revenues			
(in thousands)	Year Ended December 31, 2011	Percentage of Net Revenues	Year Ended December 31, 2010	Percentage of Net Revenues
Operating Segment				
Home respiratory therapy and home medical equipment	$ 1,176,581	51.1%	$ 1,083,207	52.1%
Home infusion therapy	1,124,798	48.9	997,511	47.9
Total	$ 2,301,379	100.0%	$ 2,080,718	100.0%

	EBIT			
(in thousands)	Year Ended December 31, 2011	Percentage of Net Revenues	Year Ended December 31, 2010	Percentage of Net Revenues
Operating Segment				
Home respiratory therapy and home medical equipment(a)	$ (696,569)	(59.2)%	$ (9,866)	(0.9)%

Home infusion therapy(b)	105,924	9.4%	114,358	11.5%
Total	$ (590,645)		$ 104,492	

(a) The 2011 EBIT for the home respiratory therapy/home medical equipment reporting unit includes the following non-cash impairment charges totalling $654.3 million:

(i) Goodwill impairment of $509.9 million;

(ii) Intangible asset impairment of $86.8 million ($56.4 million related to trade name and $30.4 million related to capitated relationships);

(iii) Patient Service Equipment impairment of $45.5 million; and

(iv) Property, equipment and improvements impairment of $12.1 million.

(b) The 2011 EBIT for the home infusion therapy reporting unit includes $3.6 million of non-cash impairment charges related to our trade name intangible asset.

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

See definition and reconciliation of EBIT to net loss 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 increased $93.4 million, or 8.6%, to $1,176.6 million in the year ended December 31, 2011 from $1,083.2 million in the year ended December 31, 2010. Revenues for the home respiratory therapy and home medical equipment segment decreased to 51.1% of total revenue in the year ended December 31, 2011 from 52.1% in the year ended December 31, 2010.

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 increased by 8.4% in the year ended December 31, 2011 compared to the year ended December 31, 2010. The increase in revenue resulted primarily from increases in sleep apnea and oxygen. Revenue in this service line was positively impacted by the acquisition of Praxair assets and negatively impacted by the termination of or changes to certain payor contracts. In addition, we experienced an increase in sleep apnea volume.

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 increased by 10.1% in the year ended December 31, 2011 compared to the year ended December 31, 2010. The increase was primarily due to an increase in overall volume. The increase in overall volume was partially offset by a decrease in revenue 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, 2011 was a negative $696.6 million (including non-cash impairment charges of $509.9 million related to goodwill, $56.4 million related to our trade name, $30.4 million related to capitated relationships, $45.5 million related to patient service equipment and $12.1 million related to property, equipment and improvements) compared to a negative $9.9 million in the year ended December 31, 2010. The negative EBIT was 59.2% of segment net revenues in the year ended December 31, 2011 compared to negative 0.9% of segment net revenues in the year ended December 31, 2010. Excluding the total non-cash impairment charges of $654.3 million, the increase in the EBIT as a percentage of segment net revenues from a negative 0.9% for the year ended December 31, 2010 to a negative 4.2% in the year ended December 31, 2011 is primarily due to an increase in sales, distribution and administrative costs as a percentage of net revenues, partially offset by a decrease in provision for bad debts as a percentage of net revenues in the year ended December 31, 2011 compared to the year ended December 31, 2010.

Home Infusion Therapy Segment. For the home infusion therapy segment, total net revenues increased $127.3 million, or 12.8% to $1,124.8 million for the year ended December 31, 2011 from $997.5 million in the year ended December 31, 2010. Revenues for the home infusion therapy segment increased to 48.9% of total revenue in the year ended December 31, 2011 from 47.9% in the year ended December 31, 2010.

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, enteral nutrients, and core drugs.

EBIT for the home infusion therapy segment in the year ended December 31, 2011 was $105.9 million (including non-cash impairment charges of $3.6 million related to our trade name) compared to $114.4 million in the year ended December 31, 2010. EBIT was 9.4% of segment net revenues in the year ended December 31, 2011 compared to 11.5% of segment net revenues in the year ended December 31, 2010. Excluding the non-cash impairment charges of $3.6 million, the decrease in EBIT as a percentage of net segment revenues from 11.5% for the year ended December 31, 2010 to 9.4% for the year ended December 31, 2011 is primarily due to a decrease in the gross profit as a percentage of segment net revenues due to an increase in specialty revenues as a percent of infusion therapy segment net revenues and an increase in the provision for doubtful accounts as a percentage of net revenues in the year ended December 31, 2011 compared to the year ended December 31, 2010.

EBIT is a measure used by our management to measure operating performance. EBIT is defined as net income (loss) plus interest expense and income taxes. EBIT is not a recognized term under Generally Accepted Accounting Principles (GAAP) and does not purport to be an alternative net income as a measure of operating performance or to cash flows from operating activities as a measure of liquidity.

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The following table provides a reconciliation from net loss to EBIT:

(in thousands)	Year Ended December 31, 2011	Year Ended December 31, 2010
Net loss(a)	$ (747,324)	$ (17,432)
Interest expense, net	131,995	129,836
Income tax expense (benefit)	24,684	(7,912)
EBIT(b)	$ (590,645)	$ 104,492

(a) Net loss for 2011 includes the non-cash impairment charges listed below based on the results of our 2011 annual impairment testing, the tax impact associated with the impairment charges and charges related to deferred tax valuation allowances. Except as noted, all of the impairment charges relate to the home respiratory therapy/home medical equipment reporting unit.

(i) Goodwill impairment of $509.9 million;

(ii) Trade name impairment of $60.0 million ($56.4 million of which relates to the home respiratory therapy/home medical equipment reporting unit and $3.6 million of which relates to the home infusion therapy reporting unit);

(iii) Capitated relationships intangible asset impairment of $30.4 million;

(iv) Patient service equipment impairment of $45.5 million;

(v) Property, equipment and improvements impairment of $12.1 million;

(vi) Tax benefit relating to the goodwill, intangible and long-lived assets impairment of $166.9 million; and

(vii) Valuation allowance against our net deferred tax assets of $220.5 million.

All of these items resulted in a $711.5 million increase in our net loss in fiscal 2011.

(b) EBIT for 2011 includes $657.9 million related to goodwill, intangible and long-lived asset non-cash impairment charges of which $654.3 million relates to our home respiratory therapy/home medical equipment reporting unit.

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*.

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.

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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 costs of $22.9 million.

The decrease in labor costs 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.

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

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Segment Net Revenues and EBIT

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

	Net Revenues			
(in thousands)	Year Ended December 31, 2010	Percentage of Net Revenues	Year Ended December 31, 2009	Percentage of Net Revenues
Operating Segment				
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	$ 2,080,718	100.0%	$ 2,094,561	100.0%

	EBIT			
(in thousands)	Year Ended December 31, 2010	Percentage of Net Revenues	Year Ended December 31, 2009	Percentage of Net Revenues
Operating Segment				
Home respiratory therapy and home medical equipment	$ (9,866)	(0.9)%	$ 50,167	4.3%
Home infusion therapy	114,358	11.5%	65,667	7.1%
Total	$ 104,492		$ 115,834	

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

See definition and reconciliation of EBIT to net loss 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.

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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 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.

The following table provides a reconciliation from net loss to EBIT:

(in thousands)	Year Ended December 31, 2010	Year Ended December 31, 2009
Net loss	$ (17,432)	$ (3,820)
Interest expense, net	129,836	128,092
Income tax benefit	(7,912)	(8,438)
EBIT	$ 104,492	$ 115,834

Impact of Inflation and Changing Prices

We experience pricing pressures in the form of continued reductions in reimbursement rates, particularly from managed care organizations and from governmental payors such as Medicare and Medicaid. We are also impacted by rising costs for certain inflation-sensitive operating expenses such as labor and employee benefits, facility and equipment leases, and vehicle fuel. However, we generally do not believe these impacts are material to our revenues or net income.

Liquidity and Capital Resources

Our principal source of liquidity is our operating cash flow, which is supplemented by our ABL Facility (as defined below), which provides for revolving credit of up to $250.0 million, subject to borrowing base availability. In recent years, we have generated operating cash flows in excess of our operating needs, which has afforded us the ability to pursue acquisitions and fund patient service equipment purchases to support revenue growth. We believe that our operating cash flow, together with our existing cash, cash equivalents, and Amended ABL Facility, will continue to be sufficient to fund our operations and growth strategies for at least the next 12 months.

In the year ended December 31, 2011, our free cash flow was $(61.3) million. For the year ended December 31, 2010 our free cash flow was $(32.5) million. See discussion below on changes in the components of free cash flow; net cash provided by operations and purchases of patient service equipment and property, equipment and improvements. Free cash flow is a financial measure which is not calculated in accordance with GAAP. Free cash flow is defined as cash provided by operating activities less purchases of patient service equipment and property, equipment and improvements, exclusive of effects of acquisitions. It is presented as a supplemental performance measure and is not intended as an alternative to any other cash flow measure calculated in accordance with GAAP. Further, free cash flow may not be comparable to similarly titled measures used by other companies.

A table reconciling free cash flow to net cash provided by operating activities is presented below.

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(in thousands)	Year Ended December 31, 2011	Year Ended December 31, 2010	Year Ended December 31, 2009
Reconciliation Free Cash Flow:			
Net loss(a)	$ (747,324)	$ (17,432)	$ (3,820)
Non-cash items(b)	931,060	224,645	254,371
Change in operating assets and liabilities	(81,921)	(122,656)	(81,125)
Net cash provided by operating activities	101,815	84,557	169,426
Less: Purchases of patient service equipment and property, equipment and improvements	(163,083)	(117,022)	(150,597)
Free cash flow	$ (61,268)	$ (32,465)	$ 18,829

(a) Net loss for 2011 includes the non-cash impairment charges listed below based on the results of our 2011 annual impairment testing, the tax impact associated with the impairment charges and charges related to deferred tax valuation allowances. Except as noted, all of the impairment charges relate to the home respiratory therapy/home medical equipment reporting unit.

(i) Goodwill impairment of $509.9 million;

(ii) Trade name impairment of $60.0 million ($56.4 million of which relates to the home respiratory therapy/home medical equipment reporting unit and $3.6 million of which relates to the home infusion therapy reporting unit);

(iii) Capitated relationships intangible asset impairment of $30.4 million;

(iv) Patient service equipment impairment of $45.5 million;

(v) Property, equipment and improvements impairment of $12.1 million;

(vi) Tax benefit relating to the goodwill, intangible and long-lived assets impairment of $166.9 million; and

(vii) Valuation allowance against our net deferred tax assets of $220.5 million.

All of these items resulted in a $711.5 million increase in our net loss in fiscal 2011.

(b) 2011 includes $657.9 million related to goodwill, intangible and long-lived asset non-cash impairment charges of which $654.3 million relates to our home respiratory therapy/home medical equipment reporting unit.

Cash Flow. The following table presents selected data from our consolidated statement of cash flows:

(in thousands)	Year Ended December 31, 2011	Year Ended December 31, 2010	Year Ended December 31, 2009
Net cash provided by operating activities	$ 101,815	$ 84,557	$ 169,426
Net cash used in investing activities	(186,395)	(95,111)	(168,656)
Net cash provided by (used in) financing activities	4,539	(38,472)	(10,625)
Net decrease in cash and equivalents	(80,041)	(49,026)	(9,855)
Cash and equivalents at beginning of period	109,137	158,163	168,018
Cash and equivalents at end of period	$ 29,096	$ 109,137	$ 158,163

The Year Ended December 31, 2011 Results Compared to the Year Ended December 31, 2010

Net cash provided by operating activities in the year ended December 31, 2011 was $101.8 million compared to $84.6 million in the year ended December 31, 2010, an increase of $17.2 million. The increase in net cash provided by operating activities resulted primarily from a $40.7 million decrease in the cash used related to the change in operating assets and liabilities to a $81.9 million use of cash in 2011 from a $122.7 million use of cash in 2010, offset by a $23.5 million increase when combining our net loss less our non-cash items.

The $40.7 million decrease in cash used by the change in operating assets and liabilities consisted primarily of the following:

$35.2 million increase in cash provided by accounts payable to a $34.5 million provision of cash in the twelve months ended December 31, 2011 from a $0.7 million use of cash in the twelve months ended December 31, 2010. The increase was primarily due to the timing of payments on invoices.

$17.7 million increase in cash provided by accrued payroll to a $10.0 million provision of cash in the twelve months ended December 31, 2011 from a $7.8 million use of cash in the twelve months ended December 31, 2010. The increase was primarily due to net changes in incentive compensation and payroll timing.

$17.4 million increase in cash provided by accrued expenses to a $8.5 million provision of cash in the twelve months ended December 31, 2011 from a $8.9 million use of cash in the twelve months ended December 31, 2010. The increase was primarily due to the timing of payments.

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$10.2 million increase in cash provided by inventories to a $4.6 million provision of cash in the twelve months ended December 31, 2011 from a $5.6 million use of cash in the twelve months ended December 31, 2010. The increase was primarily due to the timing of inventory purchases to support growth in our infusion revenue.

Offset by:

$22.4 million increase in cash used by accounts receivable to a $124 million use of cash in the year ended December 31, 2011 from a $101.5 million use of cash in the year ended December 31, 2010. The increase in the use of cash was primarily related to the overall increase in our revenue.

$10.2 million increase in cash used by income taxes to a $12.0 million use of cash in the twelve months ended December 31, 2011 from a $1.8 million use of cash in the twelve months ended December 31, 2010. The increase was primarily due to reductions to our tax contingency accruals during the twelve months ended December 31, 2011.

$9.4 million increase in cash used by prepaid expenses and other assets to a $5.0 million use of cash in the year ended December 31, 2011 from a $4.5 million provision of cash in the year ended December 31, 2010. The increase was primarily due to an increase in prepaid service contracts and timing of insurance premiums.

Net cash used in investing activities in the year ended December 31, 2011 was $186.4 million, compared to $95.1 million in the year ended December 31, 2010. The primary use of funds in 2011 was $163.1 million to purchase patient service equipment and property, equipment and improvements; $123.8 million related to patient service equipment to support revenue growth and $39.3 million related to property, equipment and improvements, primarily due to additions to our information systems and leasehold improvements. The primary use of funds in 2010 was $117.0 million to purchase patient service equipment and property, equipment and improvements; $85.2 million related to patient service equipment and $31.8 million related to property, equipment and improvements, primarily due to additions to our information systems. Additionally, there were $8.1 million related to purchases of short-term investments. This was partially offset by maturities of $31.8 million of short-term investments during this same period.

Net cash provided by financing activities in the year ended December 31, 2011 was $4.5 million compared to a $38.5 million use of cash in the year ended December 31, 2010. Net cash provided by financing activities in the year ended December 31, 2011 primarily reflected the borrowing of $10.0 million from our ABL Facility offset by a use of cash of $3.5 million related to debt issuance costs of the ABL Facility. In 2010, net cash used in financing activities primarily reflected the use of $32.5 million to pay down the book cash overdraft reported in accounts payable and debt issuance costs related to terminated offerings and registration fees of $4.1 million incurred during the period.

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

Net cash provided by operating activities in the year ended December 31, 2010 was $84.6 million compared to $169.4 million in the year ended December 31, 2009, a decrease of $84.8 million. The decrease in net cash provided by operating activities resulted from a $13.6 million increase in loss before non-cash items to $17.4 million in 2010 from $3.8 million in 2009, offset by a $41.6 million increase in the cash used related to the change in operating assets and liabilities to a $122.7 million use of cash in 2010 from a $81.1 million use of cash in 2009.

The $41.6 million increase in cash used by the change in operating assets and liabilities consisted primarily of the following:

$61.9 million increase in cash used by accounts receivable to a $101.5 million use of cash in the year ended December 31, 2010 from a $39.6 million use of cash in the year ended December 31, 2009. The increase in the use of cash was primarily related to a delay in collections due to the outsourcing of our billing and collection process and the impact of a major payor using an intermediary.

$11.7 million increase in cash used by accrued expenses to an $8.9 million use of cash in the year ended December 31, 2010 from a $2.8 million provision of cash in the year ended December 31, 2009. The increase in the use of cash was primarily due to the timing of payments on certain accruals.

Offset by:

$13.4 million decrease in cash used by accounts payable to a $0.7 million provision of cash in the year ended December 31, 2010 from a $14.1 million use of cash in the year ended December 31, 2009. The decrease was

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primarily due to the elimination of book cash overdraft from accounts payable partially offset by the timing of payment on certain invoices.

$11.7 million decrease in cash used by prepaid expenses and other assets to a $4.5 million provision of cash in the year ended December 31, 2010 from a $7.2 million use of cash in the year ended December 31, 2009. The decrease was primarily due to the change in prepaid inventory payment terms and an increase in prepaid federal taxes.

Net cash used in investing activities in the year ended December 31, 2010 was $95.1 million, compared to $168.7 million in the year ended December 31, 2009. The primary use of funds in 2010 was $117.0 million to purchase patient service equipment and property, equipment and improvements; $85.2 million related to patient service equipment and $31.8 million related to property, equipment and improvements, primarily due to additions to our information systems software and hardware. Additionally, there were $8.1 million related to purchases of short-term investments. This was partially offset by maturities of $31.8 million of short-term investments during this same period. The primary use of funds in 2009 was $150.6 million to purchase patient service equipment and property, equipment and improvements; $112.2 million related to patient service equipment and $38.4 million related to property, equipment and improvements, primarily due to additions to our information systems hardware/software and leasehold improvements on new facilities. Additionally, $37.6 million related to purchases of short-term investments during the period which was partially offset by maturities of $13.9 million of short-term investments during the same period.

Net cash used in financing activities in the year ended December 31, 2010 was $38.5 million compared to $10.6 million in the year ended December 31, 2009. Net cash used in financing activities in the year ended December 31, 2010 primarily reflected the use of $32.5 million to pay down the book cash overdraft reported in accounts payable and debt issuance costs related to terminated offerings and registration fees of $4.1 million incurred during the period. In 2009, net cash used in financing activities primarily reflected $1,010.0 million for the repayment of our senior secured bridge agreement, $19.0 million for debt issuance costs related to our Series A-1 Notes and Series A-2 Notes, and $6.6 million for repayment of indebtedness under our ABL Facility, offset by the issuance of our series A-1 and series A-2 Notes for $700.0 million and $317.5 million, respectively.

Contractual Cash Obligations. The following table summarizes the long-term cash payment obligations to which we are contractually bound. The years presented below represent 12-month periods ending December 31.

(in millions)	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years	Totals
Series A-1 Notes	$	$ 700	$	$	$ 700
Series A-2 Notes		318			318
Amended ABL Facility(1)(2)	10				10
Interest Payments on Series A-1 Notes(3)	79	158			237
Interest Payments on Series A-2 Notes(4)	39	79			118
Fees on ABL Facility(2)(5)	2	3			5
Operating Leases	67	91	51	19	228
Capitalized Leases(8)					
Purchase Obligations(6)	52	81	67	50	250
Unrecognized Tax Benefits(7)					
Total Contractual Cash Obligations	$ 249	$ 1,430	$ 118	$ 69	$ 1,866

(1) Borrowings under the Amended ABL Facility bear interest at a rate per annum equal to, at our option, either (a) a base rate determined by reference to the higher of (1) the prime rate of Bank of America, N.A. and (2) the federal funds effective rate plus 1/2 of 1%, plus an applicable margin of 1.00% to 1.50% based on the average excess availability (currently 1.00%) or (b) a LIBOR rate determined by reference to LIBOR, adjusted for statutory reserve requirements, plus an applicable margin of 2.00% to 2.50% based on average excess availability (currently 2.00%). The applicable margin for borrowings under our ABL Facility is subject to step ups and step downs based on average excess availability under the ABL Facility.

(2) The actual amounts of interest and fee payments under the ABL Facility will ultimately depend on the amount of debt and letters of credit outstanding and the interest rates in effect during each period. We are also required to pay customary letter of credit fees equal to the applicable margin on LIBOR loans and certain agency fees.

(3) Represents aggregate interest payments on $700.0 million of the Series A-1 Notes issued in May 2009 that is paid semi-annually in May and November. Interest payments on the Series A-1 Notes will total approximately $78 million

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annually until the Series A-1 Notes mature on November 1, 2014. The effective interest rate at December 31, 2011 was 11.25%.

(4) Represents aggregate interest payments on $317.5 million of the Series A-2 Notes issued in August 2009 that is paid semi-annually in May and November. Interest payments on the Series A-2 Notes will total approximately $39 million annually until the Series A-2 Notes mature on November 1, 2014. The effective interest rate at December 31, 2011 was 12.375%.

(5) The fees payable on the Amended ABL Facility are based on an assumed fee for undrawn amounts of 0.50%, which represents the fees payable under the Amended ABL Facility assuming no borrowings or drawn letters of credit. We are required to pay a commitment fee on the Amended ABL Facility, in respect of the unutilized commitments there under, ranging from 0.375% to 0.50% per annum, which fee is determined based on the utilization of our Amended ABL Facility (increasing when utilization is low and decreasing when utilization is high). The fees also include an administrative fee which is paid quarterly.

(6) The purchase obligations primarily relate to approximately $173.5 million we expect to pay under an agreement with Dell Services (formerly Perot Systems) and approximately $71.4 million we expect to pay under an agreement with Intelenet. However, if we terminated the agreements, the required obligation to vendors could be reduced to approximately $11.2 million for Dell Systems and $7.9 million for Intelenet.

(7) Gross unrecognized tax benefits of $9.8 million are included within *Income Taxes Payable and Other Non-current Liabilities* in the total liabilities section of our December 31, 2011 consolidated balance sheet. The entire $9.8 million amount is not reflected in the contractual cash obligations table above since we cannot make a reliable estimate of the period in which cash payments will occur.

(8) Less than $1 million.

Accounts Receivable. Accounts receivable before allowance for doubtful accounts increased to $391.1 million as of December 31, 2011 from $339.4 million at December 31, 2010. Days sales outstanding (calculated as of each period-end by dividing accounts receivable, less allowance for doubtful accounts, by the rolling average of total net revenues) were 51 days at December 31, 2011, compared to 49 days at December 31, 2010. The increase in accounts receivable is primarily the result of the overall increase in revenue during 2011. The increase in our days sales outstanding is primarily the result of a decrease in our allowance for doubtful accounts based upon improved collections.

Accounts aged in excess of 180 days expressed as percentages of total receivables for certain major payor categories, and in total, are as follows:

	December 31, 2011	December 31, 2010
Total	20.0%	19.3%
Medicare	15.9%	13.5%
Medicaid	20.1%	23.2%
Patient Self pay	31.5%	31.0%
Managed care/other	19.9%	18.8%

Unbilled Receivables. Included in accounts receivable are earned but unbilled receivables of $63.4 million and $55.2 million at December 31, 2011 and 2010, 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 our analysis of historical performance and collectibility. The increase in earned but unbilled receivables at December 31, 2011 from December 31, 2010 is primarily due to the overall growth in home infusion therapy revenue.

Inventories and Patient Service Equipment. Inventories consist primarily of pharmaceuticals and disposable products used in conjunction with patient service equipment. Patient service equipment consists of respiratory and home medical equipment that is provided to in-home patients for the course of their care plan, normally on a rental basis, and subsequently returned to us for redistribution after cleaning and maintenance is performed.

The branch locations serve as the primary point from which inventories and patient service equipment are delivered to patients. Certain products and services, such as infusion therapy and respiratory medications, bypass the respiratory/home medical equipment branches and are provided directly to patients from pharmacies or other central locations. The branches are supplied with inventory and equipment from central warehouses that service specific areas of the country. Such warehouses are also responsible for repairs and scheduled maintenance of patient service equipment, which adds to the frequent movement of equipment between locations. Further, the majority of our patient service equipment is located in

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patients homes. While utilization varies widely between equipment types, on the average, approximately 87.2% of equipment is on rent at any given time. Inherent in this asset flow is the fact that losses will occur. Depending on the product type, we perform physical inventories on an annual or quarterly basis. Inventory and patient service equipment balances in the financial records are adjusted to reflect the results of these physical inventories.

Long-term Debt.

Series A-1 Notes and Series A-2 Notes. We issued the Series A-1 Notes and Series A-2 Notes in May 2009 and August 2009, respectively. The Series A-1 Notes and the Series A-2 Notes bear interest at a rate equal to 11.25% per annum and 12.375% per annum, respectively. The indenture governing the Series A-1 Notes and the Series A-2 Notes, among other restrictions, limits our ability and the ability of our restricted subsidiaries to:

- incur additional debt;
- pay dividends and make other distributions;
- make certain investments;
- repurchase our stock;
- incur certain liens;
- enter into transactions with affiliates;
- merge or consolidate;
- enter into agreements that restrict the ability of our subsidiaries to make dividends or other payments to us; and
- transfer or sell assets.

Subject to certain exceptions, the indenture governing the Series A-1 Notes and the Series A-2 Notes permits us and our restricted subsidiaries to incur additional indebtedness, including senior indebtedness and secured indebtedness. The Series A-1 Notes are entitled to a priority of payment over the Series A-2 Notes in certain circumstances, including upon any acceleration of the obligations under the Series A-1 Notes, the Series A-2 Notes or any bankruptcy or insolvency event or default with respect to us or any guarantor of the Series A-1 Notes and the Series A-2 Notes.

Amended and Restated ABL Facility. On August 8, 2011, we entered into a senior secured asset-based revolving credit facility, or ABL Facility, with Bank of America, N.A., as administrative agent and collateral agent and a syndicate of financial institutions and institutional lenders. Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Capital, the investment banking division of Barclays Bank PLC joint bookrunners. The ABL Facility amended and restated our prior senior secured asset-based revolving credit facility dated October 28, 2008, which provided for a revolving credit financing of up to $150.0 million.

The ABL Facility provides for revolving credit financing of up to $250.0 million, subject to borrowing base availability, with a maturity of the earlier of (a) five years and (b) 90 days prior to the earliest maturity of our outstanding Series A-1 Notes and Series A-2 Notes, and includes both

a letter of credit and swingline loan sub-facility. The borrowing base at any time is equal to the sum (subject to certain reserves and other adjustments) of (i) 85% of eligible receivables, (ii) the least of (a) 85% of eligible self-pay accounts, (b) 10% of the borrowing base, (c) $25,000,000 and (d) the aggregate amount of self-pay accounts collected within the previous 90 days, (iii) the lesser of (a) 85% of eligible accounts invoiced but unpaid for more than 180 days but less than 360 days and (b) 10% of eligible accounts invoiced but unpaid for 180 days or less and (iv) the lesser of (a) 85% of the net orderly liquidation value of eligible inventory and (b) $35.0 million.

Borrowings under our ABL Facility bear interest at a rate per annum equal to, at our option, either (a) a base rate determined by reference to the higher of (1) the prime rate of Bank of America, N.A. and (2) the federal funds effective rate plus 1/2 of 1% (Base Rate), plus an applicable margin (currently 1.00%) or (b) a LIBOR rate determined by reference to LIBOR, adjusted for statutory reserve requirements, plus an applicable margin (currently 2.00%). The applicable margin for borrowings under our ABL Facility is subject to (a) 25 basis points step ups and step downs based on average excess availability under the ABL Facility and (b) a step down of 25 basis points based on achieving a consolidated fixed charge coverage ratio greater than 1.75 to 1.00. In addition to paying interest on outstanding amounts under our ABL Facility, we are required to pay a commitment fee, in respect of the unutilized commitments thereunder, ranging from 0.375% to 0.50% per annum, which fee will be determined based on utilization of our ABL Facility (increasing when utilization is low and decreasing when utilization is high). We also pay customary letter of credit fees equal to the applicable margin on LIBOR loans and other customary letter of credit and agency fees.

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From time to time, we issue letters of credit in connection with our business, including commercial contracts, leases, insurance and workers compensation arrangements. If the holders of our letters of credit draw funds under such letters of credit, it would increase our outstanding senior secured indebtedness.

As of December 31, 2011, there were $10.0 million in borrowings under the ABL Facility, outstanding letters of credit totaled $21.1 million and additional availability under the ABL Facility, subject to the borrowing base, was $218.9 million. As of December 31, 2011, the available borrowing base did not constrain our ability to borrow the entire $218.9 million of available borrowing capacity under our ABL Facility. At December 31, 2011, we were in compliance with all of the financial covenants required by the credit agreement governing the ABL Facility.

As market conditions warrant, we and our major equity holders, including the Sponsor and its affiliates, may from time to time, depending upon market conditions, seek to repurchase our debt securities or loans in privately negotiated or open market transactions, by tender offer or otherwise.

Covenant Compliance. Under the indenture governing our Series A-1 Notes and Series A-2 Notes and under the credit agreement governing our ABL Facility, our ability to engage in activities such as incurring additional indebtedness, making investments, refinancing certain indebtedness, paying dividends and entering into certain merger transactions is governed, in part, by our ability to satisfy tests based on Adjusted EBITDA.

Adjusted EBITDA is defined as net income (loss), plus interest expense, net, provision (benefit) for income taxes and depreciation and amortization, further adjusted for certain other non-cash items, costs incurred related to initiatives, cost reduction and other adjustment items that are permitted by the covenants included in the indenture governing the Series A-1 Notes and the Series A-2 Notes and the credit agreement governing our ABL Facility.

We believe that the presentation of Adjusted EBITDA is appropriate to provide additional information to investors about the calculation of, and compliance with, certain financial covenants in the indenture governing our Series A-1 Notes and Series A-2 Notes and in our ABL Facility. Adjusted EBITDA is a material component of these covenants. We caution investors that amounts presented in accordance with our definition of Adjusted EBITDA may not be comparable to similar measures disclosed by other issuers, because not all issuers and analysts calculate Adjusted EBITDA in the same manner.

Adjusted EBITDA is not a measurement of our financial performance under GAAP and should not be considered as an alternative to net income or any other performance measures derived in accordance with GAAP or as an alternative to cash flows from operating activities as a measure of our liquidity.

The following table provides a reconciliation from our net loss to Adjusted EBITDA:

(in thousands)	Year Ended December 31, 2011
Net loss(a)	$ (747,324)
Interest expense, net(b)	131,995
Income tax expense	24,684
Depreciation and amortization	133,608
Non-cash impairment charges (c)	657,868
Non-cash items(d)	22,169
Costs incurred related to initiatives(e)	39,337
Other adjustments(f)	6,996
Projected cost savings and synergies(g)	4,003
Adjusted EBITDA	$ 273,336

(a) Net loss for 2011 includes the non-cash impairment charges listed below based on the results of our 2011 annual impairment testing, the tax impact associated with the impairment charges and charges related to deferred tax valuation allowances. Except as noted, all of the impairment charges relate to the home respiratory therapy/home medical equipment reporting unit.

(i) Goodwill impairment of $509.9 million;

(ii) Trade name impairment of $60.0 million ($56.4 million of which relates to the home respiratory therapy/home medical equipment reporting unit and $3.6 million of which relates to the home infusion therapy reporting unit);

(iii) Capitated relationships intangible asset impairment of $30.4 million;

(iv) Patient service equipment impairment of $45.5 million;

(v) Property, equipment and improvements impairment of $12.1 million;

(vi) Tax benefit relating to the goodwill, intangible and long-lived assets impairment of $166.9 million; and

(vii) Valuation allowance against our net deferred tax assets of $220.5 million.

All of these items resulted in a $711.5 million increase in our net loss in fiscal 2011.

See *Critical Accounting Policies Goodwill and Long-Lived Assets and Results of Operations Year Ended December 31, 2011 Results Compared to the Year Ended December 31, 2010 Results* for a discussion of impairment changes for our home respiratory therapy/home medical equipment reporting unit.

(b) Reflects $132.6 million of interest expense, net of $0.6 million of interest income for the year ended December 31, 2011.
(c) In connection with the annual impairment test for fiscal 2011, we recorded the following non-cash impairment charges of $657.9 million, of which $654.3 million relates to our home respiratory therapy/home medical equipment reporting unit:
(i) Goodwill impairment of $509.9 million;

(ii) Trade name impairment of $60.0 ($56.4 million of which relates to the home respiratory therapy/home medical equipment reporting unit and $3.6 million of which relates to the home infusion therapy reporting unit);

(iii) Capitated relationships intangible asset impairment of $30.4 million;

(iv) Patient service equipment impairment of $45.5 million; and

(v) Property, equipment and improvements impairment of $12.1 million.

(d) Non-cash items are comprised of the following:

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(in thousands)	Year Ended December 31, 2011
Profit interest units compensation expense	$ 3,009
Loss on patient service equipment, disposition of assets and other(i)	19,160
Total non-cash items	$ 22,169

(i) Primarily represents non-cash losses related to the title transfer of equipment to Medicare patients at the end of the 13-month maximum rental period under the DRA and other disposals or write-offs of capital equipment. Equipment classified as 13-month rental equipment would include hospital beds, wheelchairs, nebulizers, patient lifts and CPAP devices.

(e) Costs incurred related to initiatives, executive severance and other are comprised of the following:

(in thousands)	Year Ended December 31, 2011
Costs and expenses related to initiatives(i)	$ 27,302
Acquisition of Praxair assets(ii)	10,778
Executive severance and retention(iii)	1,257
Total costs incurred related to initiatives	$ 39,337

(i) Represents salaries and wages, severance, relocation consulting fees and other expenses for the year ended December 31, 2011, primarily related to five projects: (1) the offshoring and subsequent onshoring of certain of our billing and collections functions; (2) a new billing and collections system for our home infusion therapy business; (3) centralization of our admissions process for our home infusion therapy business; (4) a new supply chain management system; and (5) sales force and operations optimization.

(ii) Represents costs related to the March 4, 2011 acquisition of Praxair assets.

(iii) Represents executive severance and retention expense as a result of the Merger for the year ended December 31, 2011.

(f) Other adjustment items primarily related to the sponsor management fee of $7.0 million for the year ended December 31, 2011.

(g) Represents projected net cost saving and synergies to be realized in connection with acquisitions and cost saving, restructuring and other similar initiatives.

Business Combinations and Asset Purchases. We periodically acquire complementary businesses. These transactions are accounted for as purchases and the results of operations of the acquired companies are included in the accompanying statements of operations from the dates of acquisition. Covenants not to compete are being amortized over the life of the respective agreements. Customer lists, favorable lease arrangements and patient referral sources are being amortized over the period of their expected benefit.

During 2011, we purchased certain assets and businesses for total consideration of $23.4 million.

During 2010, we purchased certain assets and businesses for total consideration of $2.4 million.

During 2009, we purchased the accounts receivable and/or active payment lists from certain discount agreement customers.

Off-Balance Sheet Arrangements

We are not a party to off-balance sheet arrangements as defined by the Securities and Exchange Commission. However, from time to time we enter into certain types of contracts that contingently require us to indemnify parties against third-party claims. The contracts primarily relate to: (i) certain asset purchase agreements, under which we may provide customary indemnification to the seller of the business being acquired; (ii) certain real estate leases, under which we may be required to indemnify property owners for environmental and other liabilities, and other claims arising from our use of the applicable premises; and (iii) certain agreements with our officers, directors and employees, under which we may be required to indemnify such persons for liabilities arising out of their relationship with us. In addition, we issued certain letters of credit under our ABL Facility as described under *Liquidity and Capital Resources Long-Term Debt.*

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The terms of such obligations vary by contract and in most instances a specific or maximum dollar amount is not explicitly stated therein. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, no liabilities have been recorded for these obligations on our balance sheets for any of the periods presented.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

At December 31, 2011, there were $10 million in borrowings under our ABL Facility. The credit agreement governing the ABL Facility provides interest rate options based on the following indices: Federal Funds Rate, the Bank of America prime rate or LIBOR. All such interest rate options are subject to the application of an interest margin as specified in the bank credit agreement. At December 31, 2011, all of our outstanding asset-based debt was tied to the Bank of America prime rate. See *Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources Long-term Debt.*

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INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

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ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA
REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of

Apria Healthcare Group Inc., a wholly-owned subsidiary of Sky Acquisition LLC

Lake Forest, CA

We have audited the accompanying consolidated balance sheets of Apria Healthcare Group Inc. and subsidiaries (the "Company") as of December 31, 2011 and December 31, 2010, and the related consolidated statements of operations, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2011. Our audits also included the financial statement schedule listed in the Index at Schedule II. These consolidated financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on the financial statements and financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Apria Healthcare Group Inc. and subsidiaries as of December 31, 2011 and December 31, 2010, and the results of their operations and cash flows for each of the three years in the period ended December 31, 2011, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Costa Mesa, CA
March 30, 2012

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APRIA HEALTHCARE GROUP INC.

CONSOLIDATED BALANCE SHEETS

(in thousands, except share data)	December 31, 2011	2010
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 29,096	$ 109,137
Accounts receivable, less allowance for doubtful accounts of $53,934 and $56,559 at December 31, 2011 and 2010, respectively	337,212	282,798
Inventories	57,683	73,894
Deferred income taxes	168	47,431
Deferred expenses	3,681	3,061
Prepaid expenses and other current assets	23,927	20,221
TOTAL CURRENT ASSETS	451,767	536,542
PATIENT SERVICE EQUIPMENT, less accumulated depreciation of $176,526 and $144,074 at December 31, 2011 and 2010, respectively	166,769	169,878
PROPERTY, EQUIPMENT AND IMPROVEMENTS, NET	83,768	83,893
GOODWILL	258,725	760,088
INTANGIBLE ASSETS, NET	485,366	578,957
DEFERRED DEBT ISSUANCE COSTS, NET	44,636	53,659
OTHER ASSETS	8,997	7,523
	$ 1,500,028	$ 2,190,540
LIABILITIES AND STOCKHOLDERS EQUITY		
CURRENT LIABILITIES		
Accounts payable	$ 135,572	$ 86,637
Accrued payroll and related taxes and benefits	69,217	59,073
Other accrued liabilities	67,114	63,295
Deferred revenue	28,649	26,504
Current portion of long-term debt	10,301	1,323
TOTAL CURRENT LIABILITIES	310,853	236,832
LONG-TERM DEBT, net of current portion	1,017,755	1,018,098
DEFERRED INCOME TAXES	200,225	212,146
INCOME TAXES PAYABLE AND OTHER NON-CURRENT LIABILITIES	50,795	58,152
TOTAL LIABILITIES	1,579,628	1,525,228
COMMITMENTS AND CONTINGENCIES (Note 12)		
STOCKHOLDERS EQUITY		
Common stock, $0.01 par value: 1,000 shares authorized; 100 shares issued		
Additional paid-in capital	690,870	688,458
Accumulated deficit	(770,470)	(23,146)
TOTAL STOCKHOLDERS (DEFICIT) EQUITY	(79,600)	665,312
	$ 1,500,028	$ 2,190,540

See notes to consolidated financial statements.

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APRIA HEALTHCARE GROUP INC.

CONSOLIDATED STATEMENTS OF OPERATIONS

(in thousands)	Year Ended December 31, 2011	Year Ended December 31, 2010	Year Ended December 31, 2009
Net revenues:			
Fee for service arrangements	$ 2,133,487	$ 1,921,281	$ 1,930,464
Capitation	167,892	159,437	164,097
TOTAL NET REVENUES	2,301,379	2,080,718	2,094,561
Costs and expenses:			
Cost of net revenues			
Product and supply costs	757,850	661,145	638,452
Patient service equipment depreciation	94,386	94,453	101,681
Non-cash impairment of patient service equipment home respiratory therapy/home medical equipment reporting unit	45,500		
Amortization of intangible assets			44,000
Home respiratory therapy services	25,380	27,286	34,700
Nursing services	42,095	37,407	36,345
Other	15,122	13,212	12,281
TOTAL COST OF NET REVENUES	980,333	833,503	867,459
Provision for doubtful accounts	69,551	70,859	57,919
Selling, distribution and administrative	1,225,400	1,066,953	1,050,134
Amortization of intangible assets	4,478	4,812	3,716
Non-cash impairment of property, equipment and improvements home respiratory therapy/home medical equipment reporting unit	12,100		
Non-cash impairment of goodwill and intangible assets ($596,668 related to the home respiratory therapy/home medical equipment reporting unit)	600,268		
TOTAL COSTS AND EXPENSES	2,892,130	1,976,127	1,979,228
OPERATING (LOSS) INCOME	(590,751)	104,591	115,333
Interest expense	132,579	130,849	129,200
Interest income and other	(690)	(914)	(1,609)
LOSS BEFORE TAXES	(722,640)	(25,344)	(12,258)
Income tax expense (benefit)	24,684	(7,912)	(8,438)
NET LOSS	$ (747,324)	$ (17,432)	$ (3,820)

See notes to consolidated financial statements.

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APRIA HEALTHCARE GROUP INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS EQUITY

(in thousands)	Common Stock Shares	Common Stock Par Value	Additional Paid-In Capital	Treasury Stock Shares	Treasury Stock Cost	Retained Earnings (Accumulated Deficit)	Accumulated Other Comprehensive (Loss) Income	Total Stockholders Equity
Balance at December 31, 2008		$	$ 674,714		$	$ (1,894)	$	$ 672,820
Equity contributions			2,075					2,075
Profit interest			7,656					7,656
Net loss						(3,820)		(3,820)
Balance at December 31, 2009		$	$ 684,445		$	$ (5,714)	$	$ 678,731
Cash paid on profit interest units			(92)					(92)
Profit interest			4,105					4,105
Net loss						(17,432)		(17,432)
Balance at December 31, 2010		$	$ 688,458		$	$ (23,146)	$	$ 665,312
Cash paid on profit interest units			(1,597)					(1,597)
Profit interest			3,009					3,009
Equity contribution			1,000					1,000
Net loss						(747,324)		(747,324)
Balance at December 31, 2011		$	$ 690,870		$	$ (770,470)	$	$ (79,600)

See notes to consolidated financial statements.

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APRIA HEALTHCARE GROUP INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(in thousands)	Year Ended December 31, 2011	Year Ended December 31, 2010	Year Ended December 31, 2009
OPERATING ACTIVITIES			
Net loss	$ (747,324)	$ (17,432)	$ (3,820)
Items included in net loss not requiring cash:			
Provision for doubtful accounts	69,551	70,859	57,919
Depreciation	129,130	123,850	125,327
Amortization of intangible assets	4,478	4,812	47,716
Non-cash impairment of goodwill, intangible and long-lived assets ($654,268 related to the home respiratory therapy/home medical equipment reporting unit)	657,868		
Amortization of deferred debt issuance costs	12,521	10,784	8,023
Deferred income taxes	35,343	(7,299)	(3,224)
Expense on profit interest units	3,009	4,105	7,656
Loss on disposition of assets and other	19,160	17,534	15,899
Other			(4,944)
Changes in operating assets and liabilities, exclusive of effects of acquisitions:			
Accounts receivable	(123,965)	(101,524)	(39,599)
Inventories	4,551	(5,627)	(9,048)
Prepaid expenses and other assets	(4,967)	4,481	(7,198)
Accounts payable, exclusive of book cash overdraft	34,520	(711)	(14,077)
Accrued payroll and related taxes and benefits	9,953	(7,769)	(8,596)
Income taxes payable	(11,993)	(1,794)	(2,263)
Deferred revenue, net of deferred expenses	1,525	(761)	(3,130)
Accrued expenses	8,455	(8,951)	2,785
NET CASH PROVIDED BY OPERATING ACTIVITIES	101,815	84,557	169,426
INVESTING ACTIVITIES			
Purchases of patient service equipment and property, equipment and improvements, exclusive of effects of acquisitions	(163,083)	(117,022)	(150,597)
Purchases of short-term investments		(8,087)	(37,554)
Maturities of short-term investments		31,761	13,881
Proceeds from disposition of assets	166	638	6,893
Cash paid for acquisitions	(23,478)	(2,401)	(1,279)
NET CASH USED IN INVESTING ACTIVITIES	(186,395)	(95,111)	(168,656)
FINANCING ACTIVITIES			
Payments on Senior Secured Bridge Credit Agreement			(1,010,000)
Proceeds from ABL Facility	10,000		630
Payments on ABL Facility			(6,630)
Payments on other long-term debt	(1,365)	(1,725)	(2,856)
Proceeds from issuance of Series A-1 Notes			700,000
Proceeds from issuance of Series A-2 Notes			317,500
Change in book cash overdraft included in accounts payable		(32,533)	7,902
Debt issuance costs	(3,499)	(4,122)	(19,246)
Equity contribution	1,000		2,075
Cash paid on profit interest units	(1,597)	(92)	

NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	4,539	(38,472)	(10,625)
NET DECREASE IN CASH AND CASH EQUIVALENTS	(80,041)	(49,026)	(9,855)
Cash and cash equivalents at beginning of period	109,137	158,163	168,018
CASH AND CASH EQUIVALENTS AT END OF PERIOD	$ 29,096	$ 109,137	$ 158,163

SUPPLEMENTAL DISCLOSURES See Note 7 Long-term Debt and Note 9 Income Taxes for cash paid for interest and income taxes, respectively.

NON-CASH TRANSACTIONS See Statements of Stockholders Equity, Note 5 Business Combinations and Note 10 Leases for tax benefit from liabilities assumed in acquisitions and purchase of property and equipment under capital leases, respectively.

Purchases of patient service equipment and property, equipment and improvements exclude purchases that remain unpaid at the end of the respective year. Such amounts are then included in the following year s purchases. Unpaid purchases were $19.3 million, $7.6 million and $11.0 million at December 31, 2011, 2010 and 2009, respectively.

See notes to consolidated financial statements.

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APRIA HEALTHCARE GROUP INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation: The accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America. These statements include the accounts of Apria Healthcare Group Inc. (Apria or the Company) and its subsidiaries. Intercompany transactions and accounts have been eliminated in consolidation.

On October 28, 2008, the Company completed a merger (the Merger) with Sky Merger Sub Corporation (Merger Sub), a Delaware corporation and wholly-owned subsidiary of Sky Acquisition LLC, a Delaware limited liability company (Buyer or Sky LLC). Buyer is controlled by private investment funds affiliated with The Blackstone Group (Sponsor).

Company Background: The Company operates in the home healthcare segment of the healthcare industry, providing a variety of high-quality clinical patient care management programs, related products and supplies as prescribed by a physician and/or authorized by a case manager as part of a care plan. Essentially all products and services offered by the Company are provided through the Company s network of approximately 500 locations, which are located throughout the United States. The Company provides services and products in two operating segments and within these two operating segments there are four core service lines: home respiratory therapy, home medical equipment, home infusion therapy, including transparental nutrition services and enteral nutrition services. Both segments provide products and services in the home setting to patients and are primarily paid for by a third-party payor, such as Medicare, Medicaid, managed care or other third-party insurer. Sales for both segments are primarily derived from referral sources such as hospital discharge planners, medical groups or independent physicians.

Use of Accounting Estimates: The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates. Among the significant estimates affecting the consolidated financial statements are those related to revenue recognition and the resulting accounts receivable, share-based compensation, income taxes, goodwill and long-lived assets.

Revenue Recognition and Concentration of Credit Risk: Revenues are recognized under fee for service/product arrangements for equipment the Company rents to patients, sales of equipment, supplies, pharmaceuticals and other items the Company sells to patients and under capitation arrangements with third party payors for services and equipment the Company provides to the patients of these payors. Revenue generated from equipment that the Company rents 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 7%, 8% and 8% of total net revenues for the years ended December 31, 2011, 2010 and 2009, respectively. 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. Revenues reimbursed under arrangements with Medicare and Medicaid were approximately 30%, 30% and 28% of total net revenues for the years ended December 31, 2011, 2010 and 2009, respectively. In the years ended December 31, 2011, 2010 and 2009, no other third-party payor group represented more than 8% of the Company s revenues.

Rental and sale revenues in the fee for service/product arrangement revenue line item were:

	Years Ended December 31,					
(dollars in millions)	**2011**		**2010**		**2009**	
Rental	$ 660.2	30.9%	$ 610.3	31.8%	$ 654.6	33.9%
Sale	1,473.3	69.1	1,311.0	68.2	1,275.9	66.1
Total fee for service	$ 2,133.5	100.0%	$ 1,921.3	100.0%	$ 1,930.5	100.0%

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In the Company s 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 of delivery of the products, as the supplies sold are considered a separate unit of accounting.

Cash and Cash Equivalents: Cash is maintained with various financial institutions. These financial institutions are located throughout the United States and the Company s cash management practices limit exposure to any one institution. Management considers all highly liquid instruments purchased with a maturity of less than three months to be cash equivalents.

Accounts Receivable: Included in accounts receivable are earned but unbilled receivables of $63.4 million and $55.2 million at December 31, 2011 and December 31, 2010, 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. Unbilled receivables can also be impacted by the transition of patients during the integration of acquisitions and overall revenue growth. Earned but unbilled receivables are aged from date of service and are considered in the analysis of historical performance and collectability.

Due to the nature of the industry and the reimbursement environment in which the Company operates, 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.

Deferred Revenue and Deferred Expense: A lessor is required to recognize rental income over the lease term. Rental of patient equipment is billed on a monthly basis beginning on the date the equipment is delivered. Since deliveries can occur on any day during a month, the amount of billings that apply to the next month are deferred. Only the direct costs associated with the initial rental period are deferred.

Inventories: Inventories are stated at the lower of cost (first-in, first-out method) or market and consist primarily of pharmaceuticals and items used in conjunction with patient service equipment. Inventories are reduced by a reserve for slow moving or obsolete inventory.

Patient Service Equipment: Patient service equipment is stated at cost less depreciation and consists of medical equipment rented to patients on a month-to-month basis. Depreciation is provided using the straight-line method over the estimated useful lives of the equipment, which range from one to ten years.

Property, Equipment and Improvements: Property, equipment and improvements are stated at cost less depreciation. Depreciation is provided using the straight-line method over the estimated useful lives of the assets.

Capitalized Software: Included in property, equipment and improvements are costs related to internally developed and purchased software that are capitalized and amortized over periods that the assets are expected to provide benefit. Capitalized costs include direct costs of materials and services incurred in developing or obtaining internal-use software and payroll and benefit costs for employees directly involved in the development of internal-use software. Additions to capitalized internally developed software totaled $9.8 million and $10.8 million for the years ended December 31, 2011 and 2010, respectively.

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Goodwill and Long-Lived Assets: Goodwill and indefinite-lived intangible assets are not amortized but instead tested 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 amount of the reporting unit 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 s goodwill with the carrying amount of goodwill. Management has determined that the Company s two operating segments are reporting units. As such, the Company has two reporting units: home respiratory therapy/home medical equipment and home infusion therapy. 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 to determine fair value. The market approach uses a selection of comparable companies and transactions in determining fair 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 used in the impairment tests.

The annual indefinite-lived intangible assets impairment test in 2011 resulted in an impairment of the trade name in the home respiratory/home medical equipment reporting unit as the fair value of the trade name asset was less than the carrying amount of the trade name. The fair value of the home respiratory/home medical equipment trade name was determined using a relief from royalty method under the income approach, which uses projected revenue allocable to the trade name and an assumed royalty rate. This impairment resulted in a charge of $56.4 million to reduce the value of the trade name included in the home respiratory therapy/home medical equipment reporting unit due to the lowered expectations for this reporting unit. Any further reduction in the Company s projected home respiratory therapy/home medical equipment reporting unit net revenues could lead to additional impairment of the value of the reporting unit s intangible assets. The 2011 annual impairment test related to indefinite-lived intangible assets in the home infusion therapy reporting unit, using the same method as described for the home respiratory/home medical equipment reporting unit, resulted in an impairment charge of $3.6 million as the fair value of the asset was less than the carrying amount related to the enteral business, which is part of the infusion therapy reporting unit.

Step one of the goodwill impairment test was completed for the home infusion therapy reporting unit and it was determined that there was no impairment of goodwill since the fair value of the reporting unit substantially exceeded the carrying amount.

Step one of the goodwill impairment test was completed for the home respiratory/home medical equipment reporting unit and it was determined that there was impairment of goodwill since the fair value of the reporting unit was less than the carrying amount. Accordingly, the Company first performed a test of its other identifiable assets for recoverability prior to performing a step two analysis. Recoverability of assets to be held and used is measured by the comparison of the carrying amount of an asset or asset group to future undiscounted net cash flows expected to be generated by the asset/asset group. 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. The results of this test indicated that there was impairment of the Company s long lived assets. The Company determined the fair value of its capitated relationships intangible asset using the excess of earnings method under the income approach, which uses projected revenue and estimated earnings margins. The analysis resulted in an impairment of $30.4 million.

After determining the fair value of its intangible assets, the Company determined that the remaining excess of carrying amount over fair value of the assets of the reporting unit indicated that there was economic obsolescence related to the Company s recorded tangible assets. The result of the economic obsolescence indicated an impairment of the Company s patient service equipment and property, equipment and improvements of $45.5 million and $12.1 million, respectively.

The Company then proceeded to step two of the goodwill impairment test and determined that the implied fair value of the home respiratory therapy/home medical equipment reporting unit was less than the carrying amount of the reporting unit by $509.9 million and, therefore, recorded a goodwill impairment charge of $509.9 million. The circumstances leading to the impairment include a change in expectation related to increased costs of operating the Company s intake, billing, and collections functions since those functions were offshored. The Company no longer expects that the offshored functions will be able to return to productivity and efficiency levels that were realized prior to the offshoring of those functions. A portion of the higher costs the Company expects to incur relate to the changing and increasing documentation requirements of the Company s payors. In addition, the Company expects pricing pressures from payors in the near future to negatively impact the Company s net revenues, gross margins and operating costs.

The fair value measurements recorded as described above would be considered non-recurring Level 3 measurements under fair value hierarchy. This is due to the significant unobservable inputs that were utilized to measure fair value.

Additionally, the Company recorded a tax benefit relating the goodwill, intangible and long-lived assets impairment of $166.9 million offset by a tax expense arising from recording a valuation allowance against net deferred tax assets of $220.5 million.

Remaining intangible assets on the Company s consolidated balance sheets 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.

Deferred Debt Issuance Costs: Capitalized debt issuance costs include those associated with the Company s Series A-1 Notes, Series A-2 Notes and Asset Based Revolving Credit Facility (ABL Facility). Such costs are classified as non-current assets. Costs relating to the ABL Facility are being amortized through the maturity date of August 2014. Costs relating to the Series A-1 Notes and Series A-2 Notes are amortized from the issuance date through October 2014. See Note 7 Long-term Debt.

Fair Value of Financial Instruments: The carrying value of debt approximates fair value because the underlying instruments are variable notes that reprice frequently. The fair values of cash and cash equivalents, short-term investments and the Series A-1 Notes and Series A-2 Notes are determined based upon Level 1 inputs, consisting of quoted prices in active markets for identical items. The fair value of the Series A-1 Notes and Series A-2 Notes was $721.0 million and $291.3 million at December 31, 2011, respectively. The carrying amounts of cash and cash equivalents, accounts receivable, trade payables and accrued expenses approximate fair value due to their short maturity.

Product and Supply Costs: Product and supply costs presented within cost of total net revenues are comprised primarily of the cost of supplies and equipment provided to patients, infusion drug costs and enteral product costs.

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Home Respiratory Therapy Expenses: Home respiratory therapy expenses presented within cost of total net revenues are comprised primarily of employee salary and benefit costs or contract fees paid to respiratory therapists and other related professionals who are deployed to service a patient. Home respiratory therapy personnel are also engaged in a number of administrative and marketing tasks, and accordingly, these costs are classified within selling, distribution and administrative expenses and amounted to $42.9 million, $32.5 million, and $23.5 million in the years ended December 31, 2011, 2010 and 2009 respectively.

Distribution Expenses: Distribution expenses are included in selling, distribution and administrative expenses and totaled $193.5 million, $161.3 million and $159.4 million in the years ended December 31, 2011, 2010 and 2009, respectively. Such expense represents the cost incurred to coordinate and deliver products and services to the patients. Included in distribution expenses are leasing, maintenance, licensing and fuel costs for the vehicle fleet; salaries and other costs related to drivers and dispatch personnel; and amounts paid to courier and other outside shipping vendors. Such expenses fall within the definition of shipping and handling costs and are classified within selling and administrative expenses and may not be comparable to other companies.

Self-Insurance: Coverage for certain employee medical claims and benefits, as well as workers compensation, professional and general liability, and vehicle liability are self-insured. Amounts accrued for costs of workers compensation, medical, professional and general liability, and vehicle are classified as current or long-term liabilities based upon an estimate of when the liability will ultimately be paid.

Amounts accrued as current liabilities within other accrued liabilities are as follows:

(in thousands)	December 31, 2011	December 31, 2010
Workers compensation	$ 6,464	$ 5,343
Professional and general liability/vehicle	3,134	943
Medical insurance	7,152	6,477

Amounts accrued as long-term liabilities within income taxes and other accrued liabilities are as follows:

(in thousands)	December 31, 2011	December 31, 2010
Workers compensation	$ 18,466	$ 16,351
Professional and general liability/vehicle	7,822	9,609

Income Taxes: The Company provides for income taxes under the asset and liability method. Under this approach, deferred income taxes arise from temporary differences between the carrying amounts of assets and liabilities for tax and financial reporting 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, management considers all available evidence, such as the Company s current and past performance, the market environment in which the Company operates, tax planning strategies and the length of tax benefit carryforward periods.

Profit Interest Units: The Company measures and recognizes compensation expense for all profit interest unit awards made to employees 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 the Company s 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. Profit interest unit expense is recognized on a straight-line basis over the requisite service period. The estimate of fair value of profit interest unit 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.

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Correction of Balance Sheet Classification: Subsequent to the issuance of the December 31, 2010 consolidated financial statements, management determined that certain amounts historically presented as current liabilities should be reflected as long-term liabilities in the consolidated balance sheets. This correction had no impact on the consolidated statements of operations. Previously reported amounts have been corrected on the consolidated balance sheet. As of December 31, 2010 $27.2 million was reclassified from other accrued liabilities to other non-current liabilities. In addition, as a result of this correction, $10.6 million was reclassified from current deferred income tax assets to long-term deferred income tax liabilities as of December 31, 2010.

NOTE 2 RECENT DEVELOPMENTS

Realignment of Management: On March 14, 2012, the Company announced the realignment of management responsibilities for its operating segments. In connection with these changes, Daniel E. Greenleaf was promoted to Chief Executive Officer of Coram, Inc., the principal operating subsidiary of our Home Infusion Therapy Segment. In connection with this appointment, Mr. Greenleaf no longer serves as the Chief Operating Officer of the Home Respiratory/Home Medical Equipment Segment.

In addition, Daniel J. Starck was named Chief Executive Officer of Apria Healthcare, Inc., the principal operating subsidiary for the Home Respiratory Therapy/Home Medical Equipment Segment. Mr. Starck joins Apria from CorVel Corporation, where he served as Chief Executive Officer since 2007. Norman C. Payson, M.D. will continue to serve as the Company s Executive Chairman and Chief Executive Officer of the parent company, overseeing both operating segments.

On July 11, 2011, the Company announced the realignment of management responsibility for certain functions, including those related to revenue management and information technology. In connection with these changes, James G. Gallas, who served as the Company s Executive Vice President and Chief Administrative Officer, ceased to oversee revenue management, information technology and certain related functions. Management of those functions was assumed by other members of the Company s senior management team, and Mr. Gallas assumed a special projects role during a transitional period, which concluded on January 20, 2012 in accordance with the terms of his Amended and Restated Executive Severance Agreement dated as of March 10, 2009.

NOTE 3 RECENT ACCOUNTING PRONOUNCEMENTS

Recent Accounting Pronouncements: In June 2011, the Emerging Issues Task Force (EITF) issued EITF 09-H, *Health Care Entities: Presentation of the Provision for Bad Debts and Disclosures of Net Revenues and the Allowance for Doubtful Accounts* (EITF 09-H). EITF 09-H requires certain entities to present bad debt as an offset to revenue in the statement of operations. This issue will be effective for fiscal years beginning after December 15, 2011 and interim periods within those fiscal years. The impact of EITF 09-H on the Company s financial position, results of operations, cash flows and disclosures is currently being evaluated.

In September 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2011-08, *Testing Goodwill for Impairment*, (ASU 2011-08), which amends the guidance in ASC 350-20, Intangibles Goodwill and Other Goodwill. Under ASU 2011-08, entities have the option of performing a qualitative assessment before calculating the fair value of the reporting unit when testing goodwill for impairment. If the fair value of the reporting unit is determined, based on qualitative factors, to be more likely than not less than the carrying amount of the reporting unit, then entities are required to perform the two-step goodwill impairment test. ASU 2011-08 will be effective for fiscal years beginning December 1, 2012, with early adoption permitted. The adoption of ASU 2011-08 is not expected to have a material effect on the Company s financial position, results of operations, cash flows and disclosures.

NOTE 4 PROPERTY, EQUIPMENT AND IMPROVEMENTS

Property, equipment and improvements consist of the following:

	December 31,	
(in thousands)	**2011**	**2010**
Leasehold improvements	$ 51,086	$ 39,621
Equipment and furnishings	25,964	22,487
Information systems hardware	37,737	36,948
Information systems software	57,857	40,110
	172,644	139,166

Less accumulated depreciation	(88,876)	(55,273)
	$ 83,768	$ 83,893

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Depreciation expense for property, equipment and improvements was $34.7 million, $29.4 million, and $23.7 million for the years ended December 31, 2011, 2010 and 2009, respectively.

NOTE 5 BUSINESS COMBINATIONS AND ASSET PURCHASES

The Company periodically acquires complementary businesses in specific geographic markets. The results of operations of the acquired companies are included in the accompanying condensed consolidated statements of operations from the dates of acquisition. On March 4, 2011, the Company completed its previously announced asset acquisition of Praxair, Inc. s (NYSE: PX) and Praxair Healthcare Services, Inc. s (collectively, Praxair) United States homecare business.

During the years ended December 31, 2011 and 2010, the Company purchased certain assets and businesses for total consideration of $23.4 million and $2.4 million, respectively. The 2011 total is comprised primarily of the asset acquisition of Praxair, Inc. s U.S. homecare business.

NOTE 6 GOODWILL AND INTANGIBLE ASSETS

Changes in goodwill by segment are as follows:

(in thousands)	Home Infusion Therapy	Home Respiratory Therapy and Home Medical Equipment	Total
Balance, December 31, 2009	$ 257,823	$ 501,374	$ 759,197
Acquisitions		891	891
Balance, December 31, 2010	257,823	502,265	760,088
Acquisitions	902	7,603	8,505
Impairment charge		(509,868)	(509,868)
Balance, December 31, 2011	$ 258,725	$	$ 258,725

Intangible assets consist of the following:

		December 31, 2011				December 31, 2010		
(dollars in thousands)	Average Life in Years	Gross Carrying Amount	Accumulated Amortization	Impairment Charge	Net Book Value	Gross Carrying Amount	Accumulated Amortization	Net Book Value
Intangible assets subject to amortization:								
Capitated relationships	20.0	$ 40,000	$ (6,333)	$ (30,400)	$ 3,267	$ 40,000	$ (4,333)	$ 35,667
Payor relationships	20.0	11,000	(1,742)		9,258	11,000	(1,192)	9,808
Net favorable leasehold interest	3.5	3,210	(2,904)		306	3,553	(2,325)	1,228
Customer list	1.2	1,123	(588)		535	710	(456)	254
Subtotal		55,333	(11,567)	(30,400)	13,366	55,263	(8,306)	46,957
Intangible assets not subject to amortization:								
Trade names		525,000		(60,000)	465,000	525,000		525,000
Accreditations with commissions		7,000			7,000	7,000		7,000

Subtotal	532,000		(60,000)	472,000	532,000		532,000
Total	$ 587,333	$ (11,567)	$ (90,400)	$ 485,366	$ 587,263	$ (8,306)	$ 578,957

The Company recorded impairment charges related to goodwill and intangible assets in 2011 of the $600.3 million, of which $596.7 million relates to the home respiratory therapy/home medical equipment reporting unit. See Note 1 Summary of Significant Accounting Policies for additional details. Amortization expense was $4.5 million, $4.8 million and $47.7 million for the years ended December 31, 2011, 2010 and 2009, respectively. Estimated amortization expense for each of the fiscal years ending December 31, is presented below:

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Year Ending December 31,	(in thousands)
2012	$ 1,585
2013	744
2014	744
2015	744
2016	744
Thereafter	8,805

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NOTE 7 LONG-TERM DEBT

Long-term debt consists of the following:

	December 31,	
(in thousands)	**2011**	**2010**
Series A-1 Notes	$ 700,000	$ 700,000
Series A-2 Notes	317,500	317,500
Amended ABL Facility	10,000	
Capital lease obligations (see Note 10)	556	1,921
	1,028,056	1,019,421
Less: current maturities	(10,301)	(1,323)
	$ 1,017,755	$ 1,018,098

Series A-1 Notes and Series A-2 Notes. Series A-1 Notes and Series A-2 Notes were issued by the Company in May 2009 and August 2009, respectively. The Series A-1 Notes and the Series A-2 Notes bear interest at a rate equal to 11.25% per annum and 12.375% per annum, respectively. The indenture governing the Series A-1 Notes and the Series A-2 Notes, among other restrictions, limits the Company s ability and the ability of its restricted subsidiaries to:

- incur additional debt;
- pay dividends and make other distributions;
- make certain investments;
- repurchase the Company s stock;
- incur certain liens;
- enter into transactions with affiliates;
- merge or consolidate;
- enter into agreements that restrict the ability of the Company s subsidiaries to make dividends or other payments to us; and
- transfer or sell assets.

Subject to certain exceptions, the indenture governing the Series A-1 Notes and the Series A-2 Notes permits the Company and its restricted subsidiaries to incur additional indebtedness, including senior indebtedness and secured indebtedness. The Series A-1 Notes are entitled to a priority of payment over the Series A-2 Notes in certain circumstances, including upon any acceleration of the obligations under the Series A-1

Notes, the Series A-2 Notes or any bankruptcy or insolvency event or default with respect to the Company or any guarantor of the Series A-1 Notes and the Series A-2 Notes.

The Series A-1 Notes and Series A-2 Notes will mature on November 1, 2014. On and after November 1, 2011, the Series A-1 Notes and Series A-2 Notes may be redeemed, in whole or in part, at the redemption prices described below:

Series A-1 Notes

	Percentage
November 1, 2011	105.625%
November 1, 2012	102.813%
November 1, 2013 and thereafter	100.000%

Series A-2 Notes

	Percentage
November 1, 2011	106.188%
November 1, 2012	103.094%
November 1, 2013 and thereafter	100.000%

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Amended and Restated ABL Facility: On August 8, 2011, the Company entered into a senior secured asset-based revolving credit facility, or ABL Facility, with Bank of America, N.A., as administrative agent and collateral agent and a syndicate of financial institutions and institutional lenders. Merrill Lynch, Pierce, Fenner & Smith Incorporated and Barclays Capital, the investment banking division of Barclays Bank PLC joint bookrunners. The ABL Facility amended and restated the Company s prior senior secured asset-based revolving credit facility dated October 28, 2008, which provided for a revolving credit financing of up to $150.0 million.

The ABL Facility provides for revolving credit financing of up to $250.0 million, subject to borrowing base availability, with a maturity of the earlier of (a) five years and (b) 90 days prior to the earliest maturity of the Company s outstanding Series A-1 Notes and Series A-2 Notes, and includes both a letter of credit and swingline loan sub-facility. The borrowing base at any time is equal to the sum (subject to certain reserves and other adjustments) of (i) 85% of eligible receivables, (ii) the least of (a) 85% of eligible self-pay accounts, (b) 10% of the borrowing base, (c) $25,000,000 and (d) the aggregate amount of self-pay accounts collected within the previous 90 days, (iii) the lesser of (a) 85% of eligible accounts invoiced but unpaid for more than 180 days but less than 360 days and (b) 10% of eligible accounts invoiced but unpaid for 180 days or less and (iv) the lesser of (a) 85% of the net orderly liquidation value of eligible inventory and (b) $35.0 million.

Borrowings under the Company s ABL Facility bear interest at a rate per annum equal to, at the Company s option, either (a) a base rate determined by reference to the higher of (1) the prime rate of Bank of America, N.A. and (2) the federal funds effective rate plus 1/2 of 1% (Base Rate), plus an applicable margin (currently 1.00%) or (b) a LIBOR rate determined by reference to LIBOR, adjusted for statutory reserve requirements, plus an applicable margin (currently 2.00%). The applicable margin for borrowings under the ABL Facility is subject to (a) 25 basis points step ups and step downs based on average excess availability under the ABL Facility and (b) a step down of 25 basis points based on achieving a consolidated fixed charge coverage ratio greater than 1.75 to 1.00. In addition to paying interest on outstanding amounts under the ABL Facility, a commitment fee is required to be paid, in respect of the unutilized commitments thereunder, ranging from 0.375% to 0.50% per annum, which fee will be determined based on utilization of the ABL Facility (increasing when utilization is low and decreasing when utilization is high). Customary letter of credit fees are also payable equal to the applicable margin on LIBOR loans and other customary letter of credit and agency fees.

From time to time, the Company issues letters of credit in connection with its business, including commercial contracts, leases, insurance and workers compensation arrangements. If the holders of the Company s letters of credit draw funds under such letters of credit, it would increase the Company s outstanding senior secured indebtedness.

As of December 31, 2011, there were $10 million in outstanding borrowings under the ABL Facility, outstanding letters of credit totaled $21.1 million and additional availability under the ABL Facility, subject to the borrowing base, was $218.9 million. As of December 31, 2011, the available borrowing base did not constrain our ability to borrow the entire $218.9 million available borrowing capacity under the ABL Facility. At December 31, 2011, the Company was in compliance with all of the financial covenants required by the credit agreement governing the ABL Facility.

As market conditions warrant, the Company and its major equity holders, including the Sponsor and its affiliates, may from time to time, depending upon market conditions, seek to repurchase the Company s debt securities or loans in privately negotiated or open market transactions, by tender offer or otherwise.

Maturities of long-term debt and the ABL Facility are as follows:

Year Ending December 31,	(in thousands)
2012	$ 10,301
2013	240
2014	1,017,515
2015	
2016	
Thereafter	
	$ 1,028,056

Total cash paid for interest in the years ended December 31, 2011, 2010 and 2009 amounted to $119.7, $119.6 million and $122.7 million, respectively. Amounts accrued for interest totaled $20.1 million and $19.8 million at December 31, 2011 and 2010, respectively. All such amounts are classified in other accrued liabilities.

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NOTE 8 PROFIT INTEREST UNITS AND EQUITY COMPENSATION

Profit Interest Units: In November and December of 2008, BP Healthcare Holdings LLC (BP Holdings) and Sky LLC, parent entities of the Company affiliated with the Sponsor, granted equity units to the Company s Chief Executive Officer and the Company s Chief Financial Officer for purposes of retaining them and enabling such individuals to participate in the long-term growth and financial success of the Company. In addition, in 2009, 2010 and 2011, Sky LLC (and following the Company s reorganization in March 2010, Apria Holdings LLC) granted equity units to certain management employees for purposes of retaining them and enabling such individuals to participate in the long-term growth and financial success of the Company. Profit interest units are measured at the grant date, based on the calculated fair value of the award, and are recognized as an expense over the employee s requisite service period. These equity awards were issued in exchange for services to be performed.

BP Holdings granted the Company s Chief Executive Officer 38,697,318 Class B units, all of which are subject to vesting terms based on either (i) continued service to BP Holdings or its subsidiaries and/or (ii) performance/market conditions.

Time-Vesting Units. The portion of the Class B units that vest based on continued service represent 80% of the total Class B units. These units vest over four years starting on October 28, 2008 based on continued service, but will become fully vested on an accelerated basis either (x) upon a change in control while the Company s Chief Executive Officer continues to provide services to BP Holdings or its subsidiaries or (y) if affiliates of the Sponsor receive cash proceeds in respect to 50% of their units in BP Holdings equal to at least 200% of their aggregate capital contributions in respect of such units while the Company s Chief Executive Officer continues to provide services to BP Holdings or its subsidiaries. In addition, if the Company s Chief Executive Officer s services are terminated (a) by the Company without cause or (b) by the Chief Executive Officer as a result of constructive termination, an additional number of these time-vesting Class B units will vest equal to the number that would have vested over the 24-month period following the applicable termination date. Any of these time-vesting Class B units that are unvested on termination of the executive s services will be forfeited.

Performance-Vesting Units. The remaining portion of the Class B units that vest based on performance/market conditions represent 20% of the total Class B units. One-half of these units will vest if affiliates of the Sponsor receive cash proceeds equal to at least 200% of their aggregate capital contributions in respect of all of their units in BP Holdings, with the other half eligible to vest if they receive cash proceeds equal to at least 300% of their aggregate capital contributions in respect of all of their units in BP Holdings. Any of these performance-vesting units that are unvested upon a termination of the Company s Chief Executive Officer s services (x) by the Company without cause, (y) by the executive as a result of constructive termination or (z) by the executive for any reason on or following October 28, 2012, will remain outstanding until the second anniversary of the applicable termination date (unless they vest prior to that date). If the units do not vest by such anniversary, then any unvested performance-vesting units shall be immediately forfeited.

Assumptions used were as follows:

Expected Asset Volatility(1)	23.0%
Risk Free Interest Rate(2)	2.24%
Expected Life(3)	5.0 years

(1) The expected asset volatility is derived from the asset volatilities of comparable publicly traded companies.
(2) The risk free interest rate is interpolated from the constant maturity treasury rate (CMT Rate) as of the valuation date with the maturity matching the expected life.
(3) The expected life is based on management s estimate.

The following table summarizes activity for profit interest units for the period December 31, 2009 to December 31, 2011:

	Class B Units

Balance at December 31, 2009	38,697,318
Granted	
Exercised	
Forfeited	
Balance at December 31, 2010	38,697,318

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	Class B Units
Granted	
Exercised	
Forfeited	
Balance at December 31, 2011	38,697,318
Vested units at December 31, 2011	23,218,391

There is no stated contractual life for the B units.

Sky LLC granted the Company s Chief Financial Officer 500,000 Class A-2 units, 6,675,287 Class B units and 2,225,096 Class C units, all of which are subject to vesting terms based on either (i) continued service to Sky LLC or its subsidiaries or (ii) performance/market conditions.

Class A-2 Units. The Class A-2 units vest if an initial public offering (IPO) or change of control occurs and the valuation of Class A-1 units of Sky LLC implied by the transaction exceeds 110% of the aggregate capital contributions of affiliates of the Sponsor for the Class A-1 units. The Company s Chief Financial Officer does not need to be employed at the time of the IPO or change in control to vest. The Class A-2 Units will be forfeited if an IPO or change of control occurs at a valuation that does not result in vesting.

Time-Vesting Units. The portion of the Class B units that vest based on continued service represent 66 2/3% of the total Class B units. These units vest over 57 months starting on October 28, 2008 based on continued service, but will become fully vested on an accelerated basis upon a change in control while the Company s Chief Financial Officer continues to provide services to Sky LLC or its subsidiaries. Any of these time-vesting Class B units that are unvested on termination of the executive s services will be forfeited.

Performance-Vesting Units. The remaining portion of the Class B units and all of the Class C units vest based on performance/market conditions. These units will vest if affiliates of the Sponsor receive cash proceeds equal to at least 200% of their aggregate capital contributions in respect of 25% of their units in Sky LLC while the Company s Chief Financial Officer continues to provide services to Sky LLC or its subsidiaries.

Assumptions used were as follows:

Expected Asset Volatility(1)	23.0%
Risk Free Interest Rate(2)	1.35%
Expected Life(3)	5.0 years

(1) The expected asset volatility is derived from the asset volatilities of comparable publicly traded companies.
(2) The risk free interest rate is interpolated from the CMT Rate as of the valuation date with the maturity matching the expected life.
(3) The expected life is based on management s estimates.

The following table summarizes activity for profit interest units for the period December 31, 2009 to December 31, 2011:

	Class A-2 Units	Class B Units	Class C Units
Balance at December 31, 2009	500,000	6,675,287	2,225,096
Exercised			
Forfeited			

Balance at December 31, 2010	500,000	6,675,287	2,225,096
Exercised			
Forfeited			
Balance at December 31, 2011	500,000	6,675,287	2,225,096
Vested units at December 31, 2011		2,892,335	

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There are no stated contractual lives for the A-2, B or C units.

Sky LLC (and following the Company s reorganization in March 2010, Apria Holdings LLC) granted certain management employees 42,926,504 Class B units and 14,792,550 Class C units, all of which are subject to vesting terms based on either (i) continued service to Sky LLC or its subsidiaries or (ii) performance/market conditions.

Time-Vesting Units. The portion of the Class B units that vest based on continued service represent 66 2/3% of the total Class B units. These units vest over five years starting on the later of (x) October 28, 2008 and (y) the date the employee commenced employment based on continued service, but will become fully vested on an accelerated basis upon a change in control while the employee continues to provide services to Sky LLC or its subsidiaries. Any of these time-vesting Class B units that are unvested on termination of the employee s services will be forfeited.

Performance-Vesting Units. The remaining portion of the Class B units and all of the Class C units vest based on performance/market conditions. These units will vest if affiliates of the Sponsor receive cash proceeds equal to at least 200% of their aggregate capital contributions in respect of 25% of their units in Sky LLC while the employee continues to provide services to Sky LLC or its subsidiaries.

Notwithstanding the vesting terms described above, if the employee voluntarily resigns (in the absence of constructive termination) on or prior to the second anniversary of the applicable grant date, then Sky LLC may require the forfeiture of any vested Class B or C units.

Assumptions used were as follows for the 2009 grants:

Expected Asset Volatility(1)	25.0%
Risk Free Interest Rate(2)	1.96%
Expected Life(3)	5.0 years

Assumptions used were as follows for the 2010 grants:

Expected Asset Volatility(1)	25.0%
Risk Free Interest Rate(2)	2.39%
Expected Life(3)	5.0 years

Assumptions used were as follows for the 2011 grants:

Expected Asset Volatility(1)	25.0%
Risk Free Interest Rate(2)	2.01%
Expected Life(3)	5.0 years

(1) The expected asset volatility is derived from the asset volatilities of comparable publicly traded companies.
(2) The risk free interest rate is interpolated from the CMT Rate as of the valuation date with the maturity matching the expected life.
(3) The expected life is based on management s estimate.

The following table summarizes activity for profit interest units for the period December 31, 2009 to December 31, 2011:

	Class A-2 Units	Class B Units	Class C Units

Balance at December 31, 2009	2,075,000	37,280,029	12,426,676
Granted		4,383,975	1,945,041
Forfeited		(6,322,173)	(1,736,542)
Balance at December 31, 2010	2,075,000	35,341,831	12,635,175
Granted		7,676,577	2,558,862
Forfeited	(1,000,000)	(5,282,184)	(1,760,728)
Balance at December 31, 2011	1,075,000	37,736,224	13,433,309
Vested units at December 31, 2011		10,868,223	

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There are no stated contractual lives for the A-2, B or C units.

Pursuant to a reorganization the Company conducted in March 2010, units of Sky LLC were converted or exchanged into units of Apria Holdings LLC, its parent entity.

Apria Holdings LLC granted the new Board member, Mr. Zafirovski, 5,030,651 Class B units, all of which are subject to vesting terms based on either (i) continued service or (ii) performance/market conditions.

Time-Vesting Units. The portion of the Class B units that vest based on continued service represent 33 1/3% of the total Class B units. These units vest over three years starting on the anniversary of the grant date, but will become fully vested on an accelerated basis upon a change in control while the director continues to provide services to Sky LLC or its subsidiaries. Any of these time-vesting Class B units that are unvested on termination of the director s services will be forfeited; provided however, if Mr. Zafirovski s service is terminated by the Company without cause or due to his death or disability, a pro-rata portion of the time-vesting Class B units that would have vested on the next anniversary of the grant date will vest.

Performance-Vesting Units. The remaining portion of the Class B units vest based on performance/market conditions. These units are divided into two categories, with vesting in each category based on the Company s achievement of EBITDA (as defined in the Company s credit agreement) targets and return on the investment of the Sponsor (defined as Blackstone Capital Partners V L.P. and its affiliates). The first category of the target-based Class B Units will vest if either of the following conditions is satisfied while Mr. Zafirovski continues to serve as a director (or within 24 months after termination by the Company of his service on the Board of Directors without cause): (1) the Company achieves a specified EBITDA target for each of fiscal year 2012 and fiscal year 2013; or (2) the Sponsor achieves a specified return on investment on or prior to December 31, 2014.

The second category of the target-based Class B Units will vest if both of the following conditions are satisfied while Mr. Zafirovski continues to serve as a director (or within 24 months after a termination by the Company of his service on the Board of Directors without cause): (1) the Company achieves a more challenging specified EBITDA target for either fiscal year 2012 or fiscal year 2013 (such year of achievement, the Subject Year); and (2) one of the following conditions is satisfied: (a) the Company achieves a more challenging specified EBITDA target for the fiscal year immediately succeeding the Subject Year; or (b) the Sponsor achieves a specified return on investment on or prior to December 31, 2014. The Company believes that the targets set for the target based Class B Units are reasonable, although neither automatically nor easily achieved.

The Class B units acquired by Mr. Zafirovski are similar to the other Class B units, except that the Class B units acquired by Mr. Zafirovski contain the following different economic terms than Holdings normal Class B Units: Mr. Zafirovski s special Class B Units will not entitle him to receive any value per unit unless and until the value attributable to a regular Class B unit in Holdings exceeds $0.63 per unit, at which point Mr. Zafirovski s special Class B Units will become entitled to receive $0.63 per unit and thereafter, will become entitled to receive the same amount as regular Class B Units.

Assumptions used were as follows for the 2011 grants:

Expected Asset Volatility(1)	25.0%
Risk Free Interest Rate(2)	2.01%
Expected Life(3)	5.0 years

(1) The expected asset volatility is derived from the asset volatilities of comparable publicly traded companies.
(2) The risk free interest rate is interpolated from the CMT Rate as of the valuation date with the maturity matching the expected life.
(3) The expected life is based on management s estimate.

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The following table summarizes activity for profit interest units for the period December 31, 2010 to December 31, 2011:

	Class A-2 Units	Class B Units	Class C Units
Balance at December 31, 2010			
Granted	1,000,000	5,030,651	
Balance at December 31, 2011	1,000,000	5,030,651	
Vested units at December 31, 2011			

Expense recorded related to profit interest units was $3.0 million, $4.1 million and $7.7 million in the years ended December 31, 2011, 2010 and 2009, respectively. As of December 31, 2011, total unrecognized profit interest compensation cost related to unvested profit interest units was $5.3 million, which is expected to be expensed over a weighted average period of 3.8 years.

NOTE 9 INCOME TAXES

Income tax (benefit) expense consists of the following:

(in thousands)	Year Ended December 31, 2011	Year Ended December 31, 2010	Year Ended December 31, 2009
Current			
Federal	$ (4,369)	$ 158	$ (5,912)
State	1,355	1,209	168
	(3,014)	1,367	(5,744)
Deferred			
Federal	14,123	(8,133)	(1,575)
State	13,575	(1,146)	(1,119)
	27,698	(9,279)	(2,694)
	$ 24,684	$ (7,912)	$ (8,438)

The current income tax expense/(benefit) for the years ended December 31, 2011, December 31, 2010 and December 31, 2009 includes a net tax benefit of $4.4 million, a net tax expense of $0.5 million and a net tax benefit of $5.7 million, respectively, relating to changes in the Company s tax uncertainty accruals.

A reconciliation of the differences between income tax expense and an amount calculated utilizing the federal statutory rate is as follows:

(in thousands)	Year Ended December 31, 2011	Year Ended December 31, 2010	Year Ended December 31, 2009
Income tax expense at statutory rate	$ (252,924)	$ (8,870)	$ (4,290)
Non-deductible goodwill impairment	78,589		
Non-deductible expenses	816	712	778
	(19,096)	(7)	3,342

State taxes, net of federal benefit and state loss carryforwards			
Share-based compensation	1,053	1,437	2,679
Change in federal and state valuation allowance	220,534	(396)	(4,646)
Change in liability for unrecognized tax benefits	(4,348)	495	(5,660)
Other	60	(1,283)	(641)
	$ 24,684	$ (7,912)	$ (8,438)

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Significant components of deferred tax assets and liabilities are as follows:

(in thousands)	December 31, 2011	2010
Deferred tax assets:		
Allowance for doubtful accounts	$ 24,413	$ 26,039
Overpayment reserve	4,287	3,180
Accruals	22,372	16,712
Accrued vacation	8,743	8,070
Asset valuation reserves	128	997
Net operating loss carryforward and tax credits	68,168	66,423
Book over tax depreciation	28,475	
Tax deductible goodwill	72,017	
Intangible assets	6,401	7,179
Tax benefits related to unrecognized state tax benefits and interest accrued	2,223	2,829
Other, net	8,002	7,161
	245,229	138,590
Less: valuation allowance	(224,511)	(3,977)
Total deferred tax assets	20,718	134,613
Deferred tax liabilities:		
Subsidiary basis difference	(14,522)	(14,484)
Tax over book goodwill amortization	(8,349)	(35,510)
Trade names and other indefinite-lived intangibles	(178,993)	(201,208)
Tax over book depreciation		(15,053)
Deferred expenses	(1,567)	(1,324)
Debt issuance costs and related amounts	(9,838)	(12,250)
Definite-lived intangibles	(4,753)	(18,166)
Other, net	(2,753)	(1,333)
Total deferred tax liabilities	(220,775)	(299,328)
Net deferred tax liabilities	$ (200,057)	$ (164,715)

Deferred income taxes arise from temporary differences between the carrying amounts of assets and liabilities for tax and financial reporting purposes and tax losses and credit carryforwards. 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 objective negative evidence which could result in the accrual of a valuation allowance against deferred tax assets.

For the three-year period ended December 31, 2011, the Company sustained a cumulative book loss after adjusting for non-recurring items. Therefore, the Company determined that it is more likely than not that substantially all of its net deferred tax assets (excluding deferred tax liabilities with an indefinite life) will not be realized. Accordingly, the Company increased its valuation allowance by $220.5 million from $4.0 million at December 31, 2010 to $224.5 million at December 31, 2011.

The valuation allowance will be maintained until sufficient positive evidence exists to support the reversal of all or a portion of the Company s valuation allowance.

As of December 31, 2011, federal net operating losses (NOLs) of approximately $336.3 million are available to offset future federal taxable income. Such NOLs will expire at various times and in varying amounts during calendar 2015 through 2031 tax years. A significant portion of

these NOLs are subject to an annual utilization limitation as required by Section 382 of the Internal Revenue Code of 1986, as amended.

The Company s current deferred tax assets decreased $47.2 million to $0.2 million at December 31, 2011 from $47.4 million at December 31, 2010. The Company s non-current deferred tax liabilities decreased $11.9 million to $200.2 million at December 31, 2011 from $212.1 million at December 31, 2010.

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The $47.2 million decrease in current deferred tax assets was primarily due to the accrual of valuation allowance against substantially all of our net deferred tax assets.

The $11.9 million decrease to non-current deferred tax liabilities was primarily due to recognition of deferred tax assets resulting from the goodwill; intangible asset; patient service equipment; and property, equipment and improvements impairment charges related to the Company s home respiratory therapy/home medical equipment reporting unit. The benefit from recognizing these deferred tax assets was offset by the accrual of a valuation allowance against substantially all of the Company s net deferred tax assets.

A reconciliation of the beginning and ending balances of the gross liability for unrecognized tax benefits at December 31, 2011, 2010 and 2009 is as follows:

(in thousands)	2011	2010	2009
Balance included in Income Taxes Payable and Other Non-Current Liabilities at January 1	$ 18,260	$ 20,255	$ 26,895
Balance included in Deferred Income Taxes at January 1	80,784	80,167	84,644
Total gross unrecognized tax benefits at January 1	99,044	100,422	111,539
Additions for tax positions related to the current year	401	583	1,238
Additions for tax positions related to prior years	794	4,066	3,763
Reductions for tax positions related to prior years	(3,715)	(4,747)	(13,557)
Settlements	(28)	(65)	(424)
Reductions due to lapse in statute of limitations	(9,265)	(1,215)	(2,137)
Total gross unrecognized tax benefits at December 31	$ 87,231	$ 99,044	$ 100,422

Total gross unrecognized tax benefits of $87.2 million is reflected on the Company s December 31, 2011 balance sheet as follows: (a) $7.5 million included in Income Taxes Payable and Other Non-Current Liabilities and (b) $79.7 million included in Deferred Income Taxes.

The amount of unrecognized tax benefits which, if ultimately recognized, could affect the effective tax rate in a future period is $83.0 million as of December 31, 2011 and $87.4 million as of December 31, 2010. These amounts are net of applicable tax benefits and are inclusive of penalties and net interest of $1.6 million and $2.4 million as of December 31, 2011 and December 31, 2010, respectively.

As of December 31, 2011, the Company does not expect any material increases to its unrecognized tax benefits for the rolling 12-month period ending December 31, 2012.

As of December 31, 2011, it is reasonably possible that unrecognized tax benefits could decrease by $3.0 million within the rolling 12-month period ending December 31, 2012 related to various federal and state tax uncertainties. Ultimate realization of this decrease is dependent upon the occurrence of certain events (including the completion of audits by tax agencies and expiration of statutes of limitations).

Interest expense and penalties related to unrecognized tax benefits are recognized as part of the provision for income taxes. Gross interest and penalties of $2.3 million and $3.5 million are provided for within the liability for unrecognized tax benefits as December 31, 2011 and December 31, 2010, respectively.

The Company files federal and state income tax returns in jurisdictions with varying statutes of limitations expiration dates. The Company s calendar 2008 through 2011 tax years generally remain subject to examination by tax authorities. The Internal Revenue Service is auditing the Company s calendar 2009 Federal income tax return. Additionally, certain state tax agencies are currently examining the tax years 2005 and forward.

Net income taxes refund received in 2011 and 2010 was $0.2 million and $0.8 million, respectively. Net income taxes paid in 2009 amounted to $0.6 million.

NOTE 10 LEASES

The Company leases all of its facilities. Lease terms are generally ten years or less with renewal options for additional periods. The occasionally unused facility space is subleased when a lease buyout is not a viable option. Sublease income is recognized monthly and is offset against facility lease expense. Sublease income in the years ended December 31, 2011, 2010 and 2009 was $0.3 million, $0.6 million and $0.9 million, respectively. In addition, delivery vehicles and office equipment are leased under operating leases. Many leases provide that taxes, maintenance, insurance and other expenses are the responsibility of the Company. Rentals are generally increased annually by the Consumer Price Index, subject to certain

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maximum amounts defined within individual agreements. Net rent expense in the years ended December 31, 2011, 2010 and 2009 was $77.9 million, $78.8 million and $82.1 million, respectively.

For the years ended December 31, 2011 and 2010, no infusion pumps were acquired under a capital lease arrangement. For the year ended December 31, 2009, infusion pumps totaling $0.3 million were acquired under a capital lease arrangement, with a lease term of 60 months. Related amortization amounted to $1.5 million, $1.8 million and $2.0 million for the years ended December 31, 2011, 2010 and 2009, respectively.

The following amounts for assets under capital lease obligations are included in property, equipment and improvements:

	December 31,	
(in thousands)	**2011**	**2010**
Infusion pumps	$ 5,851	$ 5,855
Vehicles	245	265
Less accumulated depreciation	(5,585)	(4,134)
	$ 511	$ 1,986

Future minimum payments, by year and in the aggregate, required under capital lease obligations and noncancelable operating leases consist of the following at December 31, 2011:

(in thousands)	**Capital Leases**	**Operating Leases**
2012	$ 322	$ 67,486
2013	247	53,415
2014	15	37,559
2015		29,985
2016		20,716
Thereafter		18,760
	584	$ 227,921
Less interest included in minimum lease payments	(28)	
Present value of minimum lease payments	556	
Less current portion	(301)	
	$ 255	

NOTE 11 EMPLOYEE BENEFIT PLANS

401(k) Savings Plan: The Company has a 401(k) defined contribution plan, whereby eligible employees may contribute up to 35% of their annual base earnings. The Company matches 25% of the first 8% of employee contributions. Total expenses related to the defined contribution plan were $3.4 million, $3.4 million and $3.2 million in the years ended December 31, 2011, 2010 and 2009, respectively.

Deferred Compensation Plan: A non-qualified deferred compensation plan is available for approximately 220 employees. The plan provides participants with the advantages of pre-tax contributions and tax deferred compounding of interest. Plan assets, which represent the fair market value of the investments, were $4.1 million and $3.3 million, and plan liabilities were $3.8 million and $3.3 million at December 31, 2011 and 2010, respectively.

NOTE 12 COMMITMENTS AND CONTINGENCIES

Litigation: The Company is 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 effect on the Company s financial condition or results of operations, cash flows and liquidity.

Medicare and Medicaid Reimbursement: There are a number of provisions contained within recent legislation or proposed legislation that affect or may affect Medicare and Medicaid reimbursement policies for items and services provided.

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The Company cannot be certain of the ultimate impact of all legislated and contemplated changes, and therefore cannot provide assurance that these changes will not have a material adverse effect on the Company s financial condition or results of operations.

Supplier Concentration: Currently, approximately 61.3% of purchases for patient service equipment and supplies are from five vendors. Although there are a limited number of suppliers, management believes that other vendors could provide similar products on comparable terms. However, a change in suppliers could cause delays in service delivery and possible losses in revenue, which could adversely affect the Company s financial condition or operating results.

Guarantees and Indemnities: From time to time, certain types of contracts are entered into that contingently require indemnification of parties against third party claims. These contracts primarily relate to (i) certain asset purchase agreements, under which indemnification may be provided to the seller of the business being acquired; (ii) certain real estate leases, which may require indemnification to property owners for environmental or other liabilities and other claims arising from use of the applicable premises; and (iii) certain agreements with officers, directors and employees, which may require indemnification of such persons for liabilities arising out of their relationship with the Company.

The terms of such obligations vary by contract and in most instances a specific or maximum dollar amount is not explicitly stated therein. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, no liabilities have been recorded for these obligations on the balance sheets for any of the periods presented.

NOTE 13 SEGMENTS

The Company has two operating segments and within these two operating segments there are four core service lines: home respiratory therapy, home medical equipment, home infusion therapy, including transparental nutrition services and enteral nutrition services. The Company has two reportable operating segments (1) home respiratory therapy and home medical equipment and (2) home infusion therapy. The home respiratory therapy and home medical equipment segment provides services and equipment to assist patients with oxygen systems, sleep apnea, ambulation and general care around the home, as well as to provide respiratory medications and related services. The home infusion therapy segment primarily provides patients with pharmaceuticals and services prescribed in conjunction with the administration of nutrients or medication intravenously or through a gastrointestinal tube.

(in thousands)	Net Revenues		
Operating Segment	**Year Ended December 31, 2011**	**Year Ended December 31, 2010**	**Year Ended December 31, 2009**
Home Respiratory Therapy and Home Medical Equipment	$ 1,176,581	$ 1,083,207	$ 1,169,609
Home Infusion Therapy	1,124,798	997,511	924,952
Total	$ 2,301,379	$ 2,080,718	$ 2,094,561

	EBIT		
Operating Segment	**Year Ended December 31, 2011**	**Year Ended December 31, 2010**	**Year Ended December 31, 2009**
Home Respiratory Therapy and Home Medical Equipment (a)	$ (696,569)	$ (9,866)	$ 50,167
Home Infusion Therapy (b)	105,924	114,358	65,667
Total	$ (590,645)	$ 104,492	$ 115,834

(a) The 2011 EBIT for the home respiratory therapy/home medical equipment reporting unit includes the following non-cash impairment charges totalling $654.3 million:

(i) Goodwill impairment of $509.9 million;

(ii) Intangible asset impairment of $86.8 million ($56.4 million related to trade name and $30.4 million related to capitated relationships);

(iii) Patient Service Equipment impairment of $45.5 million; and

(iv) Property, equipment and improvements impairment of $12.1 million.

(b) The 2011 EBIT for the home infusion therapy reporting unit includes $3.6 million of non-cash impairment charges related to our trade name intangible asset.

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Operating Segment	Depreciation and Amortization Year Ended December 31, 2011	Year Ended December 31, 2010	Year Ended December 31, 2009
Home Respiratory Therapy and Home Medical Equipment	$ 116,194	$ 113,679	$ 151,287
Home Infusion Therapy	17,414	14,983	21,756
Total	$ 133,608	$ 128,662	$ 173,043

The Company s Chief Operating Decision Maker (CODM) does not review assets assigned to segments. Therefore, such items are not reported in the table above.

Earnings before interest and taxes (EBIT). EBIT is a measure used by the Company s management to measure operating performance. EBIT is defined as net income (loss) plus interest expense and income taxes. EBIT is not a recognized term under Generally Accepted Accounting Principles (GAAP) and does not purport to be an alternative to net income as a measure of operating performance or to cash flows from operating activities as a measure of liquidity.

The following table provides a reconciliation from net (loss) income to EBIT:

(in thousands)	Year Ended December 31, 2011	Year Ended December 31, 2010	Year Ended December 31, 2009
Net loss (a)	$ (747,324)	$ (17,432)	$ (3,820)
Interest expense, net (b)	131,995	129,836	128,092
Income tax expense (benefit)	24,684	(7,912)	(8,438)
EBIT	$ (590,645)	$ 104,492	$ 115,834

(a) Net loss for 2011 includes the non-cash impairment charges listed below based on the results of the Company s 2011 annual impairment testing, the tax impact associated with the impairment charges and charges related to deferred tax valuation allowances. Except as noted, all of the impairment charges relate to the home respiratory therapy/home medical equipment reporting unit.

(i) Goodwill impairment of $509.9 million;

(ii) Trade name impairment of $60.0 million ($56.4 million of which relates to the home respiratory therapy/home medical equipment reporting unit and $3.6 million of which relates to the home infusion therapy reporting unit);

(iii) Capitated relationships intangible asset impairment of $30.4 million;

(iv) Patient service equipment impairment of $45.5 million;

(v) Property, equipment and improvements impairment of $12.1 million;

(vi) Tax benefit relating to the goodwill, intangible and long-lived assets impairment of $166.9 million; and

(vii) Valuation allowance against net deferred tax assets of $220.5 million.

All of these items resulted in a $711.5 million increase in the net loss in fiscal 2011.

(b)

Reflects $132.6 of interest expense, net of $0.6 interest income for 2011. Reflects $130.8 million of interest expense, net of $1.0 million of interest income for 2010. Reflects $129.2 million of interest expense, net of $1.1 million of interest income for 2009.

Certain expenses that are not directly attributable to a product line are allocated based upon segment headcount.

NOTE 14 CERTAIN RELATIONSHIPS AND RELATED PARTY TRANSACTIONS

Transaction and Management Fee Agreement: In connection with the Merger, Merger Sub entered into a transaction and management fee agreement with Blackstone Management Partners V L.L.C. (BMP). The Company succeeded to and assumed the rights and obligations of Merger Sub pursuant to the transaction and management fee agreement upon the closing of the Merger. Under the transaction and management fee agreement, Merger Sub agreed to pay BMP, at the closing of the Merger, an $18.7 million transaction fee in consideration for BMP undertaking financial and structural analysis, due diligence and other assistance in connection with the Merger. In addition the Company agreed to reimburse BMP for any out-of-pocket expenses incurred by BMP and its affiliates in connection with the Merger and the provision of services under the transaction and management fee agreement.

In addition, under this agreement, BMP (including through its affiliates) agreed to provide services, including without limitation, (a) advice regarding the structure, distribution and timing of debt and equity offerings and advice regarding relationships with the Company s lenders and bankers, (b) advice regarding the business and strategy of the Company, including compensation arrangements, (c) advice regarding dispositions and/or acquisitions and (d) such advice directly related or ancillary to the above financial advisory services as may be reasonably requested by the Company. In consideration for the services, the Company pays BMP at the beginning of each fiscal year a management fee equal to the greater of $7.0 million or 2.0% of the Company s consolidated EBITDA, as defined in the agreement, for the immediately preceding fiscal year. BMP shall have no obligation to provide any other services to the Company absent express agreement. In addition, in the absence of an express agreement to provide investment banking or other financial advisory services to the Company, and

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without regard to whether such services were provided, BMP is entitled to receive a fee equal to 1.0% of the aggregate transaction value upon the consummation of any acquisition, divestiture, disposition, merger, consolidation, restructuring, refinancing, recapitalization, issuance of private or public debt of equity securities (including an initial public offering of equity securities), financing or similar transaction by the Company.

At any time in connection with or in anticipation of a change of control of the Company, a sale of all or substantially all of the Company s assets or an initial public offering of common equity of the Company or its successor, BMP may elect to receive, in consideration of BMP s role in facilitating such transaction and in settlement of the termination of the services, a single lump sum cash payment equal to the then-present value of all then-current and future annual management fees payable under the transaction and management fee agreement, assuming a hypothetical termination date of the agreement to be the twelfth anniversary of such election. The transaction and management fee agreement will continue until the earlier of the twelfth anniversary of the date of the agreement or such date as the Company and BMP may mutually determine. The Company has agreed to indemnify BMP and its affiliates, directors, officers, employees, agents and representatives from and against all liabilities relating to the services contemplated by the transaction and management fee agreement and the engagement of BMP pursuant to, and the performance of BMP and its affiliates of the services contemplated by, the transaction and management fee agreement.

Intelenet Agreement: In May 2009, the Company entered into the Master Service Agreement (Intelenet Agreement) with Intelenet Global Services Private Limited (Intelenet), an Indian company affiliated with the Sponsor, regarding the outsourcing of certain functions relating to billing, collections and other administrative and clerical services. On May 31, 2011, it was announced that an affiliate of the Sponsor, along with other shareholders of Intelenet, agreed to sell Intelenet to Serco Group PLC, an international services company. The transaction closed in July 2011, but the affiliate of the Sponsor may receive additional payments based on Intelenet s performance through 2013. During the year ended December 31, 2011, the Company paid approximately $22.5 million to Intelenet.

Equity Healthcare Agreement: Effective as of January 1, 2010, the Company entered into an employer health program agreement with Equity Healthcare LLC (Equity Healthcare), an affiliate of the Sponsor, pursuant to which Equity Healthcare will provide to the Company certain negotiating, monitoring and other services in connection with the Company s health benefit plans. In consideration for Equity Healthcare s services, the Company will pay Equity Healthcare a fee of $2 per participating employee per month. As of December 31, 2011, the Company had approximately 8,400 employees enrolled in Equity Healthcare health benefit plans.

NOTE 15 SELECTED QUARTERLY FINANCIAL DATA (unaudited)

(in thousands)	First	Second	Third	Fourth (a)
2011				
Net Revenues	$ 536,743	$ 576,348	$ 584,874	$ 603,414
Gross Profit	318,867	340,916	345,320	315,943
Operating Income (Loss)	898	20,147	21,827	(633,623)
Net Loss	$ (21,024)	$ (9,437)	$ (4,687)	$ (712,176)

(in thousands)	First	Second	Third	Fourth
2010				
Net Revenues	$ 508,876	$ 518,178	$ 526,014	$ 527,650
Gross Profit	306,084	310,046	318,030	313,055
Operating Income	30,802	37,185	34,857	1,747
Net (Loss) Income	$ (803)	$ 3,366	$ (105)	$ (19,890)

(a) Net loss for 2011 includes the non-cash impairment charges listed below based on the results of the Company s 2011 annual impairment testing, the tax impact associated with the impairment charges and charges related to deferred tax valuation allowances. Except as noted, all of the impairment charges relate to the home respiratory therapy/home medical equipment reporting unit.

(i) Goodwill impairment of $509.9 million;

(ii) Trade name impairment of $60.0 million ($56.4 million of which relates to the home respiratory therapy/home medical equipment reporting unit and $3.6 million of which relates to the home infusion therapy reporting unit);

(iii) Capitated relationships intangible asset impairment of $30.4 million;

(iv) Patient service equipment impairment of $45.5 million;

(v) Property, equipment and improvements impairment of $12.1 million;

(vi) Tax benefit relating to the goodwill, intangible and long-lived assets impairment of $166.9 million; and

(vii) Valuation allowance against net deferred tax assets of $220.5 million.

All of these items resulted in a $711.5 million increase in the net loss in fiscal 2011.

NOTE 16 FINANCIAL GUARANTEES

The Company conducts substantially all of its business through its subsidiaries. Substantially all of the Company s 100% owned subsidiaries (the Guarantors) fully and unconditionally guarantee the Series A-1 Notes and Series A-2 Notes on a senior secured basis. The Guarantors also guarantee the Company s ABL Facility. See also Note 7 Long-Term Debt.

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The following condensed consolidated financial statements quantify the financial position as of December 31, 2011 and December 31, 2010, the operations for the years ended December 31, 2011, 2010 and 2009, and the cash flows for the years ended December 31, 2011, 2010 and 2009. These condensed consolidated financial statements present financial information for the parent issuer, the guarantor subsidiaries, the non-guarantor subsidiaries and consolidating adjustments, consisting of the entries that eliminate the investment in subsidiaries and intercompany balances and transactions.

The Company accrued a valuation allowance of $224.5 million at December 31, 2011 since it determined that it is more likely than not substantially all of its net deferred tax assets will not be realized. The Company utilized all available information (including cumulative consolidated three-year loss information) to determine the necessity and amount of its valuation allowance at December 31, 2011.

The following condensed financial statements reflect an allocation of consolidated valuation allowance between the parent issuer and guarantor subsidiaries. Such allocation may not be reflective of the amount of valuation allowance which would be accrued if separate financial statements were prepared because certain guarantor subsidiaries have not sustained a cumulative three-year loss.

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CONDENSED CONSOLIDATED BALANCE SHEETS

December 31, 2011

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
ASSETS					
CURRENT ASSETS					
Cash and cash equivalents	$ 43,552	$	$ 475	$ (14,931)	$ 29,096
Accounts receivable less allowance for doubtful accounts		336,396	816		337,212
Inventories		57,384	299		57,683
Deferred income taxes	443	(275)			168
Deferred expenses		3,681			3,681
Intercompany	340,259	515,672		(855,931)	
Prepaid expenses and other current assets	1,262	22,653	12		23,927
Intercompany loan	710,000			(710,000)	
TOTAL CURRENT ASSETS	1,095,516	935,511	1,602	(1,580,862)	451,767
PATIENT SERVICE EQUIPMENT, less accumulated depreciation		166,764	5		166,769
PROPERTY, EQUIPMENT AND IMPROVEMENTS, NET	43,760	39,761	247		83,768
GOODWILL		258,725			258,725
INTANGIBLE ASSETS, NET	400,000	85,366			485,366
DEFERRED DEBT ISSUANCE COSTS, NET	44,636				44,636
INVESTMENT IN SUBSIDIARIES	(203,080)	641		202,439	
OTHER ASSETS	4,116	4,881			8,997
TOTAL ASSETS	$ 1,384,948	$ 1,491,649	$ 1,854	$ (1,378,423)	$ 1,500,028
LIABILITIES AND STOCKHOLDERS EQUITY					
CURRENT LIABILITIES					
Accounts payable	$ 8,768	$ 141,491	$ 244	$ (14,931)	$ 135,572
Accrued payroll and related taxes and benefits	14,614	54,420	183		69,217
Other accrued liabilities	20,103	46,225	786		67,114
Deferred revenue		28,649			28,649
Intercompany	233,398	622,533		(855,931)	
Current portion of long-term debt	10,000	710,301		(710,000)	10,301
TOTAL CURRENT LIABILITIES	286,883	1,603,619	1,213	(1,580,862)	310,853
LONG-TERM DEBT, net of current portion	1,017,500	255			1,017,755
DEFERRED INCOME TAXES	152,043	48,182			200,225
INCOME TAXES PAYABLE & OTHER NON-CURRENT LIABILITIES	8,122	42,673			50,795
TOTAL LIABILITIES	1,464,548	1,694,729	1,213	(1,580,862)	1,579,628
COMMITMENTS AND CONTINGENCIES					
STOCKHOLDERS EQUITY					
Common stock					
Additional paid-in capital	690,870	514,352		(514,352)	690,870
(Accumulated deficit) retained earnings	(770,470)	(717,432)	641	716,791	(770,470)

TOTAL STOCKHOLDERS (DEFICIT) EQUITY					
	(79,600)	(203,080)	641	202,439	(79,600)
	$ 1,384,948	$ 1,491,649	$ 1,854	$ (1,378,423)	$ 1,500,028

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CONDENSED CONSOLIDATED BALANCE SHEETS

December 31, 2010

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
ASSETS					
CURRENT ASSETS					
Cash and cash equivalents	$ 125,137	$	$ 407	$ (16,407)	$ 109,137
Accounts receivable less allowance for doubtful accounts		281,917	881		282,798
Inventories		73,547	347		73,894
Deferred income taxes	3,748	43,683			47,431
Deferred expenses		3,061			3,061
Intercompany	344,992	256,742		(601,734)	
Prepaid expenses and other current assets	2,757	17,313	151		20,221
Intercompany loan	360,000			(360,000)	
TOTAL CURRENT ASSETS	836,634	676,263	1,786	(978,141)	536,542
PATIENT SERVICE EQUIPMENT, less accumulated depreciation		169,858	20		169,878
PROPERTY, EQUIPMENT AND IMPROVEMENTS, NET	38,818	44,887	188		83,893
GOODWILL		760,088			760,088
INTANGIBLE ASSETS, NET	460,000	118,957			578,957
DEFERRED DEBT ISSUANCE COSTS, NET	53,659				53,659
INTERCOMPANY RECEIVABLE					
INVESTMENT IN SUBSIDIARIES	362,248	702		(362,950)	
INTERCOMPANY LOAN	350,000			(350,000)	
OTHER ASSETS	3,340	4,183			7,523
TOTAL ASSETS	$ 2,104,699	$ 1,774,938	$ 1,994	$ (1,691,091)	$ 2,190,540
LIABILITIES AND STOCKHOLDERS EQUITY					
CURRENT LIABILITIES					
Accounts payable	$	$ 102,858	$ 186	$ (16,407)	$ 86,637
Accrued payroll and related taxes and benefits	12,173	46,771	129		59,073
Other accrued liabilities	20,049	42,269	977		63,295
Deferred revenue		26,504			26,504
Intercompany	202,901	398,833		(601,734)	
Current portion of long-term debt		361,323		(360,000)	1,323
TOTAL CURRENT LIABILITIES	235,123	978,558	1,292	(978,141)	236,832
LONG-TERM DEBT, net of current portion	1,017,500	350,598		(350,000)	1,018,098
DEFERRED INCOME TAXES	177,339	34,807			212,146
INCOME TAXES PAYABLE & OTHER NON-CURRENT LIABILITIES	9,425	48,727			58,152
TOTAL LIABILITIES	1,439,387	1,412,690	1,292	(1,328,141)	1,525,228
COMMITMENTS AND CONTINGENCIES					
STOCKHOLDERS EQUITY					
Common stock					
Additional paid-in capital	688,458	447,926		(447,926)	688,458
(Accumulated deficit) retained earnings	(23,146)	(85,678)	702	84,976	(23,146)

TOTAL STOCKHOLDERS	EQUITY	665,312	362,248	702	(362,950)	665,312
		$ 2,104,699	$ 1,774,938	$ 1,994	$ (1,691,091)	$ 2,190,540

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CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

Year Ended December 31, 2011

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
Operating net revenue	$	$ 2,292,094	$ 9,285	$	$ 2,301,379
Income from subsidiaries	191,619			(191,619)	
TOTAL NET REVENUES	191,619	2,292,094	9,285	(191,619)	2,301,379
TOTAL COST OF NET REVENUES		975,391	4,942		980,333
Provision for doubtful accounts		69,228	323		69,551
Selling, distribution and administrative	216,093	1,198,137	2,789	(191,619)	1,225,400
Amortization of intangible assets	917	3,561			4,478
Non-cash impairment of property, equipment and improvements home respiratory therapy/home medical equipment reporting unit		12,100			12,100
Non-cash impairment of goodwill and intangible assets ($596,668 related to the home respiratory therapy/home medical equipment reporting unit)	60,000	540,268			600,268
TOTAL COSTS AND EXPENSES	277,010	2,798,685	8,054	(191,619)	2,892,130
OPERATING INCOME	(85,391)	(506,591)	1,231		(590,751)
Interest expense	132,435	144			132,579
Interest income and other	(63,425)	62,132	603		(690)
INCOME (LOSS) BEFORE TAXES	(154,401)	(568,867)	628		(722,640)
Income tax expense (benefit)	(39,296)	63,980			24,684
NET INCOME (LOSS)	(115,105)	(632,847)	628		(747,324)
Equity in loss of subsidiaries, net of tax	(632,219)	628		631,591	
NET (LOSS) INCOME ATTRIBUTABLE TO PARENT ISSUER	$ (747,324)	$ (632,219)	$ 628	$ 631,591	$ (747,324)

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CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

Year Ended December 31, 2010

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
Operating net revenue	$	$ 2,072,401	$ 8,317	$	$ 2,080,718
Income from subsidiaries	250,208			(250,208)	
TOTAL NET REVENUES	250,208	2,072,401	8,317	(250,208)	2,080,718
TOTAL COST OF NET REVENUES		829,223	4,280		833,503
Provision for doubtful accounts		70,539	320		70,859
Selling, distribution and administrative	216,565	1,098,037	2,559	(250,208)	1,066,953
Amortization of intangible assets	917	3,895			4,812
TOTAL COSTS AND EXPENSES	217,482	2,001,694	7,159	(250,208)	1,976,127
OPERATING INCOME	32,726	70,707	1,158		104,591
Interest expense	130,228	621			130,849
Interest income and other	(66,208)	64,733	561		(914)
(LOSS) INCOME BEFORE TAXES	(31,294)	5,353	597		(25,344)
Income tax (benefit) expense	(10,291)	2,379			(7,912)
NET (LOSS) INCOME	(21,003)	2,974	597		(17,432)
Equity in income of subsidiaries, net of tax	3,571	597		(4,168)	
NET (LOSS) INCOME ATTRIBUTABLE TO PARENT ISSUER	$ (17,432)	$ 3,571	$ 597	$ (4,168)	$ (17,432)

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CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

Year Ended December 31, 2009

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
Operating net revenue	$	$ 2,087,326	$ 7,235	$	$ 2,094,561
Income from subsidiaries	220,449			(220,449)	
TOTAL NET REVENUES	220,449	2,087,326	7,235	(220,449)	2,094,561
TOTAL COST OF NET REVENUES		863,305	4,154		867,459
Provision for doubtful accounts		57,811	108		57,919
Selling, distribution and administrative	197,666	1,070,641	2,276	(220,449)	1,050,134
Amortization of intangible assets	832	2,884			3,716
TOTAL COSTS AND EXPENSES	198,498	1,994,641	6,538	(220,449)	1,979,228
OPERATING INCOME	21,951	92,685	697		115,333
Interest expense	128,363	837			129,200
Interest income and other	(71,820)	69,871	340		(1,609)
(LOSS) INCOME BEFORE TAXES	(34,592)	21,977	357		(12,258)
Income tax (benefit) expense	(15,132)	6,694			(8,438)
NET (LOSS) INCOME	(19,460)	15,283	357		(3,820)
Equity in income of subsidiaries, net of tax	15,640	357		(15,997)	
NET (LOSS) INCOME ATTRIBUTABLE TO PARENT ISSUER	$ (3,820)	$ 15,640	$ 357	$ (15,997)	$ (3,820)

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CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

Year Ended December 31, 2011

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
OPERATING ACTIVITIES					
NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES	$ (70,940)	$ 171,082	$ 197	$ 1,476	$ 101,815
INVESTING ACTIVITIES					
Purchases of patient service equipment and property, equipment and improvements, exclusive of effects of acquisitions	(16,320)	(146,634)	(129)		(163,083)
Proceeds from disposition of assets		166			166
Cash paid for acquisitions	(229)	(23,249)			(23,478)
NET CASH USED IN INVESTING ACTIVITIES	(16,549)	(169,717)	(129)		(186,395)
FINANCING ACTIVITIES					
Proceeds from ABL Facility	10,000				10,000
Payments on other long-term debt		(1,365)			(1,365)
Debt issuance costs	(3,499)				(3,499)
Equity contribution	1,000				1,000
Cash paid on profit interest units	(1,597)				(1,597)
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	5,904	(1,365)			4,539
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	(81,585)		68	1,476	(80,041)
CASH AND CASH EQUIVALENTS AT BEGINNING OF PERIOD	125,137		407	(16,407)	109,137
CASH AND CASH EQUIVALENTS AT END OF PERIOD	$ 43,552	$	$ 475	$ (14,931)	$ 29,096

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CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

Year Ended December 31, 2010

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
OPERATING ACTIVITIES					
NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES	$ (24,895)	$ 125,863	$ (4)	$ (16,407)	$ 84,557
INVESTING ACTIVITIES					
Purchases of patient service equipment and property, equipment and improvements	(19,819)	(97,023)	(180)		(117,022)
Purchases of short term investments	(8,087)				(8,087)
Maturities of short term investments	31,761				31,761
Proceeds from disposition of assets	27	611			638
Cash paid for acquisitions		(2,401)			(2,401)
NET CASH PROVIDED BY (USED IN) INVESTING ACTIVITIES	3,882	(98,813)	(180)		(95,111)
FINANCING ACTIVITIES					
Payments on other long-term debt		(1,725)			(1,725)
Change in book-cash overdraft included in accounts payable		(32,533)			(32,533)
Debt issuance costs	(4,122)				(4,122)
Cash paid on profit interest units	(92)				(92)
NET CASH USED IN FINANCING ACTIVITIES	(4,214)	(34,258)			(38,472)
NET DECREASE IN CASH AND CASH EQUIVALENTS	(25,227)	(7,208)	(184)	(16,407)	(49,026)
CASH AND CASH EQUIVALENTS AT BEGINNING OF PERIOD	150,364	7,208	591		158,163
CASH AND CASH EQUIVALENTS AT END OF PERIOD	$ 125,137	$	$ 407	$ (16,407)	$ 109,137

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CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

Year Ended December 31, 2009

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
OPERATING ACTIVITIES					
NET CASH PROVIDED BY OPERATING ACTIVITIES	$ 49,741	$ 119,426	$ 259	$	$ 169,426
INVESTING ACTIVITIES					
Purchases of patient service equipment and property, equipment and improvements	(19,426)	(131,138)	(33)		(150,597)
Purchase of short-term investments	(37,554)				(37,554)
Maturities of short-term investments	13,881				13,881
Proceeds from disposition of assets		6,893			6,893
Cash paid for acquisitions		(1,279)			(1,279)
NET CASH USED IN INVESTING ACTIVITIES	(43,099)	(125,524)	(33)		(168,656)
FINANCING ACTIVITIES					
Payments on Senior Secured Bridge Credit Agreement	(1,010,000)				(1,010,000)
Proceeds from ABL Facility	630				630
Payments on ABL Facility	(6,630)				(6,630)
Payments on other long-term debt		(2,856)			(2,856)
Proceeds from issuance of Series A-1 Notes	700,000				700,000
Proceeds from issuance of Series A-2 Notes	317,500				317,500
Change in book-cash overdraft included in accounts payable		7,902			7,902
Debt issuance costs related to Series A-1 and Series A-2 Notes	(19,039)				(19,039)
Debt issuance costs related to the ABL Facility	(207)				(207)
Equity contributions	2,075				2,075
NET CASH (USED IN) PROVIDED BY FINANCING ACTIVITIES	(15,671)	5,046			(10,625)
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(9,029)	(1,052)	226		(9,855)
CASH AND CASH EQUIVALENTS AT BEGINNING OF PERIOD	159,393	8,260	365		168,018
CASH AND CASH EQUIVALENTS AT END OF PERIOD	$ 150,364	$ 7,208	$ 591	$	$ 158,163

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NOTE 17 SUBSEQUENT EVENTS

The Company evaluated all subsequent events that occurred after the balance sheet date through the date and time the financial statements were issued.

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APRIA HEALTHCARE GROUP INC.

SCHEDULE II VALUATION AND QUALIFYING ACCOUNTS

	Balance at Beginning of Period	Charged to Costs and Expenses	Deductions	Balance at End of Period
		(in thousands)		
Year ended December 31, 2011				
Deducted from asset accounts:				
Allowance for doubtful accounts	$ 56,559	$ 69,551	$ 72,176	$ 53,934
Reserve for inventory and patient service equipment shortages	$ 1,186	$ 1,966	$ 1,491	$ 1,661
Year ended December 31, 2010				
Deducted from asset accounts:				
Allowance for doubtful accounts	$ 39,927	$ 70,859	$ 54,227	$ 56,559
Reserve for inventory and patient service equipment shortages	$ 2,177	$ 1,545	$ 2,536	$ 1,186
Year ended December 31, 2009				
Deducted from asset accounts:				
Allowance for doubtful accounts	$ 25,271	$ 57,919	$ 43,263	$ 39,927
Reserve for inventory and patient service equipment shortages	$ 6,091	$ 2,327	$ 6,241	$ 2,177

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

Our management, with the participation of our Chief Executive Officer and Chief Financial officer, has evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e)) as of the end of the period covered by this report. There are inherent limitations to the effectiveness of any system of disclosure controls and procedures, including the possibility of human error and the circumvention or overriding of the controls and procedures. Accordingly, even effective disclosure controls and procedures can provide only reasonable assurance of achieving their control objectives. Based on and as of the date of that evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that our disclosure controls and procedures are effective.

During the most recent fiscal quarter, there were no changes in our internal control over financial reporting that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

REPORT OF MANAGEMENT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

Our management is responsible for establishing and maintaining adequate internal control over our financial reporting. Our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) is designed to provide reasonable assurance regarding the reliability of our financial reporting and the preparation of financial statements for external purposes in accordance with accounting principles generally accepted in the United States. Our internal control over financial reporting includes maintaining records that in reasonable detail accurately and fairly reflect our transactions; providing reasonable assurance that transactions are recorded as necessary for preparation of our financial statements in accordance with U.S. GAAP; providing reasonable assurance that receipts and expenditures of our assets are made in accordance with management authorization; and providing reasonable assurance that unauthorized acquisition, use or disposition of our assets that could have a material effect on our financial statements would be prevented or detected on a timely basis. Our internal controls systems include the controls themselves, actions taken to correct deficiencies as identified, an organizational structure providing for division of responsibilities, careful selection and training of qualified financial personnel and a program of internal audits. Because of its inherent limitations, internal control over financial reporting is not intended to provide absolute assurance that a misstatement of our financial statements would be prevented or detected. In addition, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions or that the degree of compliance with the policies and procedures may deteriorate.

Management conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on this evaluation, management concluded that the company s internal control over financial reporting was effective as of December 31, 2011. There were no changes in our internal control over financial reporting during the quarter ended December 31, 2011 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, non-accelerated filers are no longer required to provide the attestation report of the company s registered public accounting firm after the transition period for newly public companies.

ITEM 9B. OTHER INFORMATION

None.

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PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The following table sets forth information with respect to the individuals who are the members of our Board of Directors as well as information relating to the executive officers of Apria as of December 31, 2011 (ages are as of March 26, 2012).

Name	Age	Position
Norman C. Payson, M.D.	63	Executive Chairman of the Board of Directors; Chief Executive Officer
Daniel E. Greenleaf	47	Chief Operating Officer and President, Home Infusion Therapy Segment
Chris A. Karkenny	43	Executive Vice President and Chief Financial Officer
Harriet B. Albery	45	Executive Vice President, Sales
James G. Gallas	48	Executive Vice President and Chief Administrative Officer
Neil P. Simpkins	45	Director
Michael Dal Bello	40	Director
Patrick J. Bourke III	53	Director
Mike S. Zafirovski	58	Director

Norman C. Payson, M.D. was appointed Executive Chairman of the Board of Directors and Chief Executive Officer in October 2008. He was Chief Executive Officer of Oxford Health Plans from 1998 through 2002. Dr. Payson co-founded Healthsource, Inc., a large health plan operating in 15 states, in 1985 and served as its Chief Executive Officer from 1985 through 1997. He currently serves as Vice Chairman of the Board of Directors and a member of the Finance Committee of City of Hope, a not-for-profit tertiary cancer hospital and research center.

On October 26, 2004, the SEC issued an order finding that Dr. Payson violated Section 13(d) of the Exchange Act in connection with the submission of certain Section 13D filings relating to Dr. Payson s holdings in Oxford Health Plans, Inc. that were not filed on a timely basis and that contained certain inaccurate and incomplete disclosures. At the time of his initial election to our Board of Directors in 2006, our Corporate Governance and Nominating Committee and the Board of Directors reviewed the circumstances in detail and determined that such violations were not an adverse reflection on Dr. Payson s ability to serve on the Board of Directors and that such violations are not material to the evaluation of his qualifications or integrity.

Daniel E. Greenleaf served as our Chief Operating Officer from November 2010 to April 2012 and as President of our Home Infusion Therapy Segment from April 2008. On March 14, 2012, we announced the realignment of management responsibilities for our operating segments. In connection with these changes, Mr. Greenleaf was appointed Chief Executive Officer of Coram, Inc., the principal operating subsidiary of our Home Infusion Therapy Segment. Prior to joining Apria in 2008, Mr. Greenleaf served as President and Chief Executive Officer of VioQuest Pharmaceuticals, Inc., a New Jersey-based biopharmaceutical company focused on the acquisition, development and commercialization of oncology drug therapies, from 2005 to 2007. Prior to his role at VioQuest Pharmaceuticals, Inc., Mr. Greenleaf was President of U.S. Operations for Celltech Biopharmaceuticals, a NYSE listed company prior to its sale to UCB Pharma Limited in 2004. Additional experience includes serving as Senior Vice President of Operations for Nabi Pharmaceuticals, and progressively more responsible management and executive-level positions with Schering-Plough Corporation, a global healthcare company, from 1992 to 2002. Mr. Greenleaf was a captain and navigator in the United States Air Force and served in Operation Desert Storm.

Chris A. Karkenny joined us as Executive Vice President and Chief Financial Officer in November 2006. From January 2003 to February 2006, Mr. Karkenny served as Senior Vice President of Corporate Development and Treasury Operations of PacifiCare Health Systems, Inc., a Fortune 500 company. From August 1999 to December 2002, Mr. Karkenny served as Chief Executive Officer of NetCatalyst, a California investment banking firm. From July 1998 to August 1999, Mr. Karkenny served as a partner in Technologz, a California-based business incubator, and was a founder, Board member and initial Chief Financial Officer of CardioNow, a healthcare application service provider. From 1995 to March 1998, he served as Treasurer of Quarterdeck Corporation.

Harriet B. Albery was appointed Executive Vice President, Sales on May 16, 2011, after having led the Home Infusion Therapy Segment s sales function since March of 2009. In this role, she was responsible for the sales and marketing efforts for both the Home Respiratory Therapy and Home Medical Equipment Segment and the Home Infusion Therapy Segment until the March 14, 2012 management realignment. Prior

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to joining us Ms. Albery held sales leadership and managed care positions with Walgreens Home Care and its predecessor company, Option Care, for six years, with her last position there being Vice President of Sales and Marketing for infusion and respiratory therapy home medical equipment. Her prior experience also includes five years at Coram Healthcare Corporation.

James G. Gallas served as our Executive Vice President and Chief Administrative Officer from April 2009 to January 2012. Prior to that, Mr. Gallas served as Principal in charge of KPMG s Healthcare Revenue Cycle Management Practice from January 2009 to March 2009. From September 2005 to December 2008, Mr. Gallas served as Senior Vice President in charge of the Healthcare segment of BearingPoint, Inc., formerly KPMG Consulting, Inc., a global management and technology consulting company. From January 2000 to August 2005, Mr. Gallas served as Vice President in charge of BearingPoint, Inc. s Healthcare Provider Practice. Mr. Gallas s employment with the Company terminated on January 20, 2012.

Neil P. Simpkins became one of our directors immediately after the completion of the Merger in October 2008. Mr. Simpkins has served as a Senior Managing Director in the Private Equity Group of Blackstone since December 1999 and serves on the firm s Private Equity Executive Committee. From 1993 until the time he joined Blackstone, Mr. Simpkins was a principal at Bain Capital. Prior to joining Bain Capital, Mr. Simpkins was a consultant at Bain & Company in London and the Asia Pacific region. He currently serves as Lead Director of TRW Automotive Inc. and as a director of Vanguard Health Systems, Inc., Team Health, Inc., Summit Materials, LLC and Emdeon, Inc.

Michael Dal Bello became one of our directors immediately after the completion of the Merger in October 2008. Mr. Dal Bello has been a Managing Director in the Private Equity Group of The Blackstone Group since December 2008 and was a Principal in this group from 2005 until 2008, and an Associate from 2002 until 2005. Prior to joining Blackstone, Mr. Dal Bello received an M.B.A. from Harvard Business School in 2002. Mr. Dal Bello serves on the Board of Directors of Alliant Insurance Services, Biomet, Inc., Catalent Pharma Solutions, Inc., LLC, Team Health, Inc., Emdeon, Inc. and Vanguard Health Systems, Inc.

Patrick J. Bourke III became one of our directors immediately after the completion of the Merger in October 2008. Mr. Bourke is a Senior Managing Director Operating Partner in the Private Equity Group of Blackstone. Before joining Blackstone in 2008, Mr. Bourke was the Executive Vice President of Business Operations and Chief Re-engineering Officer of Travelport Limited. Prior to Travelport Limited, Mr. Bourke was a key executive at Perot Systems, Inc. where he held numerous management roles. Mr. Bourke started his career at Electronic Data Systems Corporation in their Systems Engineering Development program. Mr. Bourke served as a director of Intelenet Global Services Private Limited until July 2011.

Mike S. Zafirovski became one of our directors on October 3, 2011. Mr. Zafirovski also serves as a Senior Advisor to The Blackstone Group. Previously, Mr. Zafirovski served on the Board of Directors and was President and Chief Executive Officer of Nortel Networks Corporation from November 2005 to August 2009 and held several positions, including director, President and Chief Operating Officer at Motorola, Inc. from June 2000 to May 2005. Prior to joining Motorola, Mr. Zafirovski spent nearly 25 years with General Electric Company, where he served in various management positions, including President and Chief Executive Officer of five General Electric businesses in the consumer, industrial, and financial services areas. Mr. Zafirovski currently serves as a director of The Boeing Company and as Chairman of the Board of DJO Global, Inc.

There are no family relationships among any of our executive officers and directors.

Corporate Governance Matters

Background and Experience of Directors. When considering whether directors and nominees have the experience, qualifications, attributes or skills, taken as a whole, to enable our Board of Directors to satisfy its oversight responsibilities effectively in light of our business and structure, our Board of Directors focused primarily on each person s background and experience as reflected in the information discussed in each of the directors individual biographies set forth immediately above. In particular, the members of our Board of Directors considered the following important characteristics: (i) Messrs. Neil P. Simpkins, Michael Dal Bello, Mike S. Zafirovski and Patrick J. Bourke III have significant financial and investment experience from their involvement in Blackstone s investment in numerous portfolio companies, particularly those in the healthcare industry, and have played active roles in overseeing those and other businesses and (ii) Norman C. Payson, M.D., the Chairman of our Board of Directors and our Chief Executive Officer, has extensive experience in the healthcare industry and in executive management.

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Board Composition

As a privately-held company with no securities listed on a national securities exchange we are not required to have independent directors on our Board of Directors or any committees of the Board of Directors. Accordingly, we have not made any determinations of independence with respect to any of our outside directors.

Committees of the Board

Our Board of Directors has an Audit Committee. Our Board of Directors may also establish from time to time any other committees that it deems necessary and advisable.

Audit Committee. Our Audit Committee consists of Mr. Dal Bello and Dr. Payson. Mr. Dal Bello is the Chairman of the Audit Committee. The Audit Committee is responsible for assisting our Board of Directors with its oversight responsibilities regarding: (i) the integrity of our financial statements; (ii) our compliance with legal and regulatory requirements; (iii) our independent registered public accounting firm s qualifications and independence; and (iv) the performance of our internal audit function and independent registered public accounting firm. While our Board of Directors has not designated any of its members as an audit committee financial expert, we believe that each of the current Audit Committee members is fully qualified to address any accounting, financial reporting or audit issues that may come before it.

Compensation Committee Interlocks and Insider Participation. Presently, our Board of Directors does not have a compensation committee. Since the Merger, all decisions about our executive compensation have been made by our Board of Directors. Dr. Payson, who is the Executive Chairman of our Board of Directors and our Chief Executive Officer, generally participates in discussions and deliberations of our Board of Directors regarding executive compensation. No other member of our Board of Directors was at any time during fiscal 2011, or at any other time, one of our officers or employees. We are parties to certain transactions with The Blackstone Group described in the Certain Relationships and Related Transactions section below. None of our executive officers has served as a director or member of a compensation committee, or other committee serving an equivalent function, of any entity, whose executive officers served as a director of our company.

Code of Ethics

We adopted a Code of Ethical Business Conduct as our code of ethics , which applies to all of the Company s directors, officers and employees, including our principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions. A copy of the Code of Ethical Business Conduct is available on the investor relations portion of the Company s website at www.apria.com. A copy of the Code of Ethical Business Conduct may also be obtained free of charge upon a request directed to Apria Healthcare Group Inc., 26220 Enterprise Court, Lake Forest, CA 92630. The Company will disclose within four business days any substantive changes in or waivers of the Code of Ethical Business Conduct granted to our principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions, by posting such information on our website as set forth above or by filing a report on Form 8-K.

ITEM 11. EXECUTIVE COMPENSATION

Compensation Committee Report

Our entire Board of Directors performs equivalent functions of a compensation committee since we do not have a compensation committee. The Board of Directors has reviewed and discussed with management the following Compensation Discussion and Analysis. Based on such review and discussions, the Board of Directors approved the inclusion of the following Compensation Discussion and Analysis in this Annual Report on Form 10-K for the fiscal year ended December 31, 2011.

Submitted by the Board of Directors:

Norman C. Payson, M.D., Executive Chairman of the Board of Directors and Chief Executive Officer

Neil P. Simpkins, Director

Michael Dal Bello, Director

Patrick J. Bourke III, Director

Mike S. Zafirovski, Director

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Compensation Discussion and Analysis

Introduction

Our executive compensation plan is designed to attract and retain individuals qualified to manage and lead our company and to also motivate them to contribute to achievement of our financial goals and ultimately create and grow our equity value.

Our named executive officers for 2011 were:

- Norman C. Payson, M.D., our Executive Chairman of the Board of Directors and Chief Executive Officer;
- Chris A. Karkenny, our Executive Vice President and Chief Financial Officer;
- James G. Gallas, our Executive Vice President and Chief Administrative Officer;
- Daniel E. Greenleaf, our Chief Operating Officer and President, Home Infusion Therapy Segment; and
- Harriet B. Albery, our Executive Vice President, Sales.

Ms. Albery was promoted to the position of Executive Vice President, Sales on May 16, 2011.

On July 11, 2011, in connection with a realignment of certain management functions, Mr. Gallas ceased to oversee revenue management, information technology and certain related functions and assumed a special projects role during a transitional period, following which Mr. Gallas s employment with us terminated effective as of January 20, 2012.

Executive Compensation Objectives and Philosophy

Our primary executive compensation objectives are to:

- attract, retain and motivate leaders who are capable of advancing our mission and strategy and, ultimately, creating and maintaining our long-term equity value. Such leaders must engage in a collaborative approach and possess the ability to execute our strategy in an industry characterized by competitiveness and a challenging business environment;
- reward senior management in a manner aligned with our financial performance; and
- align senior management s interests with our equity owners long-term interests through equity participation and ownership.

To achieve our objectives, we deliver executive compensation through a combination of the following components:

- Base salary;

Annual cash bonuses;

Long-term incentive compensation;

Broad-based employee benefits;

Supplemental executive benefits and perquisites; and

Severance benefits.

We provide competitive base salaries and other benefits and perquisites, including severance benefits, to attract and retain senior management talent. We also use annual cash incentive compensation and long-term equity incentives to ensure a performance-based delivery of pay that aligns as closely as possible the rewards of our named executive officers with the long-term interests of our equity-owners while enhancing executive retention.

Compensation Determination Process

Presently, our Board of Directors does not have a compensation committee. Since the Merger, all decisions about our executive compensation have been made by our Board of Directors. In making initial compensation determinations with respect to our named executive officers following the Merger, our Board of Directors considered a number of variables,

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consistent with our executive compensation objectives, including individual circumstances related to each executive s recruitment or retention. For example, compensation for each of Dr. Payson and Mr. Karkenny was determined as part of the negotiation of each executive s employment agreement. Our Board of Directors decided to grant to Dr. Payson substantially greater equity incentive awards with vesting terms that differ from the terms applicable to our other senior executives in light of his role as our Executive Chairman of the Board of Directors and Chief Executive Officer and his substantially greater equity investment in our ultimate parent, BP Healthcare. In addition, in connection with the negotiation of Mr. Karkenny s employment agreement, our Board of Directors considered the fact that he would be entitled to severance if he terminated his employment following the Merger pursuant to the terms of his then existing employment agreement and provided him with an overall compensation package, which included an increase in base salary and a grant of restricted equity units, intended to induce him to stay with us. The specific terms of each of Dr. Payson s employment agreement and Mr. Karkenny s employment agreement are discussed below under Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in 2011 Table Employment Agreements.

Since the Merger, our Board of Directors has not used any compensation consultants in making its compensation determinations. During 2011, our management engaged Mercer LLC to assist in assessing current market pay levels for bonus-eligible roles, gaining a clear understanding of how our current pay/rewards mix compares to market, establishing competitive and equitable pay levels, understanding employee compensation preferences, assessing job levels and internal consistency and reviewing overall compensation strategy with an eye towards optimizing total rewards. Our Board of Directors has not taken any action based on recommendations from Mercer.

Dr. Payson and Mr. Karkenny generally participate in discussions and deliberations of our Board of Directors regarding the determinations of annual cash incentive awards for our executives. Specifically, they make recommendations to our Board of Directors regarding the performance targets to be used under our annual Executive Bonus Plan and the amounts of annual cash incentive awards and any discretionary bonus amounts to be made to our senior executives. Dr. Payson also makes recommendations to our Board of Directors regarding base salary adjustments for other executives based on his annual review of each executive s performance. Our Board of Directors considers Dr. Payson s recommendations and may exercise discretion in modifying his recommendations.

Compensation Elements

The following is a discussion and analysis of each component of our executive compensation program.

Base Salary

Base salary compensates executives for performing requirements of their positions and provides executives with a level of cash income predictability and stability with respect to a portion of their total compensation. Our Board of Directors believes that the level of an executive officer s base salary should reflect that executive officer s performance, experience and breadth of responsibilities, salaries for similar positions within the community and in our industry generally and any other factors relevant to that particular job. In determining applicable base salaries with respect to those named executive officers that were hired subsequent to the Merger, namely, Dr. Payson and Mr. Gallas, our Board of Directors also consulted with outside recruiters to ensure that we could recruit the candidate of our choice by offering a competitive base salary. In connection with the negotiation of Mr. Karkenny s employment agreement, our Board of Directors increased his then annual base salary in order to provide an overall compensation package that would incentivize him to stay with us notwithstanding his entitlement to severance upon his resignation.

Base salaries may be adjusted annually and, in certain circumstances, adjusted mid-year to deal with competitive pressures or changes in job responsibilities, in the sole discretion of our Board of Directors. On May 16, 2011, in connection with the increased responsibilities entailed by her promotion to Executive Vice President, Sales, our Board of Directors increased Ms. Albery s annual salary from $240,308 to $350,000. Other than this increase in Ms. Albery s base salary, our Board of Directors did not make any adjustments to any of our named executive officers base salaries in 2011.

Bonuses

Annual Cash Incentive Compensation. Annual cash incentive awards are available to our named executive officers under our annual Executive Bonus Plan in order to motivate our executive officers to achieve short-term performance goals and tie a portion of their cash compensation to performance.

Under our Executive Bonus Plan for 2011 (the 2011 Bonus Plan), each named executive officer was eligible to earn a cash incentive award based on achievement of performance targets for 2011. These performance targets were determined by our Board of Directors early in the year, after taking into consideration Dr. Payson and Mr. Karkenny s recommendations and our budget for the year. The potential amount of the cash incentive award was based on a percentage of the executive

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officer s base salary during 2011. The following table illustrates the potential cash incentive awards for our named executive officers as a percentage of their base salaries.

	Threshold Bonus Opportunity	Target Bonus Opportunity (2)	Maximum Bonus Opportunity
Norman C. Payson, M.D.	50%	100%	200%
Chris A. Karkenny	50%	100%	200%
James G. Gallas	50%	100%	150%
Daniel E. Greenleaf (1)	50%	100%	200%
Harriet B. Albery	50%	100%	150%

(1) On November 30, 2010, in connection with his promotion to the additional position of Chief Operating Officer, our Board of Directors increased Mr. Greenleaf s maximum award under the 2011 Bonus Plan from 150% to 200% of his base salary. If Mr. Greenleaf had relocated to California on a permanent basis, he would have received no less than 100% of his target bonus for 2011.

(2) The target bonus opportunity of 100% of base salary will be earned and payable only if performance significantly exceeds the budgeted targets for EBITDA and Free Cash Flow performance that were approved by our Board of Directors. If performance equals such budgeted targets, a bonus opportunity of 60% of base salary will be earned and payable.

In 2011, the cash incentive award opportunities were based on a company-wide Adjusted EBITDA target, an EBITDA target of the particular business for which the executive has primary responsibilities, an Adjusted Free Cash Flow target or a combination of one or more of these targets. The following table lists the performance metrics and relative weightings given thereto with respect to each of our named executive officers under the 2011 Bonus Plan. The weighting for Mr. Greenleaf was changed from 24% company-wide Adjusted EBITDA under the 2010 Bonus Plan to 80% for company-wide Adjusted EBITDA to better align his incentive with his position as Chief Operating Officer.

	Company-wide Adjusted EBITDA	Home Infusion Therapy Segment EBITDA (1)	Adjusted Free Cash Flow
Norman C. Payson, M.D.	80%		20%
Chris A. Karkenny	80%		20%
James G. Gallas	80%		20%
Daniel E. Greenleaf	80%		20%
Harriet B. Albery (2)	24%/80%	56%/0%	20%

(1) Represents the EBITDA of the particular business for which the executive has primary responsibilities. For Ms. Albery, represents the EBITDA of our Home Infusion Therapy segment exclusive of the results of our Enteral business. This component applies to the first four months of the year prior to her promotion to Executive Vice President, Sales.

(2) On May 1, 2011, in connection with her promotion to the position of Executive Vice President, Sales, the weighting for Ms. Albery s incentive for the remaining eight months of the year was changed from 24% to 80% company-wide Adjusted EBITDA and from 56% to 0% Home Infusion Therapy segment EBITDA.

Company-wide Adjusted EBITDA, as used under the 2011 Bonus Plan, is calculated as Adjusted EBITDA (as calculated under the indenture governing the Notes), further adjusted for certain items approved by our Board of Directors, such as loss on disposition of assets and other, employee severance costs, employee relocation costs and other income including joint ventures. Adjusted Free Cash Flow, as used under the 2011 Bonus Plan, is calculated as Free Cash Flow (as defined under Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources), further adjusted for certain items approved by our Board of Directors, such as equity compensation expense, costs incurred related to initiatives (other than employee severance costs and employee relocation costs), the Sponsor monitoring fee and unbudgeted initiative capital expenditures. The EBITDA of our Home Infusion Therapy segment exclusive of the results of our Enteral business is calculated as earnings before interest, taxes, depreciation and amortization of our Home Infusion Therapy segment exclusive of the results of our Enteral business.

Under our 2011 Bonus Plan, no cash incentive award was to be made with respect to any performance metric unless our actual company-wide Adjusted EBITDA for 2011 was at least $226.9 million, or 90.76% of the target company-wide Adjusted EBITDA of $250 million. Payouts for

the company-wide Adjusted EBITDA metric increase in linear progression from 50% to 60% of base salary for metric achievement between $226.9 million and $250 million and from 60% to 100% of base salary for metric achievement between $250 million and $287.4 million. No cash incentive award was to be made with

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respect to any performance metric unless actual achievement of that metric equaled at least the target that corresponds to company-wide Adjusted EBITDA achievement of $226.9 million. As set forth in the table below, 50% of the target cash incentive award amount with respect to each performance metric was to be paid if actual achievement of that metric equaled the target that corresponds to company-wide Adjusted EBITDA achievement of $226.9 million; 60% of the target cash incentive award amount with respect to each performance metric was to be paid if actual achievement of that metric equaled the target that corresponds to company-wide Adjusted EBITDA achievement of $250 million; and 100% of the target cash incentive award amount with respect to each performance metric was to be paid if actual achievement of that metric equaled the target corresponding to EBITDA achievement of $287.4 million. The maximum cash incentive award amount with respect to each performance metric was to be paid if actual achievement of that metric was 120% or above of the target corresponding to a 100% payout. Straight-line interpolation determines the cash payout for performance which falls between the threshold and target or between target and maximum.

	Company-wide Adjusted EBITDA	Home Infusion Therapy Segment Adjusted EBITDA	Adjusted Free Cash Flow
Threshold target for 50% payout	$ 226.9 million	$ 96.9 million	$ (9.6 million)
Budgeted target for 60% payout	$ 250 million	$ 99.5 million	$ (19 million)(2)
Target for 100% payout	$ 287.4 million	$ 108.4 million	n/a(1)
Target for maximum payout (150% or 200%)	$ 344.88 million	$ 130.08 million	n/a(1)

(1) Our Board of Directors did not set an Adjusted Free Cash Flow target corresponding to company-wide Adjusted EBITDA achievement of $287.4 million or $344.88 million.

Notwithstanding the establishment of the performance goals and the formula for determining the cash incentive award payment amounts as illustrated in the tables above, our Board of Directors may award lesser amounts under our annual Executive Bonus Plan to one or more named executive officers, if, in the exercise of its business judgment, our Board of Directors determines that they are warranted under the circumstances and in our best interest. In addition, our Board of Directors may award a discretionary bonus in addition to the amount the executive would be eligible to receive under our annual Executive Bonus Plan.

For 2011, our actual company-wide Adjusted EBITDA performance was $247.5 million, our actual Adjusted EBITDA performance for our Home Infusion Therapy segment exclusive of the results of our Enteral business was $113.2 million and our actual Adjusted Free Cash Flow performance was $(8.89) million. The company-wide Adjusted EBITDA actual performance achievement of $247.5 million was 99% of our targeted EBITDA of $250 million. The Home Infusion Therapy Adjusted EBITDA of $113.2 million was 113.8% of the targeted EBITDA of $99.5 million, and exceeded the $108.4 million target required for a 100% payout. The actual Adjusted Free Cash Flow performance of $(8.89) million was better than the ($19.2) million Adjusted Free Cash Flow expected for EBITDA achievement of $250 million. Accordingly, the board granted our named executive officers bonuses of 58.92% of their base salaries under the 2011 Bonus Plan, except that Ms. Albery was granted a bonus equal to the sum of (i) 87.68% of four months of her base salary earned during the year, (ii) 58.92% of her base salary earned for the remainder of the year and (iii) an additional discretionary amount of $30,000 to reflect her performance. Payouts on the Adjusted EBITDA metric will increase in linear progression from 50% to 60% of base salary for metric achievement between $226.9 million and $250 million, and therefore company-wide Adjusted EBITDA achievement of $247.5 million resulted in a 58.92% payout of base salary. The Adjusted Free Cash Flow performance metric payout is linked to the Adjusted EBITDA achieved, and therefore this payout was also 58.92% of base salary. For Ms. Albery, the first four months of her bonus were based 56% on the Home Infusion Therapy EBITDA performance, 24% on the company-wide Adjusted EBITDA performance and 20% on the Adjusted Free Cash Flow performance. Achievement of Home Infusion Therapy EBITDA of $113.2 million resulted in a payout of 100%, and achievement of company-wide Adjusted EBITDA resulted in a payout of 58.92%, for an overall EBITDA payout of 87.68%. The Adjusted Free Cash Flow is linked to the EBITDA performance, resulting in an Adjusted Free Cash Flow payout of 87.68% and an overall payout of 87.68% of four months of Ms. Albery s salary earned during 2011. Based on these results,

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the payments to our named executive officers under our 2011 Bonus Plan will be as follows: Mr. Payson $441,883; Mr. Greenleaf $341,723; Mr. Karkenny $279,859; and Ms. Albery $240,862. These bonus payments were made to the named executive officers on March 9, 2012.

The performance metrics, target levels and formula for determining payout amounts under the 2012 Executive Bonus Plan have not yet been established.

Long-Term Incentive Compensation

Following the Merger, our Board of Directors determined to grant to our management employees, including our named executive officers, long-term incentive awards that are designed to promote our interests by providing our management employees with the opportunity to acquire equity interests as an incentive for the person to remain in our service. Our Board of Directors granted these long-term incentive awards to our Chief Executive Officer, Dr. Payson, in the form of Class B Units of BP Healthcare, our ultimate parent, and to our other named executive officers in the form of Class B Units and Class C Units of Sky Acquisition LLC, our direct parent, and, in the case of Mr. Karkenny, Class A-2 Units of Sky Acquisition LLC as well, as further described below. Pursuant to a reorganization we implemented in March 2010, the Class A-2 Units, Class B Units and Class C Units of Sky Acquisition LLC were converted or exchanged into Class A-2 Units, Class B Units and Class C Units of Holdings. For purposes of the discussion of equity award grants under this Long-Term Incentive Compensation section, our Board of Directors means our Board of Directors acting in its capacity as the board of directors of the applicable parent entity, unless the context indicates otherwise.

Class A-2 Units of Holdings are equity interests in Holdings and have economic characteristics that are similar to those of shares of common stock in a corporation. Certain of our executives have made equity investments in Holdings by purchasing Class A-2 Units of Holdings. In addition, our Board of Directors granted to Mr. Karkenny Class A-2 Units of Holdings, subject to vesting terms, similar to restricted common stock in a corporation. Mr. Karkenny s Class A-2 Units vest if an initial public offering or change of control occurs and the valuation of Class A-1 Units of Holdings implied by the transaction exceeds 110% of the aggregate capital contributions of affiliates of the Sponsor for the Class A-1 Units. Mr. Karkenny does not need to be employed at the time of the initial public offering or change in control to vest in his Class A-2 Units.

Class B and Class C Units of Holdings are limited liability company profits interests having economic characteristics similar to stock appreciation rights and representing the right to share in any increase in the equity value of Holdings that exceeds specified thresholds. For a Class B Unit, the threshold is the value of a Class A Unit on the grant date which generally was $1.00, so a Class B Unit generally has a value at any given time equal to the value of a Class A Unit minus $1.00. For a Class C unit, the threshold was $2.00, so a Class C Unit has a value at any given time equal to the value of a Class A Unit minus $2.00. Some Class B Units have a higher threshold representing the estimated fair value of a Class A Unit on the applicable grant date.

The Class B Units of Holdings are divided into a time-vesting portion (2/3 of the Class B Units granted) and a performance-vesting portion (1/3 of the Class B Units granted). All Class C Units are performance-vesting. See Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in 2011 Table Terms of Equity Award Grants Equity Units of Holdings Granted to Our Named Executive Officers (Other than Our Chief Executive Officer) below for a discussion of the vesting and other terms of these equity units.

Our Board of Directors granted to Dr. Payson 38,697,318 Class B units of BP Healthcare in November 2008 with a grant date fair value of $13.9 million. These Class B Units are economically equivalent to the Class B Units of Holdings. These Class B Units are 80% time-vesting and 20% performance-vesting. See Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in 2011 Table Terms of Equity Award Grants Equity Units of BP Healthcare Granted to Our Chief Executive Officer. The Class B Units of BP Healthcare granted to Dr. Payson are designed to incentivize him to remain in our service and motivate him to focus on efforts that will increase the value of our equity over the long term.

Our Board of Directors granted to Mr. Karkenny 500,000 Class A-2 Units, 6,675,287 Class B Units and 2,225,096 Class C Units of Sky Acquisition LLC in December 2008 with an aggregate grant date fair value of $3 million. These units were converted or exchanged into Class A-2 Units, Class B Units and Class C Units of Holdings in connection with the March 2010 reorganization. The Class A-2 Units granted to Mr. Karkenny are designed to motivate him to focus on efforts that will deliver our financial success and also enable him to participate in our long-term growth. Our Board of Directors granted each of our other named executive officers a combination of Class B Units and Class C Units of Sky Acquisition LLC in March 2009 and, in the case of Mr. Gallas, in April 2009 in connection with the commencement of his employment. The aggregate grant date fair values of all such Class B and Class C Units were $3.4 million. These units were converted or exchanged into Class B and Class C Units of Holdings in connection with the March 2010 reorganization. The Class B Units

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and Class C Units granted to our named executive officers are designed to motivate them to focus on efforts that will increase the value of our equity while enhancing their retention. The specific sizes of the equity grants made to our named executive officers were determined in light of the Sponsor s practices with respect to management equity programs at other private companies in its portfolio and the executive officer s position and level of responsibilities with us. In addition, in the case of Dr. Payson, consideration was also given to his substantial equity investment in BP Healthcare, and in the case of Mr. Karkenny, consideration was also given to enhancing his retention following the Merger.

Subsequent to these initial grants of equity awards, our Board of Directors has not made additional grants of equity awards to our named executive officers other than grants on September 10, 2010 and December 15, 2010 to Mr. Greenleaf and on September 10, 2010 and May 31, 2011 to Ms. Albery of Class B Units and Class C Units of Holdings. The September 10, 2010 grants consisted of 290,230 Class B Units with a grant date fair value of $0.1 million and 96,743 Class C Units with a grant date fair value of $0.03 million for Mr. Greenleaf and 145,115 Class B Units with a grant date fair value of $0.1 million and 48,372 Class C Units with a grant date fair value of $0.02 million for Ms. Albery, and were made to recognize Mr. Greenleaf, Ms. Albery and other Home Infusion Therapy top management for exceeding year-to-date financial expectations for the Home Infusion Therapy segment and serve as an additional long-term retention incentive for these executives. The December 15, 2010 grants to Mr. Greenleaf consisted of 872,193 Class B Units with a grant date fair value of $0.4 million and 290,731 Class C Units with a grant date fair value of $0.1 million and were made in connection with Mr. Greenleaf s promotion to the additional position of Chief Operating Officer. The May 31, 2011 grants to Ms. Albery consisted of 1,015,805 Class B Units with a grant date fair value of $0.6 million and 338,602 Class C Units with a grant date fair value of $0.1 million and were made in connection with Ms. Albery s promotion to Executive Vice President, Sales.

Broad-based Employee Benefits

We provide to all our employees, including our named executive officers, broad-based benefits that are intended to attract and retain employees while providing them with retirement and health and welfare security. Broad-based employee benefits include:

- a 401(k) savings plan;
- paid vacation, sick time and holidays;
- medical, dental, vision, life and accident insurance, disability coverage, dependent care and healthcare flexible spending accounts; and
- employee assistance program benefits.

Under our 401(k) savings plan, we match a portion of the funds set aside by the employee. At no cost to the employee, during 2011, we provided $50,000 in basic life and accident insurance coverage and $100,000 in business travel accident insurance to certain members of management, including the named executive officers. Other employees receive $10,000 in basic life and accident insurance coverage and $100,000 in business travel accident insurance. The employee may also select supplemental life and accident insurance, for a premium to be paid by the employee.

Supplemental Executive Benefits and Perquisites

We provide a nonqualified deferred compensation plan and modest perquisites which are also intended to attract and retain executives. The deferred compensation plan is intended to promote retention by providing to participants a long-term savings opportunity on a tax-efficient basis and is accomplished with only a modest administrative cost to us, as the employees deferrals are not matched by us. Under the deferred compensation plan, participants may defer certain portions of their salary, annual bonus and annual 401(k) savings plan refund offset amount, as more fully explained in the narrative following the Nonqualified Deferred Compensation for 2011 Table below.

Our named executive officers also receive modest perquisites provided or reimbursed by us. These perquisites include supplemental long-term disability coverage, executive medical and dental benefits and transportation-related benefits. In addition, we provide Mr. Greenleaf with a furnished corporate apartment in California in lieu of reimbursing for hotel expenses when he attends meetings at our primary office in Lake Forest. We provide these perquisites because they are cost-effective and promote retention and recruitment. These perquisites are reflected in the All Other Compensation column of the Summary Compensation Table and the accompanying footnote.

Severance Arrangements and Noncompetition Agreements

Our Board of Directors believes that severance arrangements are necessary to attract and retain the talent necessary for our long-term success. Our Board of Directors views our severance arrangements as recruitment and retention devices that

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help secure the continued employment and dedication of our named executive officers, including when we are considering strategic alternatives.

Each of our named executive officers (other than Mr. Gallas, who has resigned from his employment with us) has a severance arrangement with us either as part of his employment agreement or as a separate severance agreement. Under the terms of these severance arrangements, each named executive officer is entitled to severance benefits if he is terminated by us without cause or by him or her as a result of constructive termination or for good reason, as applicable. In connection with Mr. Gallas s resignation, we entered into a general release of claims agreement with Mr. Gallas pursuant to which we agreed to pay him severance compensation. In addition, Messrs. Karkenny and Greenleaf have separate noncompetition agreements with us. These agreements provide for additional payments upon a termination of the executive s employment by us without cause or by the executive for good reason, in each case, during a specified period.

The severance payments under these agreements are contingent upon the affected executive s compliance with the post-termination restrictive covenants contained therein. See Potential Payments to Named Executive Officers Upon Termination of Employment or Change in Control Severance Arrangements for descriptions of these agreements.

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Summary Compensation Table

The following table provides summary information concerning compensation to or on behalf of our named executive officers for services rendered to us during 2009, 2010 and 2011.

Name and Principal Position	Year	Salary ($)	Bonus ($)	Stock Awards (2) ($)	Non-Equity Incentive Plan Compensation (1) ($)	All Other Compensation (3)($)	Total ($)
Norman C. Payson, M.D.	2011	752,060			441,883	12,628	1,206,571
Executive Chairman of the Board of Directors and Chief Executive Officer	2010	752,060	375,001			12,623	1,139,684
	2009	752,060			825,175	13,737	1,590,972
Chris A. Karkenny	2011	476,305			279,859	13,711	769,875
Executive Vice President and Chief Financial Officer	2010	476,305	237,501			12,918	726,724
	2009	476,305	2,100,000		514,173	13,273	3,103,751
James G. Gallas	2011	552,764				22,859	575,623
Executive Vice President and Chief Administrative Officer	2010	539,928	269,062			16,828	825,818
	2009	396,635	412,500	685,039	284,555	67,452	1,846,181
Daniel E. Greenleaf	2011	581,593			341,722	132,891	1,056,206
Chief Operating Officer and President, Home Infusion Therapy Segment	2010	490,597	667,000	639,333		18,609	1,815,539
	2009	476,305		1,219,933	617,019	69,633	2,382,890
Harriet B. Albery	2011	309,429	30,000	697,520	210,862	2,409	1,250,220
Executive Vice President, Sales							

(1) Amounts included in this column for 2011 reflect bonus payments under the 2011 Bonus Plan. See the discussion under Compensation Discussion and Analysis Compensation Elements Bonuses.

(2) Amounts included in this column reflect the aggregate grant date fair value of Class B Units and Class C Units of Holdings granted during 2011, calculated in accordance with Financial Accounting Standards Board Accounting Standards Codification Topic 718, *Compensation Stock Compensation* (FASB ASC Topic 718), excluding the effect of estimated forfeitures, utilizing the assumptions discussed in Note 8 to our financial statements for the year ended December 31, 2011. With respect to the performance-vesting Class B Units and Class C Units, the estimate of the grant date fair value determined in accordance with FASB ASC Topic 718 assumes the vesting of 100% of the units awarded. The values of the performance-vesting Class B and Class C Units at the grant date assuming achievement of the highest performance conditions are not determinable because there are no maximum performance conditions under the terms of Class B and Class C Units. See Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in 2011 Table Terms of Equity Awards Equity Units of Holdings Granted to Our Named Executive Officers Other than Our Chief Executive Officer.

(3) Amounts reported in this column for each of the named executive officers include the premiums paid by us on behalf of the executive officer for executive long-term disability. In addition, they include:

For Mr. Payson premiums paid by us on behalf of Mr. Payson for the executive medical insurance and executive dental insurance coverage;

For Mr. Karkenny premiums paid by us on behalf of Mr. Karkenny for the executive medical insurance and executive dental insurance coverage and gas card/toll road fees paid by us and the related amount of tax gross-up;

For Mr. Gallas premiums paid by us on behalf of Mr. Gallas for the executive medical insurance and executive dental insurance coverage and gas card fees paid by us and the related amount of tax gross-up; and

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For Mr. Greenleaf corporate apartment rental expenses in the amount of $69,996, premiums paid by us on behalf of Mr. Greenleaf for the executive medical insurance and executive dental insurance coverage, gas card fees paid by us and the related amount of tax gross-up and travel expenses related to bringing his family to California on three occasions during the year and the related amount of tax gross-up.

Each perquisite was valued at the actual amount paid to the provider by us on behalf of the named executive officer.

Grants of Plan-Based Awards in 2011

The following table provides supplemental information relating to grants of plan-based awards made to our named executive officers during 2011.

				Estimated Future Payouts Under Non-Equity Incentive Plan Awards (1)			Estimated Future Payouts Under Equity Incentive Plan Awards			All Other Stock Awards: Number of Shares of Stock or Units (3) (#)	Grant Date Fair Value of Stock and Option Awards (4) ($)
Name	Grant Date	Approval Date	Type of Award	Threshold ($)	Target ($)	Maximum ($)	Threshold (#)	Target (2) (#)	Maximum (#)		
Norman C. Payson, M.D.				375,000	750,000	1,500,000					
Chris A. Karkenny				237,500	475,000	950,000					
James G. Gallas				275,625	551,250	826,875					
Daniel E. Greenleaf				290,000	580,000	1,160,000					
Harriet B. Albery				153,906	307,811	461,717					
	5/31/11	5/10/11	Class B					338,601		677,204	558,693
	5/31/11	5/10/11	Class C					338,602			138,827

(1) Reflects possible payouts under our 2011 Bonus Plan. See *Compensation Discussion and Analysis Compensation Elements Bonuses Annual Cash Incentive Compensation* for a discussion of threshold, target and maximum cash incentive compensation payouts.

(2) Reflects the number of performance-vesting Class B Units and Class C Units of Holdings granted during 2011.

(3) Reflects the number of time-vesting Class B Units of Holdings granted during 2011.

(4) Represents the aggregate grant date fair value of Class B Units or Class C Units, as applicable, calculated in accordance with FASB ASC Topic 718, utilizing the assumptions discussed in Note 8 to our financial statements for the year ended December 31, 2011. With respect to the performance-vesting Class B Units and Class C Units which are reflected under Estimated Future Payouts Under Equity Incentive Plan Awards, the estimate of the grant date fair value determined in accordance with FASB ASC Topic 718 assumes the vesting of 100% of the units awarded.

Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in 2011

Employment Agreements

Norman C. Payson

Apria and its indirect parent entity, BP Healthcare, entered into an employment agreement, effective October 28, 2008, with Dr. Payson pursuant to which Dr. Payson serves as our Chief Executive Officer and Executive Chairman of our Board of Directors. His employment agreement has a four-year term with automatic annual renewals and also contains the terms summarized below.

Compensation Arrangements

base salary at the annual rate of $750,000, subject to increases as determined by the Board of Directors;

target annual bonus award of 100% of base salary (and a maximum bonus award of 200% of base salary), based upon certain performance goals established by our Board of Directors;

eligibility for equity award grants as determined by our Board of Directors;

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participation in our employee benefit plans; and

reimbursement for reasonable and customary business expenses, as well as reimbursement for his private airplane operating expenses relating to business travel up to a maximum of $1.55 million per year.

Termination Provisions

Generally, either party may terminate Dr. Payson s employment agreement at any time, but Dr. Payson must provide 60 days advance written notice to us of his resignation. See Potential Payments upon Termination or Change-in-Control Severance Arrangements for a description of the severance provisions related to Dr. Payson s termination of employment.

In addition, if Dr. Payson resigns, or we remove him, from the position of Chief Executive Officer of Apria and/or Sky Acquisition LLC but the party initiating such action notifies the other party that it desires Mr. Payson to continue to serve as the Executive Chairman of the Board of Directors of Apria or the Chairman of the Board of Directors of Sky Acquisition, then we must terminate his employment agreement and enter into a services agreement with Dr. Payson, pursuant to which he would continue to serve as the Executive Chairman of the Board of Directors of Apria and the Chairman of the Board of Directors of Sky Acquisition and serve as a senior advisor to BP Healthcare, and we would pay him $500,000 per year for his services to Apria. The services agreement would terminate on October 28, 2012, unless earlier terminated by either party or extended by mutual agreement of the parties thereto.

Chris A. Karkenny

Apria entered into an employment agreement, effective October 28, 2008, with Mr. Karkenny pursuant to which Mr. Karkenny continues to serve as our Chief Financial Officer. His employment agreement has a five-year term with automatic annual renewals and also contains the terms summarized below.

Compensation Arrangements

base salary at the annual rate of $475,000 after December 31, 2008, subject to increases as determined by our Board of Directors;

target annual bonus award of 100% of base salary (and a maximum bonus award of 200% of base salary), based upon certain performance goals established by our Board of Directors;

eligibility for equity award grants as determined by our Board of Directors;

retention bonus payment of $2,100,000, payable on January 5, 2009, subject to a claw-back obligation described below;

participation in our employee benefit plans; and

reimbursement of reasonable and customary business expenses.

Notwithstanding the foregoing, the agreement provided that, in the event Mr. Karkenny terminated his employment with Apria, other than his resignation as a result of a constructive termination , or upon his death or disability, in each case prior to March 31, 2010, he would have been required to pay to Apria the amount by which $2,100,000 exceeds the product of (x) $140,000 and (y) the number of full months following January 1, 2009 that he was continuously employed by Apria.

Termination Provisions

Generally, either party may terminate Mr. Karkenny s employment agreement at any time, but Mr. Karkenny must provide 30 days advance written notice to Apria of his resignation. See Potential Payments Upon Termination or Change-in-Control Severance Arrangements for a description of the severance provisions related to Mr. Karkenny s termination of employment.

James G. Gallas

Apria entered into an offer letter, dated March 10, 2009, with Mr. Gallas pursuant to which Mr. Gallas served as our Chief Administrative Officer. Mr. Gallas s employment with Apria was on an at-will basis. His offer letter contained the terms summarized below.

Compensation Arrangements

base salary at the annual rate of $525,000, subject to merit based wage adjustments consistent with other senior executives under our wage administration policy;

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target annual bonus award of 100% of base salary (and a maximum bonus award of 150% of base salary), with a guaranteed minimum bonus of $262,500 for the plan year 2009.

a sign-on bonus of $150,000, a portion of which would have been required to be refunded to Apria on a ratable basis if he voluntarily terminated his employment or was terminated for misconduct before completing 24 months of employment;

eligibility for equity award grants equal to 0.365% of the fully diluted ownership of Holdings;

participation in our employee benefit plans; and

relocation benefits, including reasonable air, hotel, meal and transportation expenses associated with his temporary commute from Ohio to Southern California up to the time of completion of relocation and six months of temporary housing expenses in the Southern California area up to $5,000 per month.

Termination Provisions

We also entered into a severance agreement, dated March 10, 2009, with Mr. Gallas. See Potential Payments Upon Termination or Change-in-Control Severance Arrangements for a description of the severance arrangement agreed to in connection with Mr. Gallas s termination of employment on January 20, 2012.

Daniel E. Greenleaf

In connection with his promotion to the additional position of Chief Operating Officer, Mr. Greenleaf s employment agreement was amended and restated effective as of November 30, 2010. Mr. Greenleaf s employment with Apria is on an at-will basis. His employment agreement contains the terms summarized below.

Compensation Arrangements

base salary at the annual rate of $580,000, subject to increases from time to time by Apria;

target annual bonus award of 100% of base salary (and a maximum award of 200% of base salary), with a guaranteed minimum bonus of $517,000 for the plan year 2010;

a one-time signing bonus of $150,000;

eligibility for equity award grants equal to 0.15% of the fully diluted ownership of Holdings to consist of 872,193 Class B Units of Holdings and 290,731 Class C Units of Holdings (in addition, if Mr. Greenleaf relocated his principal residence to California on a permanent basis during 2011 or if there was a change of control of the company prior to any such relocation, Mr. Greenleaf would have received another 0.15% of the fully diluted ownership of Holdings at that time);

participation in our employee benefit plans; and

eligibility for payment by Apria of $10,856 per month for a furnished home in California for a minimum period of approximately twelve months pending the possible relocation of his principal residence to be proximal to our headquarters in Lake Forest, California and, prior to such relocation, reimbursement of reasonable costs for Mr. Greenleaf s spouse and children to travel periodically between Denver, Colorado and California. The terms described in the preceding sentence reflect the benefits actually provided to Mr. Greenleaf by Apria, which were provided in lieu of benefits described in his amended and restated employment agreement, which provided for a housing allowance of $5,000 per month for a six-month period.

Termination Provisions

Generally, either party may terminate Mr. Greenleaf s employment agreement at any time, by giving the other party at least 30 days advance written notice. In connection with his promotion to the additional position of Chief Operating Officer, Mr. Greenleaf s employment agreement was amended to provide that, upon the termination of his employment without cause or for good reason (as such terms are defined in his employment agreement), he will be entitled to receive, subject to his compliance with a noncompetition and non-solicitation agreement, severance payments in an aggregate amount equal to two times the sum of (1) his annual base salary at the rate in effect at the time of termination, (2) his target annual bonus, which shall be equal to 100% of such annual base salary and (3) his annual cost to obtain medical, dental and vision insurance under COBRA, including the cost of his participation in the senior executive medical and dental programs. His previous employment agreement provided that the bonus component of his severance would be based on the average of his annual bonuses paid or payable with respect to the two most recently completed fiscal years rather than his target annual

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bonus. See Potential Payments Upon Termination or Change-in-Control Severance Arrangements for a description of the severance provisions related to Mr. Greenleaf s termination of employment.

Harriet B. Albery

In connection with her promotion to the position of Executive Vice President, Sales, Ms. Albery s severance agreement was amended and restated effective as of May 16, 2011. Ms. Albery s employment with Apria is on an at-will basis. Her severance agreement contains the terms summarized below.

Compensation Arrangements

- base salary at the annual rate of $350,000, subject to increases from time to time by Apria;
- target annual bonus award of 100% of base salary (and a maximum award of 150% of base salary);
- eligibility for equity award grants equal to 17.5 basis points of the fully diluted ownership of Holdings to consist of 1,015,805 Class B Units of Holdings and 338,602 Class C Units of Holdings (which are in addition to the 145,115 Class B Units of Holdings and 48,372 Class C Units of Holdings that Ms. Albery held prior to her promotion); and
- participation in our employee benefit plans.

Termination Provisions

Generally, either party may terminate Ms. Albery s employment at any time, by giving the other party at least 30 days advance written notice. In connection with her promotion to the position of Executive Vice President, Sales, Ms. Albery s severance agreement was amended to provide that, upon the termination of her employment without cause or for good reason (as such terms are defined in her severance agreement), she will be entitled to receive, subject to her compliance with a noncompetition and non-solicitation agreement, severance payments in an aggregate amount equal to one times the sum of (1) her annual base salary at the rate in effect at the time of termination, (2) her average annual bonus paid or payable with respect to the two most recently completed fiscal years and (3) her annual cost to obtain medical, dental and vision insurance under COBRA. Her previous severance agreement did not include a bonus component in her severance payment calculation. See Potential Payments Upon Termination or Change-in-Control Severance Arrangements for a description of the severance provisions related to Ms. Albery s termination of employment.

Terms of Equity Awards

Equity Units of BP Healthcare Granted to Our Chief Executive Officer

Vesting Terms

The Class B Units of BP Healthcare granted to our Chief Executive Officer are 80% time-vesting and 20% performance-vesting. The time-vesting units vest over four years starting on October 28, 2008 in quarterly tranches but will become fully vested on an accelerated basis either (x) upon a change in control while he continues to provide services to us or (y) if affiliates of the Sponsor receive cash proceeds in respect of 50% of their units in BP Healthcare equal to at least 200% of their aggregate capital contributions in respect of such units while he continues to provide services to us. In addition, if his services are terminated (a) by us without cause or (b) by him as a result of constructive termination, an additional number of these time-vesting Class B Units will vest equal to the number that would have vested over the 24-month period following the applicable termination date. Any of these time-vesting Class B Units that are unvested on termination of his services will be forfeited.

One-half of the performance-vesting Class B Units granted to our Chief Executive Officer vest only if affiliates of the Sponsor receive cash proceeds equal to at least 200% of their aggregate capital contributions in respect of all of their units in BP Healthcare and the other half vest

only if they receive cash proceeds equal to at least 300% of their aggregate capital contributions in respect of all of their units in BP Healthcare. Any of these performance-vesting units that are unvested upon a termination of his services (x) by us without cause, (y) by him as a result of constructive termination or (z) by him for any reason on or following October 28, 2012 will remain outstanding until the second anniversary of the applicable termination date (unless they vest prior to that date). If the performance-vesting units do not vest by such anniversary, then they will be immediately forfeited.

Put and Call Rights

Prior to our initial public offering, if the Chief Executive Officer s employment is terminated due to death or disability, he has the right, subject to certain limitations, for a specified period following the termination date, to cause us to purchase on

one occasion all, but not less than all, of his vested Class B Units at the fair market value of such units. Our Chief Executive Officer does not have the right to require us to repurchase the Class A-2 units of BP Healthcare that he purchased.

If the Chief Executive Officer s employment is terminated by us for cause, due to his death or disability or, prior to the fourth anniversary of the vesting date, by him (other than as a result of constructive termination), then we have the right for a specified period following the termination to cause the Chief Executive Officer (or his permitted transferees) to sell to us all vested Class B units held by him at (1) the lesser of fair market value thereof and cost, in the event of termination for cause, which means that such vested units will be effectively forfeited or (2) the fair market value thereof, in the event of termination due to death or disability or voluntary termination (other than as a result of constructive termination) prior to the fourth anniversary of the vesting date.

Equity Units of Holdings Granted to Our Named Executive Officers Other than Our Chief Executive Officer

Vesting Terms

Class A-2 Units. Class A-2 Units of Holdings held by Mr. Karkenny vest if an initial public offering or change of control occurs and the valuation of Class A-1 Units of Holdings implied by the transaction exceeds 110% of the aggregate capital contributions of affiliates of the Sponsor for the Class A-1 Units. Mr. Karkenny does not need to be employed at the time of our initial public offering or change in control to vest. The Class A-2 Units will be forfeited if an initial public offering or change of control occurs at a valuation that does not result in vesting.

Class B Units. The Class B Units of Holdings granted to all of our named executive officers other than our Chief Executive Officer are divided into a time-vesting portion (2/3 of the Class B Units granted) and a performance-vesting portion (1/3 of the Class B Units granted). The time-vesting portion of these Class B Units vest over 5 years, with 20% vesting on the 12-month anniversary of the later of (x) October 28, 2008 and (y) the date of the executive s commencement of employment with us and the remainder in quarterly tranches thereafter, except that in the case of Mr. Karkenny, they vest over 57 months, with 25% vesting on October 28, 2009 and the remainder in quarterly tranches thereafter, in each case subject to the executive officer s continued employment through each vesting date. Notwithstanding the foregoing, the time-vesting Class B units of Holdings will become fully vested on an accelerated basis upon a change in control while the executive continues to provide services to us.

The performance-vesting portion of these Class B Units vest only if affiliates of the Sponsor receive cash proceeds (not subject to any clawback, indemnity or similar contractual obligation) in respect of 25% of its units equal to 200% of its aggregate capital contributions for such units.

Class C Units. All Class C Units of Holdings are performance-vesting and have the same vesting terms as the performance-vesting Class B Units.

Any of the Class B Units or Class C Units that are unvested on termination of the executive s services will be forfeited.

Put and Call Rights

Prior to an initial public offering, if the executive s employment is terminated due to death or disability, he has the right, subject to certain limitations, for a specified period following the termination date, to cause us to purchase on one occasion all, but not less than all, of his vested Class A-2, Class B or Class C Units at the fair market value thereof.

If the executive s employment is terminated due to (1) death or disability, (2) by us without cause, (3) voluntarily as a result of constructive termination or (4) voluntarily (other than as a result of a constructive termination) after the later of (x) October 28, 2010 and (y) the second anniversary of the date the executive commenced his employment with us or, in the case of Mr. Karkenny, after January 28, 2010, or the executive engages in any conduct that would be a violation of a restrictive covenant set forth in the management unit subscription agreement but for the fact that the conduct occurred outside the relevant periods, then we have the right to purchase all of the executive s vested Class B or Class C Units at the fair market value thereof.

If the executive s employment is terminated (1) by us for cause or (2) voluntarily (other than as a result of a constructive termination) on or before the later of (x) October 28, 2010 and (y) the second anniversary of the date the executive commenced employment with us or, in the case of Mr. Karkenny, on or before January 28, 2010, or the executive breaches any of the restrictive covenants set forth in the management unit subscription agreement, then we have the right to purchase all of the executive s vested Class B or Class C Units at the lesser of fair market value thereof and cost, which means that such vested Class B or Class C Units will be effectively forfeited.

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Restrictive Covenants

As a condition of receiving the units, our named executive officers have agreed to certain restrictive covenants, including confidentiality of information, noncompetition, non-solicitation and non-disparagement covenants in the management unit subscription agreements. As described above, we have the right to purchase our named executive officers vested units in the event of breach of these restrictive covenants either within or outside the periods covered by the restrictive covenants.

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Outstanding Equity Awards at 2011 Fiscal-Year End

The following table provides information regarding outstanding equity awards made to our named executive officers as of December 31, 2011. The equity awards held by Dr. Payson are Class B Units of BP Healthcare, and the equity awards held by the other named executive officers are Class B and Class C Units of Holdings.

		Stock Awards			
Name	Grant Date	Number of Shares or Units of Stock That Have Not Vested (1) (#)	Market Value of Shares or Units of Stock That Have Not Vested ($)	Equity Incentive Plan Awards: Number of Unearned Shares, Units or Other Rights That Have Not Vested (2) (#)	Equity Incentive Plan Awards: Market or Payout Value of Unearned Shares, Units or Other Rights That Have Not Vested ($)
Norman C. Payson, M.D.	11/24/2008	7,739,464	(5)	7,739,463	(5)
Chris A. Karkenny	12/19/2008	1,557,568	(5)	4,950,189	(5)
James G. Gallas	4/29/2009	706,226	(5)	1,412,452	(5)
Daniel A. Greenleaf	(3)	1,616,415	(5)	3,290,274	(5)
Harriet B. Albery	(4)	981,945	(5)	1,354,407	(5)

(1) Reflects time-vesting Class B Units that have not vested. The following provides information with respect to the vesting schedule of the time-vesting Class B Units that have not vested as of December 31, 2011:

Dr. Payson 1,934,866 units vest every three months starting on January 28, 2011 until all of them vest on October 28, 2012.

Mr. Karkenny 222,510 units vest every three months starting on January 28, 2011 until all of them vest on July 28, 2013.

Mr. Gallas 70,623 units vest every three months starting on January 29, 2011 until all of them vest on April 29, 2014.

Mr. Greenleaf For the units granted on March 11, 2009, 125,766 units vest every three months starting on January 28, 2011 until all of them vest on October 28, 2013. For the units granted on September 10, 2010, 38,697 units vested on September 10, 2011 and 9,674 units will vest every three months starting on December 10, 2011 until all of them vest on September 10, 2015. For the units granted on December 15, 2010, 116,292 units vested on December 15, 2011 and 29,073 units will vest every three months starting on March 15, 2012 until all of them vest on December 15, 2015.

Ms. Albery For the units granted on March 11, 2009, 29,023 units vest every three months starting on January 28, 2011 until all of them vest on October 28, 2013. For the units granted on September 10, 2010, 19,349 units vested on September 10, 2011 and 4,837 units will vest every three months starting on December 10, 2011 until all of them vest on September 10, 2015. For the units granted on May 31, 2011, 135,441 units will vest on May 31, 2012 and 33,860 units will vest every three months starting on August 31, 2012 until all of them vest on May 31, 2016.

Vesting will be accelerated under specified events while the executive continues to provide services to us, as described under Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in 2011 Table Terms of Equity Awards.

(2) Reflects performance-vesting Class B Units and Class C Units and, with respect to Mr. Karkenny, Class A-2 Units. The terms of these performance-vesting units are described under Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in 2011 Table Terms of Equity Awards.

(3) Mr. Greenleaf received grants of equity awards on March 11, 2009, September 10, 2010 and December 15, 2010.

(4) Ms. Albery received grants of equity awards on March 11, 2009, September 10, 2010 and May 31, 2011.

(5) Because there was no public market for Class B Units of Holdings and BP Healthcare or the Class C Units of Holdings as of December 31, 2011, the market values of such units are not determinable. For purposes of FASB ASC Topic 718, the grant date fair value of Dr. Payson s Class B Units was $0.36 per unit, the grant date fair value of Mr. Karkenny s Class A-2, Class B and Class C Units were $0.75 per unit, $0.35 per unit and $0.15 per unit, respectively, and the grant date fair value for Messrs. Gallas and Greenleaf and Ms. Albery s 2009 Class B and Class C units were $0.28 per unit and $0.13 per unit. Mr. Greenleaf s and Ms. Albery s 2010 Class B and Class C units had a grant date fair value of $0.44 per unit and $0.33 per unit. Ms. Albery s 2011 Class B and Class C units had a grant date fair value of $0.55 per unit and $0.41 per unit.

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Option Exercises and Stock Vested in 2011

The following table provides information regarding the number of equity units that vested for our named executive officers during 2011. The equity units are Class B Units of BP Healthcare for Dr. Payson and Class B Units of Holdings for the other named executive officers.

	Stock Awards	
Name	Number of Shares Acquired on Vesting (#)	Value Realized on Vesting ($)
Norman C. Payson, M.D.	7,739,464	(1)
Chris A. Karkenny	890,039	(1)
James G. Gallas	282,490	(1)
Daniel A. Greenleaf	667,729	(1)
Harriet B. Albery	140,278	(1)

(1) Because there was no public market for the Class B Units of Holdings and BP Healthcare as of the vesting dates, the market values of such units are not determinable. For purposes of FASB ASC Topic 718, the grant date fair value of Dr. Payson s Class B Units was $0.36 per unit, the grant date fair value of Mr. Karkenny s Class B Units was $0.35 per unit and the grant date fair value for Messrs. Gallas and Greenleaf and Ms. Albery s 2009 Class B units was $0.28 per unit. Mr. Greenleaf s and Ms. Albery s 2010 Class B units had a grant date fair value of $0.44 per unit. Ms. Albery s 2011 B units had a grant date fair value of $0.55 per unit.

Pension Benefits for 2011

We do not offer pension benefits to our named executive officers.

Nonqualified Deferred Compensation for 2011

The following table provides information regarding activity in our nonqualified deferred compensation plan for the named executive officers during 2011.

Name	Executive Contributions in Last FY (1) ($)	Registrant Contributions in Last FY ($)	Aggregate Earnings in Last FY (1) ($)	Aggregate Withdrawals/ Distributions ($)	Aggregate Balance at Last FYE (1) ($)
Norman C. Payson, M.D.					
Chris A. Karkenny					
James G. Gallas					
Daniel A. Greenleaf	123,709		(1,735)		196,113
Harriet B. Albery					

(1) The amount in the Executive Contributions in Last FY column was reported in the Summary Compensation Table in the Salary column. The amount in the Aggregate Earnings in Last FY column has not been included in the Summary Compensation Table. Of the amount in the Aggregate Balance at Last FYE column, $68,285 was included in the Summary Compensation Tables for previous years.

Under our nonqualified deferred compensation plan, the participants may defer up to 50% of their salary, up to 100% of their annual bonus, and 100% of their annual 401(k) savings plan refund offset amount, the latter of which is an amount equal to their refund (if any) from our 401(k) savings plan. Returns on deferrals in an individual s account under the nonqualified deferred compensation plan are credited or debited based on the performance of hypothetical measurement funds selected by the individual, which selection can be changed as often as daily, from a menu of options offered in connection with the plan. We do not match amounts that are deferred by employees pursuant to the nonqualified deferred compensation plan.

An individual may choose to receive distributions in either a lump sum or in annual installments at death, retirement, or termination of employment with us or, in the event of an in-service distribution, at a date specified by the individual at least three years after the end of the year in which the deferral is made. An individual may also receive a distribution if he or she experiences an unforeseeable financial emergency, as defined in the nonqualified deferred compensation plan.

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Potential Payments Upon Termination or Change-in-Control

The following table describes the potential payments and benefits that would have been payable to our named executive officers under existing plans and contractual arrangements assuming (1) a termination of employment and (2) a change of control occurred on December 31, 2011. We have also separately described the amounts we agreed to pay to Mr. Gallas pursuant to the general release of claims agreement, dated as of January 20, 2012, which were consistent with the amounts to which he has entitled pursuant to his executive severance agreement.

The amounts shown in the table do not include payments and benefits to the extent they are provided generally to all salaried employees upon termination of employment and do not discriminate in scope, terms or operation in favor of the named executive officers. These include accrued salary, distributions of plan balances under our 401(k) savings plan and distributions of plan balances under the non-qualified deferred compensation plan. Furthermore, the amounts shown in the table do not include amounts that may be payable to a named executive officer upon the sale or purchase of his vested equity units pursuant to the exercise of the put or call rights described under Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in 2011 Table Terms of Equity Awards.

Name	Unpaid Annual Bonus ($)	Cash Severance Payment ($) (1)	Continuation of Group Health Plans ($) (2)	Total Termination Benefits (Excluding Accelerated Vesting of Equity Awards) ($) (3)
Norman C. Payson, M.D.				
Without Cause or as a result of Constructive Termination	441,883		14,924	456,807
Chris A. Karkenny				
Without Cause or as a result of Constructive Termination	279,859	2,650,000	27,366	2,957,225
Daniel A. Greenleaf				
Without Cause or with Good Reason		3,111,928		3,111,928
Harriet B. Albery				
Without Cause or with Good Reason		489,406		489,406

(1) Cash severance payment includes the following:

Mr. Karkenny (1) two times the sum of (x) his annual base salary rate of $475,000 and (y) his target annual bonus of $475,000 and (2) only in the event there has been a change of control within the preceding two years, $750,000 payable under the noncompetition agreement we entered into with him prior to the Merger;

Mr. Greenleaf (1) two times the sum of (x) his annual base salary rate of $580,000, (y) his target annual bonus of $580,000 and (z) an amount equal to the annual cost of providing him with a continuation of medical, dental and vision insurance under COBRA, including the cost of his participation in the senior executive medical and dental programs ($20,964) and (2) only in the event there has been a change of control within the preceding two years, $750,000 payable under the noncompetition agreement we entered into with him prior to the Merger; and

Ms. Albery (1) one times her annual base salary rate of $350,000, (2) the average of her actual bonus for 2009 and 2010 ($134,320) and (3) an amount equal to the annual cost of providing her with a continuation of medical, dental and vision insurance under COBRA ($5,086).

(2) Reflects the cost of providing the executive officer with a continuation of medical, dental and vision insurance under COBRA, including the cost of his participation in the senior executive medical and dental programs, for one year after termination in the case of Dr. Payson and for two years after termination in the case of Mr. Karkenny. We have included such costs because notwithstanding the specific contractual provisions in the applicable named executive officer s employment agreement or severance agreement, we would pay out such amounts in the event the named executive officers were terminated under the scenarios illustrated in the table above.

(3) If Dr. Payson were terminated by us without cause or by him as a result of constructive termination, an additional number of his time-vesting Class B Units of BP Healthcare equal to the number that would have vested over the 24-month period following the termination date would become immediately vested. Total termination benefits for Dr. Payson excludes the market value of 7,739,464 such unvested time-vesting Class B Units that would become immediately vested. Because there was no public market for the Class B Units of BP Healthcare as of December 31, 2011, the market value as of that date is not determinable.

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In addition, upon a change of control, our other named executive officers unvested time-vesting Class B Units of Holdings would become immediately vested. As of December 31, 2011, the number of Class B Units that were subject to acceleration of vesting upon a change of control was as follows: Mr. Karkenny 1,557,568; Mr. Greenleaf 1,616,415 and Ms. Albery 981,945. Because there was no public market for the Class B Units of Holdings as of December 31, 2011, the market value as of that date is not determinable. For purposes of FASB ASC Topic 718, the grant date fair value of each of Class B Unit of Holdings was $0.35 per unit for Mr. Karkenny and $0.28 per unit for Mr. Greenleaf and Ms. Albery. Mr. Greenleaf s and Ms. Albery s grant date fair value of each Class B Unit of Holdings was $0.44 for their 2010 grants. Ms. Albery s grant date fair value of each Class B Unit of Holdings was $0.55 for her 2011 grants.

Severance Arrangements

Norman C. Payson

Pursuant to the terms of Dr. Payson s employment agreement, if Dr. Payson s employment is terminated without cause by Apria or by him as a result of a constructive termination, Dr. Payson will be entitled to receive the following benefits:

- a pro rata portion of an annual bonus in respect of the year of termination; and
- continued coverage under our group health plans until the earlier of (x) 12 months from the date of his termination of employment with Apria and (y) the date he is or becomes eligible for comparable coverage under health plans of another employer.

The amounts payable to Dr. Payson upon a termination of employment described above are subject to Dr. Payson providing a release of all claims to us. Following termination without cause or as a result of a constructive termination, except as set forth above, Dr. Payson will have no further rights to any compensation or any other benefits under his employment agreement.

Furthermore, if Dr. Payson fails to comply with the non-competition, non-solicitation and confidentiality covenants contained in his employment agreement, we have the right to terminate the payments described above. The confidentiality covenant has an indefinite term, whereas the non-competition and non-solicitation covenants have terms of 12 and 24 months, respectively. The term of a particular covenant will be extended by the length of any period that Dr. Payson is in breach of such covenant; however, we have the right to waive a breach of any covenant by Dr. Payson.

In addition, pursuant to the terms of Dr. Payson s employment agreement, if Dr. Payson resigns, or we remove him, from the position of Chief Executive Officer of Apria and/or Sky Acquisition, and we terminate his employment agreement and enter into a services agreement with him, then we would pay him $500,000 per year for his services to Apria under the services agreement. Any such resignation by Dr. Payson does not constitute cause and any such removal by us does not constitute constructive termination under the terms of his employment agreement. See Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in 2011 Table Employment Agreements Norman C. Payson.

For purposes of Dr. Payson s employment agreement, cause means (1) Dr. Payson s willful and continued failure to substantially perform his duties to us or our affiliates (other than as a result of total or partial incapacity due to physical or mental illness or as a result of him resigning as our Chief Executive Officer); (2) his engagement in fraud or willful dishonesty (other than dishonesty that has no material detrimental impact on our reputation or business and our affiliates); (3) any act on the part of Dr. Payson that constitutes a felony (other than traffic offenses) or its equivalent under applicable non-U.S. law or (4) his material breach of the restrictive covenant provisions of the agreement; provided, further, that cause ceases to exist for an event on the 90th day following the later of its occurrence or the knowledge thereof by a majority of our Board of Directors, unless we or our affiliates have given him written notice thereof prior to such date.

For purposes of Dr. Payson s employment agreement, constructive termination means the occurrence of one of the following: (1) our failure to pay or cause to be paid Dr. Payson s base salary, annual bonus (if any) or reimbursable expenses when due; (2) except in certain circumstances, a reduction in his base salary or target annual bonus; (3) any substantial and sustained diminution in his authority or responsibilities; (4) any material breach by us of any material agreement with him; provided that none of these events shall constitute constructive termination unless we fail to cure such event within 30 days after receipt from him of written notice specifying in reasonable detail the event which constitutes constructive termination; provided, further, that constructive termination ceases to exist for an event on the 90th day following the later of its occurrence or his knowledge thereof, unless he has given Apria written notice thereof prior to such date.

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Chris A. Karkenny

Pursuant to the terms of Mr. Karkenny s employment agreement, if Mr. Karkenny s employment is terminated without cause by Apria or by him as a result of a constructive termination, Mr. Karkenny will be entitled to receive the following severance benefits:

- a pro rata portion of an annual bonus in respect of the year of termination;
- subject to his compliance with the restrictive covenants described below, an amount, payable over 24 months, equal to two times the sum of (x) his annual base salary and (y) his target annual bonus; and
- continued coverage under our group health plans until the earlier of (x) 24 months from his date of termination of employment with Apria and (y) the date he is or becomes eligible for comparable coverage under health plans of another employer.

The amounts payable to Mr. Karkenny upon a termination of employment described above are subject to Mr. Karkenny providing a release of all claims to us. Following termination without cause or as a result of a constructive termination, except as set forth above, Mr. Karkenny will have no further rights to any compensation or any other benefits under his employment agreement.

Furthermore, the payment of severance compensation equal to two times the sum of (x) his annual base salary and (y) his target annual bonus described above is contingent upon Mr. Karkenny s continued compliance with the non-competition, non-solicitation, non-disparagement and confidentiality covenants contained in his employment agreement. The confidentiality covenant has an indefinite term, and the non-competition, non-disparagement and non-solicitation covenants each have a term of eighteen months. The term of a particular covenant will be extended by the length of any period that Mr. Karkenny is in breach of such covenant.

In addition, pursuant to the terms of Mr. Karkenny s employment agreement, if Mr. Karkenny had terminated his employment prior to March 31, 2010, other than as a result of constructive termination or upon his death or disability, he would have been required to pay to us a portion of his $2,100,000 retention bonus equal to the amount by which $2,100,000 exceeds the product of (x) $140,000 and (y) the number of full months following January 1, 2009 that he was continuously employed by us.

For purposes of Mr. Karkenny s employment agreement, cause generally means that our Board of Directors has determined that Mr. Karkenny has (1) engaged in or committed willful misconduct; (2) engaged in or committed theft, fraud or other illegal conduct; (3) refused or demonstrated an unwillingness to substantially perform his duties for a 30-day period after written notice from Apria; (4) refused or demonstrated an unwillingness to reasonably cooperate in good faith with certain investigations; (5) engaged in or committed insubordination; (6) engaged in or committed any willful act that is injurious to our reputation or business; (7) willfully violated his fiduciary duty or his duty of loyalty to us or our Code of Ethical Business Conduct in any material respect; (8) used alcohol or drugs (other than prescribed drugs for their intended purpose) in a manner which materially and repeatedly interferes with the performance of his duties; or (9) engaged in or committed a material breach of his employment agreement for a 30-day period after written notification is delivered by us.

For purposes of Mr. Karkenny s employment agreement, constructive termination means the occurrence of one of the following: (1) our failure to pay or cause to be paid Mr. Karkenny s base salary, annual bonus (if any) or retention payments when due; (2) a reduction in Mr. Karkenny s retention payments, base salary or target annual bonus; (3) any substantial and sustained diminution in his authority or responsibilities; (4) a material reduction in, or the failure of Apria to provide in all material respects, the employee benefits to which he is entitled to or receiving as of the date hereof (excluding any reductions generally applicable to all senior executives); (5) a relocation of his principal place of business which will result in an increase by more than 30 miles in his one-way commute; (6) a reduction in his title or a material reduction in the nature, status or scope of his authorities, duties and/or responsibilities; (7) the failure of a successor employer to Apria to assume Mr. Karkenny s employment agreement in writing; (8) our delivery of a written notice to not extend the employment term; or (9) his not being the Executive Vice President and Chief Financial Officer of the operating entity following the occurrence of a change of control; provided that none of these events shall constitute constructive termination unless we fail to cure such event within 30 days after receipt from him of written notice specifying in reasonable detail the event which constitutes constructive termination; provided, further, that constructive termination shall cease to exist for an event on the 90th day following the later of its occurrence or his knowledge thereof, unless he has given Apria written notice thereof prior to such date.

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Daniel E. Greenleaf

Pursuant to the terms of Mr. Greenleaf s employment agreement, if Mr. Greenleaf s employment is terminated without cause by Apria or by him with good reason, Mr. Greenleaf will be entitled to receive a severance payment equal in the aggregate to:

> two times the sum of (x) his annual base salary at the rate in effect at the time of termination, (y) his target annual bonus (which will be equal to his annual base salary), and (z) an amount equal to the annual cost of providing him with a continuation of medical, dental and vision insurance under COBRA, including the cost of his participation in the senior executive medical and dental programs.

The amounts payable to Mr. Greenleaf upon a termination of employment described above shall be paid in periodic installments over a period of 24 months provided that Mr. Greenleaf executes a release of all claims to us. Such payments are also contingent upon Mr. Greenleaf s continued compliance with certain non-competition, non-solicitation, non-disparagement and confidentiality covenants contained in his employment agreement. The confidentiality covenant has an indefinite term, whereas the non-competition and non-solicitation covenants each have a term of 24 months and the non-disparagement covenant has a term of 12 months. If we believe that Mr. Greenleaf is in violation of the non-competition, non-solicitation, non-disparagement or confidentiality covenant after his termination, we may suspend all of the payments described above until he establishes that he is not in violation of such covenant. However, we also have the right to waive a breach of any covenant by Mr. Greenleaf.

For purposes of Mr. Greenleaf s employment agreement, cause generally means that our Board of Directors determines that the executive has done any of the following: (1) engaged in or committed willful misconduct; (2) engaged in or committed theft, fraud or other conduct constituting a felony (other than traffic related offenses or as a result of vicarious liability); (3) refused or demonstrated an unwillingness to substantially perform his duties for a 30-day period after written demand from Apria; (4) refused or demonstrated an unwillingness to reasonably cooperate in good faith with certain investigations; (5) engaged in or committed any willful act that is injurious to our business or reputation; (6) willfully violated his fiduciary duty or his duty of loyalty to us or our Code of Ethical Business Conduct in any material respect; (7) used alcohol or drugs (other than prescribed drugs for their intended purposes) in a manner which materially and repeatedly interferes with the performance of his duties or which has the effect of materially injuring our business or reputation; (8) failed to spend at least 60% of his non-traveling business days at our Lake Forest, California headquarters in any three-month period, if such failure is not cured within the subsequent two-month period following his receipt of a specified written notification from us; or (9) engaged in or committed a material breach of his amended and restated employment agreement for a 30-day period after written notice from Apria.

For the purposes of Mr. Greenleaf s employment agreement during a period that (1) begins with the first to occur of (x) the initial public announcement of a change of control or (y) the 90th day preceding a change of control and (2) ends two years following such change of control, cause generally means only the occurrence of either or both of the following: (A) Mr. Greenleaf s conviction for committing an act of fraud, embezzlement, theft, or other act constituting a felony (other than traffic related offenses or as a result of vicarious liability); or (B) the willful engaging by Mr. Greenleaf in misconduct that is significantly injurious to us. For purposes of the above clause (B) no act, or failure to act, on Mr. Greenleaf s part shall be considered willful unless done or omitted to be done, by him not in good faith or without reasonable belief that his action or omission was in the best interest of Apria.

For purposes of Mr. Greenleaf s employment agreement during the period that begins with the first to occur of (x) the initial public announcement of a change of control or (y) the 90th day preceding a change of control and ends two years following such change of control, good reason means, without the executive s written consent, the occurrence of any of the following: (1) a material reduction in the nature, status or scope of Mr. Greenleaf s authorities, duties, and/or responsibilities from their level in effect on the day immediately prior to the change of control; (2) a reduction in Mr. Greenleaf s base salary from its highest level in effect at any point in the three months preceding the change of control or a significant reduction in Mr. Greenleaf s aggregate incentive opportunities under our short and/or long-term incentive programs, as such opportunities exist immediately prior to the change of control; (3) our failure to maintain Mr. Greenleaf s relative level of coverage and accruals under our employee benefit and/or retirement plans, policies, practices or arrangements in which he participates immediately prior to the change of control; (4) Mr. Greenleaf is informed by us that his principal place of employment will be relocated to a location that will result in an increase of more than 30 miles in his one-way commute, except in connection with his commitment to spend a substantial majority of his time in our Lake Forest, California headquarters; or (5) we do not permit Mr. Greenleaf to continue to serve as our Chief Operating Officer or in another mutually acceptable senior executive position.

For purposes of Mr. Greenleaf s employment agreement, in circumstances unrelated to a change of control or subsequent to the expiration of the two-year period following a change of control, good reason generally means the

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occurrence of any one of the following events without Mr. Greenleaf s written consent: (1) Mr. Greenleaf s annual base salary is reduced, except for a one-time across-the-board salary reduction not exceeding 10% which is imposed simultaneously on all executive officers; (2) we require Mr. Greenleaf to be based at an office location which will result in an increase of more than 30 miles in his one-way commute, except in connection with his commitment to spend a substantial majority in our Lake Forest, California headquarters or in connection with any relocation of those headquarters; or (3) we do not permit Mr. Greenleaf to serve continue to serve as our Chief Operating Officer or in another mutually acceptable senior executive position.

Harriet B. Albery

Pursuant to the terms of Ms. Albery s severance agreement, either party may terminate Ms. Albery s employment at any time. If Ms. Albery s employment is terminated without cause by Apria or with good reason by Ms. Albery s, then the terminating party must give the other party at least 30 days advance written notice.

If Ms. Albery s employment is terminated without cause by us or terminated with good reason by Ms. Albery s, she will be entitled to receive a severance payment equal in the aggregate to the sum of:

her annual base salary at the rate in effect at the time of termination;

the average of her two most recent annual bonuses, if any, received prior to termination; and

an amount equal to the annual cost of providing her with a continuation of medical, dental and vision insurance under COBRA.

The amounts payable to Ms. Albery upon a termination of employment described above shall be paid in periodic installments over a period of 12 months provided that Ms. Albery executes a release of all claims to us. Such payments are also contingent upon Ms. Albery s continued compliance with certain non-competition, non-solicitation and confidentiality covenants contained in her employment agreement. The confidentiality covenant has an indefinite term, whereas the non-competition and non-solicitation covenants each have a term of 12 months. If we believe that Ms. Albery is in violation of the non-competition or non-solicitation covenant after her termination, we may suspend all of the payments described above until she establishes that she is not in violation of such covenants. However, we also have the right to waive a breach of any covenant by Ms. Albery.

For purposes of Ms. Albery s executive severance agreement, cause generally means that we have determined that Ms. Albery has (1) engaged in or committed willful misconduct; (2) engaged in or committed theft, fraud or other illegal conduct; (3) refused or demonstrated an unwillingness to substantially perform her duties after written notice from Apria; (4) refused or demonstrated an unwillingness to reasonably cooperate in good faith with certain investigations; (5) engaged in or committed insubordination; (6) engaged in or committed any willful act that is injurious to our reputation or business; (7) violated her fiduciary duty or her duty of loyalty to us or our Code of Ethical Business Conduct in any material respect; (8) used alcohol or drugs (other than prescribed drugs for their intended purpose) in a manner which materially and repeatedly interferes with the performance of her duties; or (9) engaged in or committed a material breach of her severance agreement.

Under her severance agreement, good reason generally means (1) the reduction of Ms. Albery s annual base salary (except in the case of certain reductions affecting all executive officers equally); (2) the addition of greater than 30 miles to Ms. Albery s one-way commute; or (3) our failure to require our successor to expressly assume and perform Ms. Albery s severance agreement. However, good reason will cease to exist under Ms. Albery s severance agreement if Ms. Albery agrees to any of the above conditions in writing, fails to terminate her employment within 120 days after the occurrence of such conditions, or if we remedy such conditions within 30 days after receipt of written notice (within 60 days of the initial existence of the condition from Ms. Albery).

James G. Gallas

In connection with his resignation as of January 20, 2012, we entered into a general release of claims agreement with Mr. Gallas pursuant to which we agreed to pay him a total of $991,795 in severance compensation, subject to standard withholding for federal and state taxes, which consists of the following components:

(1) $551,250, which is 100% of Mr. Gallas s annual base salary;

(2) $408,059, which is 100% of the average of the annual bonuses for the two most recently completed fiscal years ($547,055 for 2009 and $269,062 for 2010); and

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(3) $32,486, which is 100% of the annual cost of obtaining medical, dental and vision insurance under COBRA.

all of which is consistent with Mr. Gallas s severance agreement and shall be payable in accordance with Apria s regular payroll procedures in 26 consecutive bi-weekly installments over a 12-month period.

Such payments are contingent upon Mr. Gallas s continued compliance with certain non-competition, non-solicitation and confidentiality covenants contained in his severance agreement. The confidentiality covenant has an indefinite term, whereas the non-competition and non-solicitation covenants each have a term of 12 months. If we believe that Mr. Gallas is in violation of the non-competition or non-solicitation covenant after his termination, we may suspend all of the payments described above until he establishes that he is not in violation of such covenants. However, we also have the right to waive a breach of any covenant by Mr. Gallas.

As of January 20, 2012, Mr. Gallas was vested in respect of 706,226 of his Class B Units in Holdings and was vested in none of his Class C Units in Holdings, pursuant to his subscription agreements for such Units. All of Mr. Gallas s unvested Class B Units and all Class C Units were forfeited on January 20, 2012 with no consideration payable therefor. We will cause one of our affiliates to purchase, and Mr. Gallas (and any of his affiliates or family members, if applicable) will sell, all of the vested 706,226 Class B Units held by Mr. Gallas (and any of his affiliates or family members, if applicable), in exchange for a payment, on or before the 210th day following January 20, 2012, by us or such affiliate. The purchase price will be based on the product of (a) said number of vested Class B Units and (b) the Fair Market Value (as defined in the subscription agreements for such Units) per Class B Unit as of January 20, 2012, which has been determined to be $0.10 per Class B Unit.

Noncompetition Agreements

We have noncompetition agreements with Mr. Karkenny and Mr. Greenleaf that they entered into prior to the Merger. These noncompetition agreements provide for a payment of $750,000 upon a termination of the executive s employment with us either by us without cause or by the executive for good reason, in each case, during the period that begins with the first to occur of (1) the initial public announcement of a change of control or (2) the 90th day preceding a change of control and ends two years following such change of control. The payments under these noncompetition agreements are contingent upon the affected executive s compliance with the post-termination noncompetition covenant contained therein.

For purposes of the noncompetition agreements, during the period that begins with the first to occur of (x) the initial public announcement of a change of control or (y) the 90th day preceding a change of control, and ends two years following such change of control, cause means only the occurrence of either or both of the following: (1) the executive s conviction for committing an act of fraud, embezzlement, theft, or other act constituting a felony; or (2) the willful engaging by the executive in misconduct that is significantly injurious to us.

Good reason during the same period means the occurrence of any of the following: (1) a material reduction in the nature, status or scope of the executive s authorities, duties, and/or responsibilities from their level in effect on the day immediately prior to the change of control; (2) a reduction in the executive s base salary from its highest level in effect at any point in the three months preceding the change of control or a significant reduction in the executive s aggregate incentive opportunities under our short and/or long-term incentive programs, as such opportunities exist immediately prior to the change of control; (3) our failure to maintain the executive s relative level of coverage and accruals under our employee benefit and/or retirement plans, policies, practices or arrangements in which the executive participates immediately prior to the change of control; (4) the executive is informed by us that his principal place of employment will be relocated to a location that will result in an increase of more than thirty miles in the executive s one-way commute; and (5) for purposes of the employment agreements, we are not permitting the executive to continue to serve in a mutually acceptable senior executive position.

Director Compensation

On October 3, 2011, Mike S. Zafirovski was appointed to our Board of Directors. He is the only director who currently receives separate compensation for service on our Board of Directors. Our other directors receive no separate compensation for service on our Board of Directors or committees of our Board of Directors.

Mr. Zafirovski is entitled to an annual cash retainer of $100,000, payable quarterly, for his service as a director.

In connection with joining our Board of Directors, Mr. Zafirovski purchased 1,000,000 Class A-2 Units of Holdings and was granted 5,030,651 Class B Units of Holdings. The Class A-2 Units acquired by Mr. Zafirovski contain the following different economic terms than Holdings normal Class A-2 Units: Mr. Zafirovski paid $1.00 per unit. However, Mr. Zafirovski s special Class A-2 Units will not entitle him to receive any value above $1.00 per unit unless and until the value attributable to a regular Class A-2 Unit in Holdings exceeds $1.63 per unit, at which point the special Class A-2 Units

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will become entitled to receive $0.63 per unit and thereafter will become entitled to receive the same amount as regular Class A-2 Units.

The Class B Units granted to Mr. Zafirovski contain a special term that would require the value of Holdings Class A-2 Units to exceed $1.63 for him to receive any value, such that no payment would be made in respect of a Class B Unit if the value of a Class A-2 Unit fails to exceed $1.63. These Class B Units are divided into a time-vesting portion (1/3 of the Class B Units granted) and a target-based vesting portion (2/3 of the Class B Units granted).

The time-vesting Class B Units generally vest in equal parts on the first, second and third anniversaries of the grant date. These units will vest on a pro-rata basis based on the number of days before the applicable anniversary if Mr. Zafirovski s service on the Board of Directors is terminated by us without cause or as a result of his death or disability. In addition, these units will vest in full if a change in control of Holdings occurs while Mr. Zafirovski still serves as a director.

The target-based Class B Units granted to Mr. Zafirovski are divided into two categories, with vesting in each category based on our achievement of EBITDA (as defined in the credit agreement) targets and return on the investment of the Sponsor. The first category of the target-based Class B Units will vest if either of the following conditions is satisfied while Mr. Zafirovski continues to serve as a director (or within 24 months after termination by us of his service on the Board of Directors without cause): (1) we achieve a specified EBITDA target for each of fiscal year 2012 and fiscal year 2013; or (2) the Sponsor achieves a specified return on investment on or prior to December 31, 2014.

The second category of the target-based Class B Units will vest if both of the following conditions are satisfied while Mr. Zafirovski continues to serve as a director (or within 24 months after a termination by us of his service on the Board of Directors without cause): (1) we achieve a more challenging specified EBITDA target for either fiscal year 2012 or fiscal year 2013 (such year of achievement, the Subject Year); and (2) one of the following conditions is satisfied: (a) we achieve a more challenging specified EBITDA target for the fiscal year immediately succeeding the Subject Year; or (b) the Sponsor achieves a specified return on investment on or prior to December 31, 2014. We believe that the targets set for the target-based Class B Units are reasonable, although neither automatically nor easily achieved.

Director Compensation for 2011

Name	Fees Earned or Paid in Cash ($)	Stock Awards ($)	Option Awards ($)	Non-Equity Incentive Plan Compensation ($)	Change in Pension Value and Nonqualified Deferred Compensation Earnings	All Other Compensation ($)	Total ($)
Mike S. Zafirovski	24,658	2,766,858(1)					2,791,516

(1) The amount included in this column reflects the aggregate grant date fair value of $2,766,858 of Class B Units of Holdings granted to Mr. Zafirovski on October 3, 2011, calculated in accordance with FASB ASC Topic 718, excluding the effect of estimated forfeitures, utilizing the assumptions discussed in Note 8 to our financial statements for the year ended December 31, 2011. With respect to the performance-vesting Class B Units, the estimate of the grant date fair value determined in accordance with FASB ASC Topic 718 assumes the vesting of 100% of the units awarded. The values of the performance-vesting Class B Units at the grant date assuming achievement of the highest performance conditions are not determinable because there are no maximum performance conditions under the terms of Class B Units. See Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in 2011 Table Terms of Equity Awards Equity Units of Holdings Granted to Our Named Executive Officers Other than Our Chief Executive Officer. As of December 31, 2011, Mr. Zafirovski held 5,030,651 unvested Class B Units of Holdings.

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

Holdings owns 100% of the issued and outstanding common stock of Apria Finance Holdings Inc., which owns 100% of the limited liability company interests of Sky Acquisition LLC, which owns 100% of issued and outstanding common stock of the Issuer. The limited liability company interests of Holdings consist of Class A-1 Units, Class A-2 Units, Class B Units and Class C Units. Class A-1 and Class A-2 Units are equity interests in Holdings and have economic characteristics that are similar to those of shares of common stock in a corporation. The Class A-2 Units generally have the same voting and economic rights as Class A-1 Units, subject to certain restrictions and put and call rights applicable to units held by employees. Class B and Class C units are limited liability company profits interests having economic characteristics similar to stock appreciation rights and representing the right to share in any increase in the equity value of Holdings that exceeds specified thresholds. Class B Units and Class C Units are subject to different vesting schedules and other conditions including certain transfer restrictions and put and call rights applicable only to employees. For additional information, see Management Executive Compensation Compensation Discussion and Analysis Compensation Elements Long-Term Incentive Compensation , Management Executive Compensation Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards in 2011 Table Terms of Equity Award Grants and Certain Relationships and Related Party Transactions.

The following table sets forth information with respect to the beneficial ownership of the Class A-1 Units and Class A-2 Units of Holdings taken together as a single class, the Class B Units of Holdings, the Class C Units of Holdings, and the aggregate Class A-1 Units, Class A-2 Units, Class B Units and Class C Units taken together as a single class, in each case, as of March 5, 2012 for (i) each individual or entity known by us to own beneficially more than 5% of the aggregate Units, (ii) each of our named executive officers, (iii) each of our directors and (iv) all of our directors and our executive officers as a group.

The amounts and percentages of Units beneficially owned are reported on the basis of SEC regulations governing the determination of beneficial ownership of securities. Under SEC rules, a person is deemed to be a beneficial owner of a security if that person has or shares voting power or investment power, which includes the power to dispose of or to direct the disposition of such security. A person is also deemed to be a beneficial owner of any securities of which that person has a right to acquire beneficial ownership within 60 days. Securities that can be so acquired are deemed to be outstanding for purposes of computing such person s ownership percentage, but not for purposes of computing any other person s percentage. Under these rules, more than one person may be deemed to be a beneficial owner of the same securities and a person may be deemed to be a beneficial owner of securities as to which such person has no economic interest.

Except as otherwise indicated in the footnotes below, each of the beneficial owners has, to our knowledge, sole voting and investment power with respect to the indicated Class A-1 Units, Class A-2 Units, Class B Units and Class C Units. Unless otherwise noted, the address of each beneficial owner of is c/o Apria Healthcare Group Inc., 26220 Enterprise Court, Lake Forest, CA 92630.

Name and Address of Beneficial Owner	Class A Units Amount and Nature of Beneficial Ownership	Percent	Class B Units Amount and Nature of Beneficial Ownership	Percent	Class C Units Amount and Nature of Beneficial Ownership	Percent	Aggregate Amount and Nature of Beneficial Ownership	Percent
Blackstone Funds	673,333,333(1)	99.62%	42,457,196(1)	47.1%	671,863(1)	4.34%	716,462,392(2)	91.67%
Norman C. Payson, M.D.	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)
Chris A. Karkenny	500,000(4)	*	6,675,287	7.40%	2,225,096	14.38%	9,400,383	1.20%
Daniel E. Greenleaf			4,935,412	5.47%	1,645,137	10.63%	6,580,549	*
Harriet B. Albery			2,031,610	2.25%	677,204	4.38%	2,708,814	*
Neil P. Simpkins(5)								
Michael Dal Bello(6)								
Patrick J. Bourke(7)								
Mike S. Zafirovski(8)	1,000,000	*	5,030,651	5.58%			6,030,651	*
All Directors and Executive Officers as a Group (8 persons)	1,500,000(4)	*	18,672,960	20.7%	4,547,437	29.39%	24,720,397	3.16%

* Less than 1%.

(1) Units of Holdings shown as beneficially owned by the Blackstone Funds (as hereinafter defined) are held directly by BP Healthcare Holdings LLC (BP Holdings). Through BP Holdings, the Blackstone Funds beneficially own all of the Class A-1 Units of Holdings,

including (i) 388,296,685 Class A-1 Units in which Blackstone Capital Partners V L.P. (BCP V) has an economic interest, representing 57.45% of the Class A Units of Holdings, (ii) 101,814,701 Class A-1 Units in which Blackstone Capital Partners V-AC L.P. (BCP V-AC) has an economic interest, representing 15.06% of the Class A Units of Holdings, (iii) 2,051,801 Class A-1 Units in which Blackstone Family Investment Partnership V L.P (Family) has an economic interest,

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representing 0.30% of the Class A Units of Holdings, (iv) 895,435 Class A-1 Units in which Blackstone Participation Partnership V L.P. (Participation) has an economic interest, representing 0.13% of the Class A Units of Holdings, (v) 96,388,572 Class A-1 Units in which BCP V-S L.P. (BCP V-S) has an economic interest, representing 14.26% of the Class A Units of Holdings, (vi) 73,886,139 Class A-1 Units held by BCP V Co-Investors L.P. (BCP V Co-Investors, and collectively, the Blackstone Funds), representing 10.93% of the Class A Units of Holdings. Dr. Payson owns 10,000,000 Class A-2 Units and 38,697,318 Class B Units of BP Holdings. By virtue of the limited liability company agreement of BP Holdings, which provides that BCP V has the sole authority to appoint members of the board of directors of BP Holdings, BCP V may also be deemed to beneficially own 10,000,000 Class A-2 Units of Holdings, representing 1.48% of the Class A Units of Holdings, and 38,697,318 Class B Units of Holdings, representing 42.92% of the Class B Units of Holdings, held by BP Holdings in which Dr. Payson has an economic interest. Upon any redemption, cancellation or forfeiture of Class B Units or Class C Units of Holdings not held by BP Healthcare, the number of Class B Units or Class C Units of Holdings, as applicable, held by BP Healthcare increases on a one-for-one basis. Upon the grant of any Class B Units or Class C Units of Holdings to a recipient other than BP Healthcare, the number of Class B Units or Class C Units, as applicable, held by BP Healthcare, if any, decreases on a one-for-one basis. The general partner of BCP V, BCP V-AC, BCP V-S and BCP V Co-Investors is Blackstone Management Associates V L.L.C. BMA V L.L.C. is the sole member of Blackstone Management Associates V L.L.C. The general partner of Family and Participation is BCP V Side-By-Side GP L.L.C. Blackstone Holdings III L.P. is the managing member and majority in interest owner of BMA V L.L.C. and the sole member of BCP V Side-By-Side GP L.L.C. Blackstone Holdings III L.P. is indirectly controlled by The Blackstone Group L.P. and is owned, directly or indirectly, by Blackstone professionals and The Blackstone Group L.P. The Blackstone Group L.P. is controlled by its general partner, Blackstone Group Management L.L.C., which is in turn wholly owned by Blackstone s senior managing directors and controlled by its founder, Stephen A. Schwarzman. Each of such Blackstone entities and Mr. Schwarzman may be deemed to beneficially own the securities beneficially owned by the Blackstone Funds directly or indirectly controlled by it or him, but each disclaims beneficial ownership of such securities. The address of each of the entities listed in this note is c/o The Blackstone Group, L.P., 345 Park Avenue, New York, New York 10154.

(2) The securityholders agreement of Holdings provides (i) that each unit of Holdings owned by an employee will vote in the same proportion as the units held by BP Holdings LLC, (ii) that BP Holdings has the right to require each unit owned by an employee to participate in any transaction constituting a change of control or any other transaction involving a transfer of units owned by BP Holding to a third-party and (iii) generally restricts the transfer of each unit owned by an employee until the earliest of (x) six months following an initial public offering, (y) a change of control or (z) October 28, 2015. As a result, BP Holdings and BCP V may be deemed to beneficially own 100% of outstanding Units of Holdings. The units of Holdings held by employees that may be so deemed beneficially owned by BP Holdings and BCP V are not reported in the table above. For additional information, see Management Executive Compensation Compensation Discussion and Analysis Compensation Elements Long-Term Incentive Compensation and Certain Relationships and Related Party Transactions.

(3) Dr. Payson owns 10,000,000 Class A-2 Units and 38,697,318 Class B Units of BP Holdings. For additional information, see Note 8, Profit Interest Units, Share-Based Compensation and Stockholders Equity.

(4) Represents Class A-2 Units.

(5) Mr. Simpkins is a Senior Managing Director of The Blackstone Group. Mr. Simpkins disclaims beneficial ownership of any shares owned directly or indirectly by the Blackstone Funds. Mr. Simpkins address is c/o The Blackstone Group, L.P., 345 Park Avenue, New York, New York 10017.

(6) Mr. Dal Bello is a Managing Director of The Blackstone Group. Mr. Dal Bello disclaims beneficial ownership of any shares owned directly or indirectly by the Blackstone Funds. Mr. Dal Bello s address is c/o The Blackstone Group, L.P., 345 Park Avenue, New York, New York 10017.

(7) Mr. Bourke is an Operating Partner in the Private Equity Group of The Blackstone Group. Mr. Bourke disclaims beneficial ownership of any shares owned directly or indirectly by the Blackstone Funds. Mr. Bourke s address is c/o The Blackstone Group, L.P., 345 Park Avenue, New York, New York 10017.

(8) Mr. Zafirovski owns 1,000,000 Class A-2 Units of Holdings and 5,030,651 Class B Units of Holdings. The vesting terms of Mr. Zafirovski s Class B Units of Holdings are described above under Director Compensation. Mr. Zafirovski is a Senior Advisor to The Blackstone Group. Mr. Zafirovski disclaims beneficial ownership of any shares owned directly or indirectly by the Blackstone Funds. Mr. Zafirovski s address is c/o The Blackstone Group, L.P., 345 Park Avenue, New York, New York 10017.

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

Transaction and Management Fee Agreement

In connection with the Merger, Merger Sub entered into a transaction and management fee agreement with Blackstone Management Partners V L.L.C. (BMP). The Company succeeded to and assumed the rights and obligations of Merger Sub pursuant to the transaction and management fee agreement upon the closing of the Merger. Under the transaction and management fee agreement, Merger Sub agreed to pay BMP, at the closing of the Merger, an $18.7 million transaction fee in consideration for BMP undertaking financial and structural analysis, due diligence and other assistance in connection with the Merger. In addition the Company agreed to reimburse BMP for any out-of-pocket expenses incurred by BMP and its affiliates in connection with the Merger and the provision of services under the transaction and management fee agreement.

In addition, under this agreement, BMP (including through its affiliates) agreed to provide services, including without limitation, (a) advice regarding the structure, distribution and timing of debt and equity offerings and advice regarding relationships with the Company s lenders and bankers, (b) advice regarding the business and strategy of the Company, including compensation arrangements, (c) advice regarding dispositions and/or acquisitions and (d) such advice directly related or ancillary to the above financial advisory services as may be reasonably requested by the Company. In consideration for the services, the Company pays BMP at the beginning of each fiscal year a management fee equal to the greater of $7.0 million or 2.0% of the Company s consolidated EBITDA, as defined in the agreement, for the immediately preceding fiscal year. BMP shall have no obligation to provide any other services to the Company absent express agreement. In addition, in the absence of an express agreement to provide investment banking or other financial advisory services to the Company, and without regard to whether such services were provided, BMP is entitled to receive a fee equal to 1.0% of the aggregate transaction value upon the consummation of any acquisition, divestiture, disposition, merger, consolidation, restructuring, refinancing, recapitalization, issuance of private or public debt of equity securities (including an initial public offering of equity securities), financing or similar transaction by the Company.

At any time in connection with or in anticipation of a change of control of the Company, a sale of all or substantially all of the Company s assets or an initial public offering of common equity of the Company or its successor, BMP may elect to receive, in consideration of BMP s role in facilitating such transaction and in settlement of the termination of the services, a single lump sum cash payment equal to the then-present value of all then-current and future annual management fees payable under the transaction and management fee agreement, assuming a hypothetical termination date of the agreement to be the twelfth anniversary of such election. The transaction and management fee agreement will continue until the earlier of the twelfth anniversary of the date of the agreement or such date as the Company and BMP may mutually determine. The Company has agreed to indemnify BMP and its affiliates, directors, officers, employees, agents and representatives from and against all liabilities relating to the services contemplated by the transaction and management fee agreement and the engagement of BMP pursuant to, and the performance of BMP and its affiliates of the services contemplated by, the transaction and management fee agreement.

Limited Liability Company Agreements, Securityholders Agreements and Subscription Agreements of Sky Acquisition and BP Holdings

In connection with the Merger, certain funds affiliated with the Sponsor and Dr. Payson entered into a limited liability company agreement with BP Holdings setting forth the economic and governance rights of the holders of units representing limited liability company membership interests of BP Holdings. In addition, BP Holdings, Mr. Karkenny and other members of our management entered into a limited liability company agreement with Sky Acquisition setting forth the economic and governance rights of the holders of units representing limited liability company membership interests of Sky Acquisition. The limited liability company agreements of BP Holdings and Sky Acquisition include provisions governing the appointment of the directors and officers of BP Holdings and Sky Acquisition, the distributions to the members of BP Holdings and Sky Acquisition, and other corporate governance provisions and indemnification provisions.

In connection with their subscription for equity units of BP Holdings, certain funds affiliated with the Sponsor and Dr. Payson entered into securityholders and subscription agreements with BP Holdings. In addition, BP Holdings, Mr. Zafirovski, Mr. Karkenny and other members of our management entered into securityholders and subscription agreements with Sky Acquisition in connection with their subscription for equity units of Sky Acquisition. The securityholders and subscription agreements contain certain rights and obligations of the parties thereto with respect to voting, transfer restrictions and rights, including tag-along rights, drag-along rights, registration rights and rights of first refusal, and certain other matters.

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In March 2010, we conducted a reorganization pursuant to which we added two new companies, Holdings and Apria Finance, to our corporate structure. Upon the completion of the reorganization, Holdings became a company beneficially owned by the Sponsor and other members of the Investor Group and all of the equity securities of Sky Acquisition held by such holders were converted or exchanged into equivalent securities of Holdings. In connection with the reorganization, the security holders and subscription agreements with Sky Acquisition were assigned to Holdings.

Intelenet Agreement

In May 2009, the Company entered into the Master Service Agreement (Intelenet Agreement) with Intelenet Global Services Private Limited (Intelenet), an Indian company affiliated with the Sponsor, regarding the outsourcing of certain functions relating to billing, collections and other administrative and clerical services. On May 31, 2011, it was announced that an affiliate of the Sponsor, along with other shareholders of Intelenet, agreed to sell Intelenet to Serco Group PLC, an international services company. The transaction closed in July 2011, but the affiliate of the Sponsor may receive additional payments based on Intelenet s performance through 2013. During the year ended December 31, 2011, the Company paid approximately $22.5 million to Intelenet.

Equity Healthcare Agreement

Effective as of January 1, 2010, the Company entered into an employer health program agreement with Equity Healthcare LLC (Equity Healthcare), an affiliate of the Sponsor, pursuant to which Equity Healthcare will provide to the Company certain negotiating, monitoring and other services in connection with our health benefit plans. In consideration for Equity Healthcare s services, the Company will pay Equity Healthcare a fee of $2 per participating employee per month (the PEPM Fee). As of December 31, 2011, the Company had approximately 8,400 employees enrolled in Equity Healthcare health benefit plans.

Equity Healthcare may also receive a fee (Health Plan Fees) from one or more of the health plans with whom Equity Healthcare has contractual arrangements if the total number of employees joining such health plans from participating companies exceeds specified thresholds. If and when Equity Healthcare reaches the point at which the aggregate of its receipts from the PEPM Fee and the Health Plan Fees have covered all of its allocated costs, it will apply the incremental revenues derived from all such fees to (a) reduce the PEPM Fee otherwise payable by us; (b) avoid or reduce an increase in the PEPM Fee that might otherwise have occurred on contract renewal; or (c) arrange for additional services to us at no cost or reduced cost.

Equity Healthcare is an affiliate of Blackstone, with whom Neil P. Simpkins, Michael Dal Bello, Patrick J. Bourke III and Mike S. Zafirovski, members of our Board, are affiliated and in which they may have an indirect pecuniary interest.

Expense Reimbursement

Pursuant to the terms of Dr. Payson s employment agreement, we reimbursed Dr. Payson for his private airplane operating expenses relating to business travel in the amount of $637,206 during 2011. See Management Executive Compensation Narrative Disclosure to Summary Compensation Table and Grants of Plan-Based Awards Employment Agreements Norman C. Payson for a description of Dr. Payson s employment agreement.

Procedures with Respect to Review and Approval of Related Person Transactions

The Board of Directors has not adopted a formal written policy for the review and approval of transactions with related persons. However, the Board of Directors reviews and approves transactions with related persons as appropriate.

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ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

Disclosure of Fees Paid to Independent Registered Public Accounting Firm

Aggregate fees billed to the Company for the fiscal year ended December 31, 2011 and 2010 represent fees billed by the Company s principal independent registered public accounting firm, Deloitte & Touche LLP, the member firms of Deloitte Touche Tohmatsu, and their respective affiliates, which includes Deloitte Consulting (collectively, Deloitte & Touche).

	Year Ended	
Fee Category	**2011**	**2010**
Audit Fees(a)	1,065,675	1,386,000
Audit-Related Fees(b)	578,203	408,820
Total Audit and Audit Related Fees	1,643,878	1,794,820
Tax Fees(c)	897,186	432,245
All Other Fees		
Total	$ 2,541,064	$ 2,227,065

(a) Audit Fees primarily consisted of audit work performed for the preparation of the Company s annual consolidated financial statements and reviews of interim consolidated financial information and in connection with regulatory filings.

(b) Audit-Related Fees consisted primarily of fees paid for accounting consultation services related to various projects.

(c) Tax Fees include tax compliance, planning and support services.

The audit committee pre-approves all audit and non-audit services provided by its independent registered public accounting firm. The audit committee considered whether the non-audit services rendered by Deloitte & Touche were compatible with maintaining Deloitte & Touche s independence as the independent registered public accounting firm of the Company s consolidated financial statements and concluded they were.

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PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) Exhibits

Exhibit No.	Description
2.1*	Agreement and Plan of Merger, dated as of June 18, 2008, by and among Apria Healthcare Group Inc., Sky Acquisition LLC and Sky Merger Sub Corporation
3.1**	Second Amended and Restated Certificate of Incorporation of Apria Healthcare Group Inc.
3.2**	Amended and Restated Bylaws of Apria Healthcare Group Inc.
4.1**	Indenture, dated as of May 27, 2009 (the Indenture), among Apria Healthcare Group Inc., the guarantors thereto and U.S. Bank National Association, as trustee.
4.2**	First Supplemental Indenture, dated as of August 13, 2009, among Apria Healthcare Group Inc., the guarantors thereto and U.S. Bank National Association, as trustee
4.3**	Second Supplemental Indenture, dated as of July 13, 2010, among Apria Healthcare Group Inc., the guarantors thereto and U.S. Bank National Association
4.4	Third Supplemental Indenture, dated as of August 8, 2011, among Apria Healthcare Group Inc., the guarantors thereto and U.S. Bank National Association, as trustee
4.5**	Form of Note (attached as exhibit to Exhibit 4.1)
10.1**	Transaction and Management Fee Agreement, dated as of October 28, 2008, among Apria Healthcare Group Inc. (as successor to Sky Merger Sub Corporation) and Blackstone Management Partners V L.L.C.
10.2**+	Master Service Agreement (the Master Service Agreement), dated as of May 14, 2009, between Apria Healthcare Group Inc. and Intelenet Global Services Private Limited, and amendments thereto
10.3**+	Amendment No. 1 to the Master Service Agreement, dated as of September 18, 2009
10.4**	Employment Agreement, dated November 21, 2008, among Norman C. Payson, Apria Healthcare Group Inc. and BP Healthcare Holdings LLC
10.5**	Employment Agreement, dated December 19, 2008, between Chris A. Karkenny and Apria Healthcare Group Inc.
10.6**	Amended and Restated Executive Severance Agreement, dated as of March 10, 2009, between James Gallas and Apria Healthcare Group Inc.
10.7***	Amended and Restated Employment Agreement, dated as of November 30, 2010 between Daniel E. Greenleaf and Apria Healthcare Group Inc.
10.8**	Amended and Restated Noncompetition Agreement, dated as of March 7, 2007, between Apria Healthcare Group Inc. and Chris A. Karkenny
10.9**	Amended and Restated Noncompetition and Nonsolicitation Agreement, dated as of October 24, 2008, between Apria Healthcare Group Inc. and Daniel E. Greenleaf
10.10	Summary of revised compensation arrangements between Apria Healthcare Group Inc. and Daniel E. Greenleaf
10.11	Second Amended and Restated Executive Severance Agreement dated as of May 16, 2011, between Apria Healthcare Group Inc. and Harriet B. Albery
10.12**	Management Unit Subscription Agreement (Class B Units), dated as of November 21, 2008, between Norman C. Payson and BP Healthcare Holdings LLC
10.13**	

	Management Unit Subscription Agreement (Class A-2 Units, Class B Units and Class C Units), dated as of December 19, 2008, between and Chris A. Karkenny and Sky Acquisition LLC
10.14**	Form of Management Unit Subscription Agreement for Class B Units and Class C Units of Apria Holdings
10.15**	Assignment and Assumption Agreement, dated as of March 25, 2010, between Sky Acquisition LLC and Apria Holdings LLC
10.16**	Form of Annual Executive Bonus Plan of Apria Healthcare Group Inc.

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Exhibit No.	Description
10.17****	Amended and Restated Credit Agreement, dated as of August 8, 2011 (the ABL Credit Agreement), among Apria Healthcare Group Inc., Sky Acquisition LLC, the other borrowers party thereto, Bank of America, N.A. as administrative agent and collateral agent thereunder (the ABL Collateral Agent), and the other agents and lenders parties thereto
10.18**	Guaranty, dated as of October 28, 2008 (the ABL Guaranty), among Sky Acquisition LLC, certain subsidiaries of Sky Acquisition LLC from time to time party hereto and the ABL Collateral Agent
10.19**	Supplement No. 1 to the ABL Guaranty, dated as of July 13, 2010
10.20**	Security Agreement, dated as of October 28, 2008 (the ABL Security Agreement), among Sky Acquisition LLC, Sky Merger Sub Corporation, Apria Healthcare Group Inc., the other grantors party thereto and the ABL Collateral Agent
10.21**	Supplement No. 1 to the ABL Security Agreement, dated as of July 13, 2010
10.22****	Affirmation of Guaranties, Collateral Documents and Intercreditor Agreement and Consent to Amendment and Restatement, dated as of August 8, 2011, among Apria Healthcare Group Inc., Sky Acquisition LLC, the other borrowers party thereto and the ABL Collateral Agent
10.23**	Security Agreement, dated as of October 28, 2008 (the Notes Security Agreement), among Sky Acquisition LLC, Sky Merger Sub Corporation, Apria Healthcare Group Inc., the other grantors party thereto and Bank of America, N.A. as Collateral Agent
10.24**	Supplement No. 1 to the Notes Security Agreement, dated as of July 13, 2010, among U.S. Bank National Association, as collateral agent, and the grantors party thereto
10.25	Supplement No. 2 to the Notes Security Agreement, dated as of August 8, 2011, among U.S. Bank National Association, as collateral agent, and the grantors party thereto
10.26**	Lien Subordination and Intercreditor Agreement, dated as of October 28, 2008, among the ABL Collateral Agent, the Term Debt Collateral Agent, Sky Acquisition LLC, Sky Merger Sub Corporation, Apria Healthcare Group Inc., and the Guarantors party thereto
10.27	Intercreditor and Collateral Agency Agreement, dated as of May 27, 2009, among Apria Healthcare Group Inc., Bank of America, N.A. as Collateral Agent and U.S. Bank National Association as Trustee++
12.1	Computation of Ratio of Earnings to Fixed Charges
21.1	Subsidiaries of Apria Healthcare Group Inc.
31.1	Certification (pursuant to Securities Exchange Act Rule 13a-14a) by Chief Executive Officer.
31.2	Certification (pursuant to Securities Exchange Act Rule 13a-14a) by Chief Financial Officer.
32.1	Section 1350 Certification (pursuant to Section 906 of the Sarbanes-Oxley Act of 2002) by Chief Executive Officer.
32.2	Section 1350 Certification (pursuant to Section 906 of the Sarbanes-Oxley Act of 2002) by Chief Financial Officer.
101	The following material from Apria Healthcare Group Inc s Annual Report on Form 10-K for the year ended December 31, 2011, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets as of December 31, 2011 and December 31, 2010, (ii) Consolidated Statements of Operations for each of the three years in the period ended December 31, 2011, (iii) Consolidated Statements of Stockholders Equity for each of the three years in the period ended December 31, 2011, (iv) Consolidated Statements of Cash Flows for each of the three years in the period ended December 31, 2011 and (v) Notes to the Consolidated Financial Statements.

* Incorporated by reference to Current Report on Form 8-K, dated June 18, 2008, filed on June 20, 2008.
** Incorporated by reference to Registration Statement on Form S-4 (File No. 33-0488566) of the Company.
*** Incorporated by reference to Annual Report on Form 10-K for the year ended December 31, 2010.
**** Incorporated by reference to Quarterly Report on Form 10-Q, for the quarterly period ended June 30, 2011.
\+ Portions of this exhibit have been omitted pursuant to a request for confidential treatment.
++ On August 13, 2009, U.S. Bank National Association succeeded Bank of America, N.A. as the Notes collateral agent.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Act of 1934, the registrant has duly caused this Annual Report to be signed on its behalf by the undersigned, thereunto duly authorized, in the City of Lake Forest, State of California, on March 30, 2012.

APRIA HEALTHCARE GROUP INC.

By: /S/ NORMAN C. PAYSON, M.D.
Name: Norman C. Payson, M.D.
Title: Executive Chairman of the Board of Directors

and Chief Executive Officer

Pursuant to the requirements of the Securities Act of 1934, this Annual Report has been signed by the following persons in the capacities and on the dates indicated.

Signature	Title	Date
/S/ NORMAN C. PAYSON, M.D. Norman C. Payson, M.D.	Executive Chairman of the Board of Directors and Chief Executive Officer (Principal Executive Officer)	March 30, 2012
/S/ CHRIS A. KARKENNY Chris A. Karkenny	Executive Vice-President and Chief Financial Officer (Principal Financial Officer)	March 30, 2012
/S/ PETER A. REYNOLDS Peter A. Reynolds	Chief Accounting Officer and Controller (Principal Accounting Officer)	March 30, 2012
/S/ NEIL P. SIMPKINS Neil P. Simpkins	Director	March 30, 2012
/S/ MICHAEL DAL BELLO Michael Dal Bello	Director	March 30, 2012
/S/ PATRICK J. BOURKE III Patrick J. Bourke III	Director	March 30, 2012
/S/ MIKE S. ZAFIROVSKI Mike S. Zafirovski	Director	March 30, 2012